This is to certify that the

dissertation entitled

The Implications of Separation-Individuation Difficulties and Parent Eating Preoccupation for Disordered Eating in Late Adolescent Women

presented by

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has been accepted towards fulfillment
of the requirements for

Ph.D. degree in Psychology

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Date 12/2/94

THE IMPLICATIONS OF SEPARATION-INDIVIDUATION DIFFICULTIES AND PARENT EATING PREOCCUPATION FOR DISORDERED EATING IN LATE ADOLESCENT WOMEN

By

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A DISSERTATION

Submitted to
Michigan State University
in partial fulfillment of the requirements
for the degree of

DOCTOR OF PHILOSOPHY

Department of Psychology

1994

ABSTRACT

THE IMPLICATIONS OF SEPARATION-INDIVIDUATION DIFFICULTIES AND PARENT EATING PREOCCUPATION FOR DISORDERED EATING IN LATE ADOLESCENT WOMEN

By

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The present investigation sought to determine whether difficulties in the separation-individuation process in relation to mothers and fathers are associated with disordered eating specifically, and adjustment problems more generally, in late adolescent women. In addition, it explored whether adolescents' perceptions of their parents' eating and weight preoccupation increase the risk for disordered eating, in the context of problems with separation-individuation. Specifically, this research measured a number of aspects of autonomy versus dependency in relationships with parents in college women through a semi-structured interview and several self-report questionnaires. In addition, participants' reports of eating and adjustment problems were assessed using self-report questionnaires, and a new measure (Parent Eating Attitudes Scale) was developed to assess perceptions of their parents' preoccupation with eating, food, and weight. Participants were 79 women ages 17 to 22; 40 received scores at or above the clinical cutoff on a measure of eating pathology (disordered eating group), and 39 received scores that are not indicative of eating problems (comparison group).

Results indicated that perceptions of both mother's and father's preoccupation with their own and their daughter's eating and weight were direct predictors of daughter's eating pathology. However, the results

regarding autonomy from mothers versus fathers were somewhat different. Separation-individuation difficulties in relation to fathers appeared to be more pathognomic for disordered eating than similar difficulties with mothers. In the relationship with mothers, low levels of autonomy were predictive of adjustment problems, rather than eating disturbance. Several interaction effects were also found, and indicated that at least some types of autonomy may be associated with both risks and benefits for late adolescent women. The findings suggest that, although often overlooked, fathers play an important role in the development of disordered eating in late adolescent women, both with regard to their attitudes about eating and weight, and in the level of autonomy daughters experience in their relationships with their fathers.

ACKNOWLEDGMENTS

First, my thanks go to Susan Frank, my chairperson and mentor, for her guidance, constant encouragement, and invaluable assistance. She has challenged me, been available to me, and through her energy and enthusiasm, has intensified my interest in research. I would also like to thank the other members of my dissertation committee, Ellen Strommen, Elaine Donelson, and Jacqueline Lerner, who have been inspirational through their own interests and work in female and adolescent development.

I would like to express my sincere appreciation to Carla Monestere and Lisa Crandell, without whose help and contributions I could not have completed this project. The assistance of Jackie Dean, Audrey Duncan, Allison Pollan, Tonya Walaskay, and Jodi Wildrom was also invaluable; their reliability and competence assured the smooth operation of this project. I am also very grateful to the women who participated in this study and shared their experiences so willingly and openly.

Finally, I would like to acknowledge all of my family members for their unwavering confidence and encouragement. I wish to express my deepest appreciation to my husband, JohnWalker, for his constant support, caring, and faith in me, for being someone I can count on, and for always being there, through even the most difficult times. My infinite thanks go to my parents for all they have given me, but especially for giving me both "roots" and "wings".

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Introduction

Problematic eating behavior, excessive weight concerns, body dissatisfaction, and even full-blown eating disorders have become increasingly serious problems in college populations within the last few decades. In fact, researchers have noted that dieting and disturbed eating behaviors are so common among college women that they are actually the norm, rather than the exception (Mintz & Betz, 1988; Polivy & Herman, 1987; Thompson & Schwartz, 1982). Many theorists have offered sociocultural explanations for the prevalence of dieting and weight concerns among adolescent females, and societal factors no doubt "set the stage" for body and weight preoccupation. However, theories that include variables at an individual or family level of analysis are needed in order to understand which women actually develop eating disorders in the context of a social environment that places a high value on thinness and attractiveness for females.

Psychoanalytic and family systems theorists typically focus on parent-child and family relationships in etiological discussions of eating disorders. A common theme that joins most of these theories is the primary role played by separation-individuation issues (Amdur, Tucker, Detre & Markhus, 1969; Bruch, 1973; Minuchin, Rosman, & Baker, 1978). Although the pictures that are painted of anorexic families as opposed to bulimic families differ in potentially important ways (differences that may account for the distinctive disturbed eating patterns), both family environments appear to contribute to the failure of the eating disordered

daughter to become truly independent from her family and gain a sense of autonomy.

There is some empirical evidence that autonomy from parents may be as important in subclinical populations as it is in clinical populations. However, because eating symptomatology in college women is not always pathognomic, and may in fact be quite transitory (Thelen, Farmer, Mann & Pruitt, 1990), it is important to identify factors that predict severity and chronicity as well as prevalence of eating problems in subclinical populations. Frank & Jackson-Walker (in press) reported that risk for severe eating pathology in college women (defined as the association between eating symptoms and specific forms of personality dysfunction) is greater among women reporting higher levels of dependency on their parents. Yet, dependency on parents has been associated with a number of other problems for college women in addition to eating disorders, so that separation-individuation problems may be indicative of broader difficulties in adjustment. Hence, it is also important to determine which factors, in the context of separation difficulties, lead a woman to develop an eating disorder rather than a different symptom or type of pathology.

As it appears that both family and sociocultural factors are implicated in eating problems, it is likely that the interplay between the two is critical. When the family strongly endorses society's attitudes about thinness in women, or family members (especially parents) are themselves caught up in struggles surrounding weight, dieting, and food, it is conceivable that the risk of developing an eating disorder as a response to family dysfunction is increased.

The purpose of the current study is to investigate these issues empirically in order to determine the impact of problems in separation-

individuation in the parent-adolescent relationship, as well as the family's attitudes about weight and dieting, on the development of disordered eating in late adolescent women. Specifically, this research measured experiences of autonomy versus dependency in relation to parents in college women (N=80) through a semi-structured interview and several self-report questionnaires. Forty of the women received scores at or above the clinical cutoff on a measure of eating pathology (disordered eating group), and 40 received scores that are not indicative of eating problems (comparison group). In addition, participants' reports of adjustment problems and perceptions of their parents' attitudes about eating, food, and weight were assessed using self-report questionnaires.

Distinctions between Anorexia Nervosa and Bulimia

At this point, it is necessary to distinguish between the two primary types of eating disorders that occur in adolescent and young adult women. Anorexia nervosa and bulimia are defined in the Diagnostic and Statistical Manual of Mental Disorders-Third edition-Revised (DSM-III-R) as separate and distinct categories. Diagnostic criteria for anorexia nervosa are as follows: refusal to maintain body weight over a minimal normal weight for age and height (15% below expected body weight); intense fear of gaining weight or becoming fat, even though underweight; distorted body image; and amenorrhea in females. The essential features of bulimia include: recurrent episodes of binge eating (minimum of two binge eating episodes a week for at least three months); feeling of lack of control over eating behavior during binges; self-induced vomiting, use of laxatives or diuretics, strict dieting or fasting, or vigorous exercise in order to prevent weight

gain; and persistent overconcern with body shape and weight (American Psychiatric Association, 1987).

It is important to note and keep in mind that, although bulimia and anorexia nervosa are separate diagnostic categories, bulimic and anorexic symptomatology are not mutually exclusive. Often, symptoms of both disorders are expressed, and many times, females who initially exhibit bulimic symptomatology become anorexic or those who initially exhibit anorexic symptoms later become bulimic. For this reason, the term "bulimic-anorexic" has been used to refer to women who exhibit aspects of both disorders, i.e. those who have bulimic symptoms but have also lost the amount of weight required for a diagnosis of anorexia (15% of body weight). Although there appear to be many similarities between anorexics and bulimics, particularly with regard to underlying weight concerns and body dissatisfaction, important differences have been found at the individual, interpersonal, and family levels. A number of studies comparing anorexic, bulimic, and bulimic-anorexic groups have indicated that bulimic-anorexic women are more similar to normal-weight bulimics than to restricting anorexics, in personality style and family functioning (Garner, Garfinkel & O'Shaughnessy, 1985; Shisslak, McKeon & Crago, 1990; Strober, 1981).

In non-clinical populations, these distinctions are less clear and there may be even more overlap between types of eating disorders. Mintz & Betz (1988), in a study of college women, provide some evidence that there is a continuum of eating pathology, ranging from normal eating, to subthreshold or atypical eating disorders, to anorexia or bulimia. Probably for these reasons, studies of eating problems in college student samples commonly explore the severity of more generalized "eating disturbance"

and other characteristics associated with eating disorders, rather than making distinctions between anorexia and bulimia.

A variety of theories have addressed risk factors and etiological contributions to eating disorders, and to anorexia and bulimia specifically. Perhaps the first issue to address, in providing a theoretical framework for understanding factors that increase the risk of developing these disorders, is the pervasiveness of eating problems and weight concerns in young women.

Sociocultural Influences

Because eating disorders occur almost exclusively among adolescent and young adult females, and they have been increasing in prevalence over the past several decades, it is important to explore the contribution of sociocultural factors to the development of these disorders. Societal attitudes towards women and the female body provide a backdrop for pervasive overconcern with body image and weight in girls and women. Throughout history, women's bodies have been viewed as objects of beauty, and there has been pressure on women to strive toward the ideal body image of the period (Orbach, 1986; Striegel-Moore, Silberstein & Rodin, 1986). In the more recent past, the ideal body image for women and the models held up for women to emulate, have become increasingly thinner. However, while society and the media have provided encouragement for women to reduce their weight, the average weight for a young woman has actually been increasing (Garner, Garfinkel, Schwartz & Thompson, 1980), moving women even farther from society's ideal. These sociocultural factors no doubt play a major role in the pervasiveness of dieting and body dissatisfaction in adolescent girls and college-age women, and it is likely

that these factors are especially influential for women who develop full-fledged eating disorders.

Some empirical evidence for the contention that societal factors play a role in the development of eating disorders is provided by Garner & Garfinkel (1980), who found that women who experienced greater demands for thinness and dieting by virtue of their career choice (dance or modelling) were at higher risk for anorexia and subclinical types of anorexia than were normal controls. In addition, several studies demonstrated that bulimics endorsed societal beliefs about female thinness and attractiveness to a higher degree than did other college women, including those reporting subclinical levels of eating symptomatology (Mintz & Betz, 1988; Striegel-Moore et al., 1986). Similarly, in a non-clinical sample of college females, Timko, Striegel-Moore, Silberstein & Rodin (1987) found that level of eating symptomatology was associated with the importance the participants placed on appearance. Steiner-Adair (1990) interviewed high school girls regarding their perceptions of societal and their own ideal images of women. One pattern that emerged from these interviews was labeled the "Super Woman pattern", in which the societal ideal image of women included being autonomous and successful, as well as thin and beautiful. The girls who described this pattern and identified it as their <u>own</u> ideal image were more likely to report disordered eating than girls who rejected these societal ideal images for themselves.

Feminist theories also point to societal and sex-role linked pressures as central to the development and increasing prevalence of eating disorders among females. Orbach (1986) discussed two major societal demands for women that can be linked to eating disorders. She suggested that, consistent with society's dictates, women's identities and feelings of self-

worth are equated with their image of their bodies. Consequently, in this society, a positive self-image is dependent on the extent to which women perceive themselves as attractive and thin. The resulting body insecurity and instability in self-image are, in turn, reinforced by society, media, and the weight control industry (Striegel-Moore et al, 1986). Compounding the demands regarding their bodies are demands regarding women's roles in society. As mothers and "nurturers", women are expected to meet others' needs, and deny their own. Food is one medium through which this dynamic is clearly expressed. In fact, food has been so central to the role of "nurturer" that it has become women's special domain (Orbach, 1986). A woman is expected to cook for and nurture others, but not be nurtured or "fed" herself. Anorexia can thus be thought of as an extreme expression of the feminine role: strict adherence to society's demands for thinness, and the ultimate denial and repression of one's own most basic needs (i.e. food and nurturance). On the other hand, however, anorexia can also be viewed as a contradiction and repudiation of the feminine role, as the anorexic "defeminizes" her body (e.g. through amenorrhea, and loss of body fat), thereby avoiding the pressures that accompany adult female status. Indeed, many analytic and neoanalytic theorists discuss the "fear of maturity" as a major component of the disorder (Crisp, 1965; Selvini-Palazzoli, 1978).

Although societal pressures and demands create a context in which eating disorders are likely to flourish, sociocultural theories do not provide adequate information about the factors that place some women at higher risk for developing eating disorders than others. For this reason, it is essential to look beyond societal influences in order to gain a more complete understanding of eating disordered women.

Psychoanalytic Theories

Several major classes of theories have focused on family relationships as central to the pathology of both bulimia and anorexia. Psychoanalytic conceptualizations of eating disorders typically point specifically to the mother-daughter relationship as the locus of the difficulty. Based on her extensive clinical observations, Bruch (1971; 1973; 1978; 1980) postulated that early mother-infant interactions, particularly surrounding feeding, are significantly disturbed in girls who later develop anorexia nervosa. She contended that these mothers are poorly attuned to their infant's needs and desires, and their responses to the child are based on their own needs or on misinterpretations of the child's needs. For example, with regard to the feeding process, the mother will provide food for the child at a specified time, or when she herself is hungry, as opposed to when the child gives a signal indicating that she is hungry. The lack of appropriate responses to the child's cues disrupts the normal interactive process through which the child learns to recognize and differentiate her own feelings, sensations, and internal bodily states, as well as develop a basic sense of security and trust. The confusion in perceptual awareness (interoceptive confusion), in turn, provokes a sense of ineffectiveness, a feeling of not being in control of one's body and behavior, and deficits in the development of a separate and individual identity. These difficulties in early separation-individuation are reawakened during the second individuation process of adolescence (Blos, 1967), when demands for autonomy become stronger, and these girls' deficits become more apparent. Bruch (1973) suggested that the eating disorder is essentially a struggle for control, self-efficacy, and an individual identity, and the eating concerns and weight

loss are symptomatic expressions of the underlying personality disturbance.

Similarly, self-psychologists point to problems in a specific component of the mother-child relationship, that is, "empathic mirroring", in mothers with an eating-disordered child (Atkins, 1989). Empathic mirroring involves an ongoing interaction between mother and infant, in which the child provides cues indicating the existence of a need, the mother accurately interprets and responds to, or "mirrors" the child's cues, and the child gradually learns to distinguish his/her individual needs and feelings. When the mother is deficient in empathy and mirroring skills, and fails to accurately read the child's cues, the child has difficulty learning to differentiate his/her needs and subsequently feels misunderstood and dependent on others (Atkins, 1989).

Schwartz (1988) theorized that bulimics, like anorexics, act out conflicts surrounding separation-individuation, which are first experienced early in life and are reactivated during adolescence. Failure to separate from the mother in the first years of life leads to disturbances in self-other differentiation, which is particularly problematic during adolescence. Krueger (1989) suggested that the developmental task of the first separation-individuation process is to develop a distinct sense of self (what is inside), other (what is outside), and boundaries between the two. The primary difficulties in the mother-infant relationship, which prevent the bulimic from mastering this developmental task, lie in the mother's empathic unavailability, overintrusiveness, and inconsistency of response to her infant. Because the bulimic fails to develop a separate sense of self, she later uses food to create an experience of self. Food, in essence, represents the mother; it stimulates the body and is temporarily able to

regulate affective states. The bulimic symptomatology is the bulimic's attempt to satisfy her unmet needs; however, the binge is not genuinely soothing, and the bulimic does not receive the nurturance and empathy she craves, nor does she learn to be self-nurturant (Krueger, 1989).

Humphrey & Stern (1988) integrated psychoanalytic and family systems theories in their conceptualization of bulimic etiology. Similar to other theories about eating disorders, they note deficits in nurturance, soothing, and empathy in the early mother-child relationship, which lead to problems for the child in separating from the mother and developing a stable sense of self. In particular, the mother is unable to adequately adjust her responses to the infant's alternating needs for autonomy and dependence. However, while theories about anorexics have contended that the parents respond negatively to the child's attempts to separate and more positively to dependent behavior, Humphrey & Stern contended that the bulimic's parents generally respond negatively to both types of behavior. The child's attempts to separate from the parents are invalidated, and the child is threatened with abandonment or punishment. However, dependent behavior is not rewarded either, because it places undesired demands on the parent. The parent's support is given only when the child meets the parent's needs. The authors hypothesized that this occurs because in bulimic families, parents as well as children experience a sense of emotional deprivation and neediness. Parents repeat the cycle that has been played out in their own families: For example, just as the bulimic child is expected to nurture and meet the needs of her mother, the bulimic's mother has had to nurture her own mother. Moreover, the whole family uses food as an attempt to satisfy their emotional needs. The bulimic symptomatology, then, can be viewed as a metaphor for the family. The

binge represents the attempt to satisfy overwhelming cravings for nurturance and soothing. The purge, on the other hand, is an attempt to expel the results of the overindulgence, as well as the "bad" and inadequate parts of the self.

Beattie (1988) offers an explanation for the gender-specificity of eating disorders, based on theories of separation-individuation and the notion that difficulties in this process play a major role in the development of both bulimia and anorexia. Chodorow (1978) contends that separation-individuation from the mother is a much more difficult and protracted process for girls than it is for boys. Whereas mothers tend to create distinct boundaries between themselves and their sons, they are more likely to identify with their daughters, and have more blurred boundaries in their relationships with their daughters. As a result, mother-daughter relationships are typically more intense and ambivalent than mother-son relationships. Although both girls and boys are required to separate and develop distinct identities from their mothers, boys are able to identify with their fathers in order to accomplish this task, while girls must simultaneously separate from and identify with their mothers. This leads to a good deal of ambivalence in the struggle for individuation for girls, which, in combination with gender-linked societal factors previously discussed, may greatly increase females' risk for developing eating disorders (Beattie, 1988).

In light of the postulation that girls typically have more difficulty with separation-individuation than boys, it is conceivable that girls who have even more difficulty with this task than other girls may be at particularly high risk for adjustment problems or eating disorders. In fact, Lopez, Campbell & Watkins (1986) found that for girls, too little separation

from parents was associated with poor adjustment, whereas for boys, too much separation was associated with poor adjustment.

Family Influences

Although psychoanalytic theorists focus heavily on mother-child relationships, they have also addressed the broader family backgrounds and environments of girls and women with eating disorders. Clinical observations of families of anorexics were summed up by Bruch (1973) as follows: Typically they were upper middle class, successful, perfectionistic, and achievement-oriented. Anorexic daughters were compliant, submissive, and perfectionistic as well. Amdur et al. (1969) added that these families were very rational, expressed little warmth or emotion, and were overly concerned with outward appearances. The parents reported stable marriages, and presented a picture of "normality", generally denying any problems within the family. However, treatment frequently revealed underlying tension and marital or family conflict (Bruch, 1971; Crisp, Hsu, Harding & Hartshorn, 1980). In a review of family issues involved in anorexia, Yager (1982) reported that families of anorexics are consistently described as presenting a pleasant and untroubled facade, appearing "superficially" healthy.

Family systems theorists, most notably Minuchin and colleagues (Minuchin, Baker, Rosman, Liebman, Milman & Todd, 1975; Minuchin et al., 1978), have delineated a number of family interaction patterns they believed to be characteristic of anorexic families. These patterns include enmeshment, overprotectiveness, rigidity, lack of conflict resolution, and triangulation of the child in marital conflict. Enmeshment within the family is characterized by intrusiveness into other family members' lives,

poor differentiation between sense of self and other, and poor boundaries between family members and family subsystems. These families are also overly concerned with one another's welfare, and attempt to take over functions which could be performed by the individual. For a child, this prevents the development of a sense of competence and individual autonomy. Rigidity involves the refusal to alter family patterns and modes of interaction in response to demands for change or growth. This is particularly troublesome during the child's transition to adolescence, when the family needs to adapt to the adolescent's increasing autonomy-strivings. These families refuse to negotiate changes in decision-making power or independence for the adolescent. They have a low threshold for conflict, so they either avoid or suppress conflict or refuse to negotiate disagreements, leading to a lack of conflict resolution. Finally, the child is triangulated in marital conflict, typically making it possible for parents to avoid conflict. Each of these interaction patterns contributes to a family style that does not allow individuality and prevents the child from becoming a differentiated and autonomous individual.

Although some theorists suggest that the interaction patterns discussed by Minuchin are also characteristic of bulimic families (Schwartz, Barrett, & Soba, 1985), Humphrey & Stern (1988) suggest that bulimic families differ in noteworthy ways. Similar to anorexic families, bulimic families attempt to present a facade of well-being, and rely heavily on idealization of family members. However, their facade is less convincing; they outwardly appear more dysfunctional and negative, and their deficits in nurturance and empathy are easily apparent. Nevertheless, and in spite of apparent differences between bulimic and

anorexic families, both family systems are believed to stifle the development of autonomy in their daughters.

Father-Daughter Relationships

The focus in the theoretical literature on eating disorders has almost exclusively been on mother-daughter relationships, whereas father-daughter relationships have commonly been overlooked. This is also the case with the literature on separation-individuation, particularly when referring to early separation-individuation processes, because in general the mother has always been considered the primary caretaker. However, the father-daughter relationship likely also has important implications for adolescent autonomy development, adjustment, and even disordered eating. Girls have been found to be more dependent on and emotionally involved with their mothers, perhaps partially explaining the continued focus on mother-daughter relationships throughout adolescence. However, it has been suggested that while mothers typically provide a foundation of security and attachment for adolescents, fathers encourage independence and individuation (Campbell, Adams & Dobson, 1984). It appears that fathers may be particularly instrumental in helping their daughters to differentiate from their mothers. Chodorow (1978) contends that when girls become involved in the process of individuation, they view their fathers as symbols of autonomy, and their relationships with their fathers provide a way to separate from their mothers and gain a sense of independence. Hence, differentiation may be particularly problematic for the daughter when the father is unable to help in this process, because he is either emotionally or physically absent, rejecting, or is himself enmeshed with the daughter.

Through her clinical work, Maine (1991) has explored the relationship between fathers, daughters, and eating disorders, and postulates that a major problem for girls who develop disordered eating is that their fathers are unavailable to them. A possible explanation Maine offers for this phenomenon is that with the onset of puberty, fathers may become uncomfortable with their daughter's emerging sexuality and may try to distance themselves from her. On the other hand, it may be simply a consequence of society's dictates and role expectations that fathers are more unavailable to their children than are mothers. Regardless of the cause of fathers' unavailability, Maine suggests that it is very threatening for girls to separate from their mothers when their fathers are not there to provide assistance. Eichenbaum & Orbach (1983), too, suggest that fathers are commonly uninvolved with childrearing in early life (during the first separation-individuation process) or during adolescence (during the second individuation process), and therefore cannot help with the troublesome aspects of mother-daughter separation.

Alternatively, as our society has evolved and more and more fathers are becoming involved with their children, it may be that the opposite pattern leads to similar difficulties. Indeed, family systems conceptualizations of families with an eating disordered daughter suggest that the whole family (including the father) may be characterized as enmeshed and overinvolved. If the daughter is overly dependent on or enmeshed with her father, he will clearly not be able to help her to differentiate from her mother.

There is some empirical evidence that in addition to relationships with mothers, relationships with fathers are problematic for eating disordered women. Engel & Stienen (1988) found that fathers of anorexics

were more likely than fathers of controls to be either negative and rejecting or overprotective and overly close to their daughters. Humphrey & Stern (1988) also suggested that fathers of bulimics may have difficulty in establishing boundaries between themselves and their daughters. They reported that father-daughter relationships in bulimic families were typically very close, but these relationships appeared to meet the fathers' needs, rather than the daughters'. The authors also suggested that often, fathers were very close to their bulimic daughters before puberty, then became more emotionally distant, perhaps out of guilt over inappropriate impulses towards their daughters, or discomfort with their daughter's sexuality. This shift in the relationship may be troublesome in and of itself for the daughter, but may also hinder the process of separating from her mother, because she may fear losing both parents.

Evidence for Psychoanalytic and Family Systems Theories

A large body of literature empirically exploring the theories discussed above has provided somewhat mixed support for the role of specific family characteristics in the development of eating disorders. However, support for the role of separation-individuation difficulties and family discouragement of autonomy is much more consistent. One group of studies using clinical populations to examine family characteristics provides support for the notions that bulimic family environments are negative and conflictual, and family members demonstrate little closeness or empathy for one another, and that anorexic family environments are characterized by denial and avoidance of conflict, and appear on the surface to be "healthy". Other studies find the families of women with anorexic versus bulimic symptomatology to be more similar. Taking first the studies

that report differences, Garner et al. (1985) found that bulimic-anorexics and normal-weight bulimics reported more family conflict than did restricting anorexics. The researchers suggested that the restricting anorexics' descriptions of their family environments as essentially "normal" is likely indicative of substantial denial and idealization of their families. In addition, Humphrey (1989) found that although bulimics' and their parents' reported experiences of their family relationships were consistent with observational data, anorexics and their families denied problems, and reported that their relationships were much more positive and adaptive than observational data indicated.

Results of a number of self-report studies comparing bulimics to controls (but not to anorexics) concurred that bulimics described less closeness and supportiveness, less open expression of feelings, and more conflict in their families (Dolan, Lieverman, Evans & Lacey, 1990; Johnson & Flach, 1985; Shisslak et al., 1990). Moreover, Humphrey (1986a) found that mothers and fathers (as well as bulimic daughters) described their families as less supportive, more conflictual and detached, and more chaotic and disorganized than controls. In an observational study, Humphrey, Apple & Kirschenbaum (1986) found that families of bulimic-anorexics had more disturbed interactional styles than control families; that is, they used negative (e.g. belittling and ignoring) and contradictory styles of communication more frequently, and were less likely to use positive communication styles (e.g. nurturing, helping, and trusting). In addition, Pole, Waller, Stewart & Parkin-Feigenbaum (1988) reported that bulimics perceived their mothers to be less caring and empathic than did non-eating-disordered women.

Several researchers reported that bulimics were more likely than controls to experience their families as discouraging strivings for autonomy (Johnson & Flach, 1985; Shisslak et al., 1990), and as having poor boundaries among family members (Humphrey, 1986a). In an observational study, in which parents and their bulimic-anorexic daughter took part in a family discussion, Humphrey (1986b) found that parents provided contradictory messages regarding autonomy for their daughters, by both offering autonomy and simultaneously taking control. Daughters, in turn, responded ambivalently, and alternated between attempting to assert their autonomy and resentfully submitting to their parents. The confusing interactions undermined the daughter's autonomy-strivings, as these struggles typically ended with parents controlling and daughters submitting.

In contrast to the studies that found differences between bulimic and anorexic families, another group of studies compared these populations, and found few or no differences between the family environments among eating disorder subtypes. In a self-report questionnaire study, Stern, Dixon, Jones, Lake, Menzer & Sansone (1989) compared two bulimic groups (bulimic-anorexic and normal-weight), a restricting anorexic group, and a non-eating-disordered control group. All eating disorder groups reported that their families were less encouraging of open expression of feelings than the control group. Both bulimic groups also reported that there was less closeness among family members than controls, and parents of bulimic-anorexics reported more conflict in their families than parents of controls. However, there were no significant differences between eating disorder groups on these variables, although the bulimic-anorexic group generally reported the most dysfunction.

Calam, Waller, Slade & Newton (1990) found that both bulimic and anorexic women perceived their mothers and fathers as less caring than did controls (although normal-weight bulimics reported the least care from their parents overall), and their fathers as more intrusive and overprotective. Steiger, Van der Feen, Goldstein & Leichner (1989) found that anorexics and bulimics reported receiving less caring and empathy from their fathers than controls, while Rhodes & Kroger (1992) reported that eating disordered women experienced their mothers as less caring and more rejecting, as well as more intrusive than controls.

Again, eating disordered women (both bulimic and anorexic) reported more difficulties and anxieties over separation-individuation than non-eating disordered women (Armstrong & Roth, 1989; Rhodes & Kroger, 1992). Likewise, Strauss & Ryan (1987) reported that both anorexics and bulimic-anorexics had more poorly-differentiated concepts of self than normal controls. Kenny & Hart (1992) found that women with eating disorders (primarily bulimics) reported that their parents were less encouraging of their autonomy-strivings than college student controls. Williams, Chamove & Millar (1990) found that bulimics and anorexics felt they had little personal control over their lives or their emotions, had difficulty asserting themselves, and described a family environment which was not encouraging of independence. However, although the researchers found significant differences on these variables from both normal controls and women who frequently dieted, only family discouragement of independence distinguished eating disordered women from psychiatric controls.

In a series of observational studies, Humphrey found both similarities and differences between bulimics and anorexics. She reported

that both bulimics and anorexics perceived their parents as rejecting, neglectful, and blaming. However, bulimics perceived their parents, and especially their fathers, as significantly lacking in nurturance and empathy, as compared to anorexics (Humphrey, 1986). Humphrey also reported that parents of anorexics gave confusing messages of nurturance, on one hand, and neglect of their daughter's need to express her true feelings, on the other hand. The combination of overconcern along with invalidation of the anorexic's needs and feelings worked together to keep the anorexic dependent and prevent her from separating from her parents. In contrast, bulimics appeared to be more "hostilely enmeshed" with their parents; that is, little affection was expressed, and family members were mutually blaming, belittling, and appeasing. The bulimic's attempts at separation and self-assertion were met with hostility, keeping her dependent on her parents as well (Humphrey, 1989). In sum, although all of these studies of clinical populations taken together suggest that there are both similarities and differences between bulimic and anorexic families, one consistent finding is that the parent-adolescent relationship is marked by difficulties surrounding separation-individuation.

In attempts to identify factors that predict severe eating problems in college women, it is important to determine whether nonclinical populations describe family patterns similar to those found in clinical populations. Again, findings regarding specific family characteristics appear to be somewhat inconsistent. For example, in a college student sample, Kent & Clopton (1992) compared a group of women meeting DSM-III-R criteria for bulimia, a group of women who could be described as subclinical bulimics, and a control group of women without eating problems. Although bulimics reported that their families were less

expressive of feelings than the other two groups, there were no differences among groups in either perceived family conflict or perceived parental caring. However, although most participants overall reported that they were closer to their mothers than their fathers, both the bulimics and the subclinical bulimics were more likely than controls to report that they were closer to their fathers. Similarly, Scalf-McIver & Thompson (1989) found that family conflict was not associated with severity of bulimic problems in a college population. However, both lack of family closeness and parental inconsistency of affection were related to bulimic behavior, with mother's inconsistency being the best predictor. McNamara & Loveman (1990) found that college women meeting DSM-III-R criteria for bulimia reported that their families were more enmeshed and overinvolved than other families. At the same time, they were more emotionally disengaged and had poor communication and problem-solving skills. Finally, Reeves & Johnson (1992) found that among college sorority members, reports of family problems, such as the inability to express feelings and needs, lack of empathy, and poor conflict resolution, were related to aspects of personality disturbance found to discriminate eating disordered from non-eating disordered women.

A number of studies provided evidence that women with subclinical eating problems, like women with clinically significant eating pathology, have difficulties with separation-individuation and perceive their families as discouraging autonomy. Friedlander & Siegel (1990) found that women reporting high levels of eating pathology, as defined by a variety of eating symptoms and other characteristics associated with eating disorders, were less differentiated from their fathers and reported a high level of resentment and anger in relation to their fathers. The pattern of results

found in relation to mothers was somewhat more complex. Those women reporting high levels of bulimic symptoms and a number of problematic personality characteristics also reported being less differentiated from their mothers. Those who reported a strong desire to be thinner (but did not report other personality disturbances) were more dependent on their mothers for help in making decisions as well as for providing emotional support. Smolak & Levine (1993) found that college women exhibiting both anorexic-like and bulimic-like symptoms reported more feelings of guilt and resentment regarding separation from their parents than women without eating symptomatology. However, the women with bulimic-like symptoms reported being less dependent on their parents in determining their attitudes and values than controls and anorexic-like women. This may reflect the alienation bulimics reportedly experience with regard to their parents, as greater attitudinal independence has been associated with lower personal adjustment in college students (Hoffman, 1984).

Zakin (1989) found that eating symptomatology in a college population was associated with lack of emotional separation from parents, and especially from mother. Other researchers found that, among college students, women with more severe eating problems had more insecure and anxious attachments to their parents, and were more fearful of abandonment and rejection and of losing their sense of self in a close relationship (Heesacker & Neimeyer, 1990; Steiger & Houle, 1991). In another college student sample, Schupak-Neuberg & Nemeroff (1993) found that women exhibiting bulimic symptomatology perceived their identities as being enmeshed with others, and desired more separation from their mothers than did controls. In addition, Frank & Jackson-Walker (in press) reported that risk for severe eating pathology in college women was higher

among those who continued to idealize and depend excessively on their parents.

The above review of the literature indicates that problems with autonomy are consistently associated with eating disturbance. However, the operational definitions of "autonomy problems" are numerous and vary widely across studies. Kenny & Hart (1992) argue that we need a better understanding of the specific aspects of separation that are associated with eating disorders, and which are associated with psychological distress more generally. Hence, a more in-depth exploration of the process of separation-individuation throughout adolescence, and its relationship to emotional adjustment, is warranted.

Separation-Individuation and Adjustment

Although theorists have referred to early adolescence as the second individuation process (e.g. Blos, 1967), it has become clear that adolescents continue to grapple with separation-individuation issues throughout late adolescence and even into early adulthood (Frank, Avery & Laman, 1988). As a result, researchers have begun to explore the implications of autonomy for college student adjustment. During the first few years of college in particular, separation-individuation issues are reawakened, because it is often the first time adolescents have lived away from home. Living away from home provides an opportunity for late adolescents to successfully negotiate challenges and make gains in autonomy. However, if their coping skills are not sufficient to handle the new environment and its accompanying demands, it can be a time of stress and anxiety, and can lead to problems in adjustment.

Recently, there has been an ongoing debate in the literature regarding the positive vs. negative implications of autonomy for adolescent adjustment. One difficulty in deciding this debate is that different definitions of autonomy currently exist in the literature. Analytic and neoanalytic theorists have argued that autonomy involves "individuation", in which adolescents become increasingly more self-governing, relinquish idealized perceptions of and identifications with parents, and loosen close ties with them (Blos, 1967; Josselson, 1980). Others have argued that autonomy is defined by "mutuality", which involves parental encouragement of increased adolescent independence, respect for the adolescent's individual decisions and opinions, as well as reciprocal respect on the part of the adolescent for the parent (Grotevant & Cooper, 1986; Kenny, 1987). These theorists have suggested that mutuality occurs in the context of close, connected parent-adolescent relationships, which are supportive of autonomy. These different definitions, or perhaps different types of autonomy are likely to have unique implications for adjustment. A number of researchers have begun to explore this question, focusing on one or the other type of autonomy.

Ryan & Lynch (1989), based on findings with early and middle adolescents, suggest that individuation, which in their work was defined by a measure of "emotional autonomy" (Steinberg & Silverberg, 1986), has negative implications for adjustment and may be better described as detachment, because it is associated with insecurity and feelings of rejection in relation to parents. In response to this contention, Lamborn & Steinberg (1990) suggested that the implications of emotional autonomy for adolescent adjustment may be affected by the emotional climate of the parent-adolescent relationship. And in fact, they found such differences for

adolescents (ninth through twelfth grades) who experienced secure as opposed to insecure (anxious or avoidant) relationships with their mothers. Those adolescents who reported insecure relationships with their mothers were most well-adjusted when they reported moderate to high levels of emotional autonomy, whereas those who reported secure relationships were most well-adjusted when they reported moderate to low levels of emotional autonomy. The authors suggested that among secure adolescents, emotional autonomy, as Ryan & Lynch have suggested, may be indicative of detachment and lead to negative outcomes. In contrast, for insecure adolescents, emotional autonomy may represent an adaptive level of separation from parents and lead to more positive outcomes. In this group, rebellion and separation from parents may allow the adolescent to gain emotional distance in order to rework negative relationships with parents. Similarly, Frank & Poorman (1992) found that emotional disengagement from parents was more strongly linked to insecurity about separation among late adolescents who perceived their parents as having a more (as compared to less) well-functioning parenting partnership.

The age or developmental level of the adolescent or young adult in question is clearly an important factor that must be taken into account in understanding the implications of autonomy. There is some evidence indicating that although individuation has more negative implications for younger adolescents, it has increasingly more positive implications for older adolescents. Whereas Ryan & Lynch (1989) reported that emotional autonomy was associated with insecurity among fifth through twelfth grade adolescents, Frank & colleagues have suggested that individuation is a more "mixed bag" for late adolescents, and is associated with both opportunities and pitfalls. Using a number of college student samples, they

found that higher levels of individuation in college students were related to more positive self-concepts, less identity foreclosure, and fewer difficulties in intimate relationships, but also to more alcohol and drug problems (Frank, Pirsch & Wright, 1990; Frank & Burke, 1992).

Hoffman (1984), based on psychoanalytic descriptions of the early separation-individuation process (Mahler, 1968; Blos, 1967), separated the construct of individuation into four distinct aspects of adolescent independence in order to determine whether particular aspects of autonomy would be more or less associated with different aspects of adjustment (i.e. personal adjustment, academic adjustment, and adjustment in romantic relationships). The four aspects of individuation were measured by the Psychological Separation Inventory (PSI), and included functional independence (ability to make decisions and run one's life without depending on parents), emotional independence (not needing an excessive amount of approval and emotional support from parents), attitudinal independence (ability to determine one's own values and beliefs), and conflictual independence (freedom from guilt, resentment, and other negative feelings regarding parents). He found, generally, that greater conflictual independence was related to fewer problems in romantic relationships for both college men and women, and to personal adjustment in women. Lopez, Campbell, & Watkins (1988) found a similar relationship between conflictual independence and personal adjustment in both college men and women. In addition, in Hoffman's study, greater emotional independence was associated with fewer academic problems, but greater attitudinal independence was associated with less personal adjustment for both men and women, and to more problems in romantic relationships for

men. Functional independence was not significantly associated with any of the adjustment measures (Hoffman, 1984).

Frank & Jackson-Walker (in press) explored both individuation and mutuality, as they related to eating pathology. They found that individuation and mutuality were negatively correlated, but both were related to less personality dysfunction. In addition, individuation moderated the relationship between eating symptomatology and personality disturbance associated with severe eating disorders, such that eating symptoms were more strongly linked to personality dysfunction among less individuated as compared to more individuated women. However, mutuality did not moderate this relationship.

Other researchers have explored another aspect of autonomy development that appears to be related to mutuality, but which may in fact be a separate dimension. In particular, researchers have examined "anxieties about separation from parents", and have consistently found positive relationships between this factor and adjustment problems. For example, Holmbeck & Wandrei (1993) found that college females' reports of anxieties surrounding separation and difficulties regulating distance in interpersonal relationships were associated with depression and physical symptoms. Similarly, Kenny & Donaldson (1991) reported that late adolescents' perceptions of their families' anxieties about separation were associated with psychological symptoms and lower social competence in the late adolescents.

Rice, Cole & Lapsley (1990) factor analyzed a number of different autonomy measures and obtained two factors: The first factor was similar to what has been referred to here as "individuation", and was labeled "independence from parents". It was defined by functional, emotional, and

attitudinal independence (as measured by the PSI). The second factor was labeled "positive separation feelings" and was defined by positive outlooks toward separation experiences, lack of anxieties about separation, and conflictual independence (from the PSI). Interestingly, although conflictual independence was conceptually developed as a part of individuation, it appears to be associated with other measures of the affective experience regarding separation, and also has relatively consistent positive relationships with adjustment. In this study, independence from parents and positive separation feelings were positively correlated; however, the researchers found that it was positive feelings about separation, rather than actual independence, that was related to positive adjustment.

In sum, individuation, mutuality, and feelings about separation all appear to have notable, although somewhat different, implications for adolescent adjustment. In addition, it appears that a positive affective experience regarding separation is most consistently associated with psychological adjustment in late adolescents, or conversely, that anxieties about separation are associated with various types of emotional distress. An important task is to determine whether a specific aspect of autonomy development is more predictive of eating disorders than others, and whether any of the different aspects or types of autonomy are specifically predictive of disordered eating rather than adjustment problems more generally.

Parent Eating Preoccupation

Although lack of autonomy appears to be a major issue for women with eating disorders, it is as yet unclear why their dysfunction is

expressed through an eating problem. Returning to Bruch's discussion of the etiology of eating disorders, she contends that feeding is a particular trouble spot in mother-infant interactions for girls who develop eating disorders. Moreover, the resulting difficulties in recognizing their own feelings, sensations, and internal bodily states could clearly lead to problems in regulating eating behavior, as a response to distress.

However, moving beyond the mother-daughter relationship, I suggested earlier that the interplay between family and sociocultural factors may also be relevant in predicting risk for eating disorders. Again, sociocultural theories do not explain why some women are more susceptible to societal pressures than others. It may be that when the family endorses or mirrors sociocultural attitudes about thinness in women or models unhealthy or maladaptive eating attitudes or behaviors, the daughters are more likely to internalize these attitudes themselves, and hence, are more likely to express dysfunction through an eating problem. In a review of the literature, Yager (1982) summarized the "typical" anorexic family as one that has excessive concerns with weight, thinness, and exercise, as well as a strong investment in maintaining "appearances". However, he pointed out the need to move beyond descriptive data, and argued for more substantial empirical evidence for these claims.

Several theorists and researchers have, in fact, explored whether weight problems within the family, the family's preoccupation with food or weight, or dysfunctional attitudes toward dieting or eating are pathognomic for the development of eating disorders in daughters (Scalf-McIver & Thompson, 1989; Crisp et al, 1980). A number of uncontrolled studies of anorexic patients and their families suggested that a relatively high

number of parents of anorexics had weight problems themselves, being either overweight, underweight, or even anorexic (Crisp et al., 1980; Kalucy, Crisp, & Harding, 1977). In contrast, a controlled study found no differences in current weight between parents of anorexic daughters and control parents (Halmi, Struss & Goldberg, 1978). Garfinkel, Garner, Rose, Darby, Brandes, O'Hanlon, & Walsh (1983) also found no differences between parents of anorexics and parents of controls on measures of weight, dietary restraint, or eating pathology. In addition, they reported that parents of anorexics were not overly concerned with dieting or weight loss. A more recent study examining parents of bulimic daughters found that although bulimics' fathers' weight histories did not differ from fathers of normal controls, mothers of bulimics currently weighed more (controlling for height), and had higher lifetime-maximum weights than mothers of controls (Yates, 1992).

Rather than focusing on actual weight problems in the family, other investigators have explored relationships between the family's overconcern with food, eating, or weight and daughter's eating problems. Again, clinical observations of anorexics and their families suggested that parents were unusually preoccupied with weight, dieting, and physical appearance (Amdur et al., 1969; Beattie, 1988; Bruch, 1978), leading some researchers to suggest that the eating disordered daughter mirrors her parents' preoccupation with their own weight and appearance (Stoltz, 1985). Similarly, Schwartz et al. (1985) noted that bulimic families seemed to be very conscious of appearances and often attached a special meaning to food and eating.

There has been some empirical support for these claims. Kent & Clopton (1992) found that both bulimics and subclinical bulimics were more

likely to report maladaptive eating patterns and weight concerns in their family members than were controls. They suggested that the association could be attributed to genetic influences, simple behavioral modeling, or modeling of a family style in which food is used as a means of getting nurturance or of coping with emotional difficulty.

Pike & Rodin (1991) suggested that mothers in particular may "operate as society's messengers", and directly pressure their daughters to diet and lose weight. On the other hand, daughters may simply model their mothers' attitudes or concerns about weight and attractiveness. In a study exploring this issue in high school girls and their mothers, the authors found that mothers of daughters with high levels of eating pathology had more disordered eating behaviors themselves, and their attitudes regarding their daughters differed from those of other mothers. These mothers thought their daughters should lose more weight than did mothers of daughters with no eating pathology, even after accounting for weight differences among the girls. Moreover, they rated their daughters as significantly less attractive than the daughters rated themselves, while this difference was not evident in the other mother-daughter pairs. The researchers concluded that mothers likely model unhealthy eating attitudes and behaviors as well as modeling the use of these maladaptive behaviors as styles of coping with difficulty. Moreover, they appear to hold very critical opinions of their daughters' appearances. These attitudes may create a context in which separation difficulties are expressed as eating pathology.

Again, the father's influence on the daughter's eating problems has been largely ignored. However, in a study of normal children and adolescents, Striegel-Moore & Kearney-Cooke (1994) found a strong

relationship between parent dieting and parent encouragement of the child to diet in both mothers and fathers. In addition, contrary to their expectations, they found that mothers were more likely to praise their children's appearance than were fathers, pointing out the possibility that fathers' lack of praise, or even criticism of children's appearance, may be a very relevant factor in children's body image development.

In addition to parents' weight preoccupations and concerns about their daughter's weight and eating, the use of food as a means of getting or providing nurturance has been suggested as an important theme in eating disordered families (Kent & Clopton, 1992). Humphrey (1986b) found that bulimics experience deficits in parental nurturance and empathy, and are also deficient in self-nurturance and self-acceptance. She suggested that for this reason, bulimics turn to food as a substitute for the empathy and nurturance they crave. Lehman & Rodin (1989) provided some empirical support for their contentions that bulimics utilize food as their primary means of self-nurturance, have difficulty gaining gratification from sources other than food, and are unable to be comforting or accepting of themselves. However, although the researchers also suggested, as did Stoltz (1985), that other members of bulimic families may similarly use food as a means of nurturance and soothing, this hypothesis was not supported in Lehman & Rodin's sample.

Despite evidence that family concerns with weight and food, as well as using food as nurturance, may be associated with eating disorders, most researchers point out that family weight and food concerns alone are not likely to lead to eating disorders. Rather, within the context of a dysfunctional family environment, these concerns are likely to increase risk. For example, Strober & Humphrey (1987) suggested that personal

deficits produced by an adverse family environment, in the context of pressures to diet and be slim, is likely to be especially pathognomic for eating disorders. Likewise, Johnson & Flach (1985) and Pike & Rodin (1991) point out that although family relationships and interactions are probably central to the pathology of eating disorders, the family's preoccupation with food and weight may be responsible for the specific expression of the disorder.

Hypotheses

The purpose of the present investigation is to determine whether difficulties in the separation-individuation process in relation to mothers and fathers are associated with disordered eating specifically, and adjustment problems more generally, in a nonclinical population of late adolescent women. An additional goal is to gain more clarity with regard to the particular aspects of autonomy, if any, that lead to eating versus general adjustment problems. A final question to be addressed is whether adolescents' perceptions of their parents' eating and weight preoccupation increase the risk for disordered eating, in the context of problems with separation-individuation. In order to address these questions, I measured a variety of aspects of autonomy, intended to assess both individuation and mutuality (as well as its opposite, anxieties about separation) and then tested the following hypotheses:

1) It is hypothesized that low levels of autonomy in relation to mothers and fathers will be associated with eating pathology in college women. In particular, it is predicted that college women who experience anxieties about separating from their mothers and their fathers, and who report low

levels of mutuality and individuation from both their mothers and their fathers will be more likely to be disordered eaters.

2) It is predicted that low levels of autonomy (i.e. anxieties about separation, lack of individuation, and lack of mutuality) from both mothers and fathers will also be predictive of general adjustment problems in college women.

3) It is hypothesized that separation-individuation difficulties will moderate the relationship between daughters' perceptions of parents' preoccupation with weight and eating and daughters' eating pathology. That is, there will be a stronger relationship between eating pathology and daughters' reports of parent eating preoccupation (i.e. parents' concerns with weight and eating, concerns with their daughter's weight and eating patterns, and use of food as a means of providing nurturance) among women who describe problems with autonomy in relation to their parents than among women who describe higher levels of autonomy.

4) It is predicted that difficulties with autonomy will <u>not</u> moderate the relationship between perceptions of parent eating preoccupation and adjustment problems. That is, parent eating concerns, within the context of separation-individuation difficulties, will be a <u>specific</u> risk factor for eating pathology, but not adjustment problems.

Method

Participants

Two samples were used in this study: the first sample was used to develop and conduct a factor analysis on a measure of parent eating preoccupation (the Parent Eating Attitudes Scale), and the second sample was used to test the hypotheses presented here.

The first sample consisted of 272 female undergraduates from intact families. Participants ranged in age from 17 to 22 (M=19.2); 43.4% were freshmen, 32.4% were sophomores, 20.6% were juniors, and 3.7% were seniors. The large majority (90%) were Caucasian, and most were from middle to upper middle class backgrounds.

The second sample initially consisted of 80 female undergraduates from intact families. Only participants from intact families were selected in order to be able to equally assess current relationships with both parents. In addition, because parental divorce is likely to have an independent effect on adolescent autonomy, I controlled for this factor. Forty women who received scores at or above the clinical cutoff on a measure of eating pathology were selected (disordered eating group), and 40 who received scores not indicative of eating problems were selected (comparison group). One comparison subject did not complete a large number of the questionnaires, reducing the number of participants to 79.

Table 1 presents demographic data for Sample 2. Participants ranged in age from 17 to 22 (M=18.9); 53.2% were freshmen, 30.4% were sophomores, 15.2% were juniors, and 1.3% were seniors. They were

Table 1. Demographic Characteristics of Participants in Sample 2

Age	Number	Percent
17	1	1.3
18	36	45.6
19	19	24.1
20	19	24.1
21	3	3.8
22	1	1.3
Class		
Freshman	42	53.2
Sophomore	24	30.4
Junior	12	15.2
Senior	1	1.3
Race		
Caucasian	74	93.7
Asian-American	4	5.1
African-American	1	1.3

predominantly Caucasian (93.7%), but a small number were Asian-American (5.1%) or African-American (1.3%). They were from primarily middle to upper middle class backgrounds: approximately 87% of their fathers and 79% of their mothers had had at least some college education, and 82% of their fathers and 67% of the mothers were in middle to high status occupations (ranging from secretaries and semiprofessionals to major professionals and higher executives). Comparisons were similar to disordered eaters in age and socioeconomic status, and there were no differences between groups on any of the other demographic variables.

Measures

Sample 1:

Participants were administered a demographics questionnaire and the Parent Eating Attitudes Scale (Frank, Jackson-Walker, & Monestere, 1992; unpublished measure). The PEATS was developed in order to provide a measure of respondents' perceptions of their parents' preoccupation with eating and weight, while the respondent was growing up. It assesses perceptions of parents' concerns about their own weight and dieting ("My mother was always worried about gaining weight or being too fat"), their parents' concerns about their daughter's weight and eating patterns ("My father thought it was very important for me to be thin"), and their parents' use of food as a means of providing nurturance ("When I was upset, my mother gave me food to comfort me"). It also assesses parents' attitudes about drinking and drug use, although these items were not included in the analyses here. The PEATS is completed separately for each parent, and has 32 items which are answered on a 4-point Likert scale, ranging from "very true" to "very false". Some of the items from this scale were based on

items from the Somatopsychological Differentiation Scale (Chatoor, Atkins, Bernard, & Rohrbeck, 1988).

Sample 2:

Participants were administered an interview assessing autonomy in their relationships with their parents, and a number of questionnaires measuring autonomy, adjustment/self-concept, and eating attitudes and behaviors (both their own and their perceptions of their parents'). In addition, they provided personal and family background information through a demographics questionnaire and a health history questionnaire.

Eating Attitudes and Behaviors

The Health History (adapted from Johnson, 1985) was used to obtain information about weight and height, eating patterns, binging and purging behaviors, and exercise habits. In addition, it assesses depressive symptoms (e.g. depression, crying episodes, difficulties sleeping) and psychiatric history. This measure was based on the Diagnostic Survey for Eating Disorders (DSED), a standardized interview developed to obtain intake information for women with anorexia nervosa or bulimia. It has been used both in interview and in self-report formats (Johnson, 1985), and was administered in the current study as a self-report questionnaire. Although the validity of height and weight estimates obtained through self-reports has been questioned, Yates (1992) found that actual body mass index (BMI) correlated highly with BMI calculated through bulimic (r=.84) and control subjects' (r=.90) estimates of their heights and weights.

The Eating Attitudes Test (EAT) (Garner & Garfinkel, 1979) assesses a range of maladaptive eating attitudes and behaviors (e.g. "I am terrified

of being overweight"; "I weigh myself several times a day"). The 40 items are answered on a 6-point Likert-type scale, ranging from "always" to "never". Scores above the "clinical cutoff" (of 30) on the EAT are viewed as symptomatic of an eating disorder, although they are not considered to be diagnostic. The EAT is widely used in studies of disordered eating, and in addition to assessing clinical populations, has been used to identify disturbed eating behavior among college students (Garner, Olmstead, & Polivy, 1983).

Although the EAT was initially developed to measure symptoms of anorexia nervosa, it appears to reflect bulimic symptomatology as well. A factor analysis of the EAT resulted in a "Dieting" factor and a "Bulimia and Food Preoccupation" factor (Garner, Olmsted, Bohr, & Garfinkel, 1982). Another widely-used measure, the Eating Disorders Inventory (EDI), was developed to assess a broad range of characteristics associated with both anorexia and bulimia, including cognitive and psychological aspects (Garner et al., 1983). In one sample in a series of validational studies for the EDI, the EAT "Dieting" factor correlated highly with the EDI Drive for Thinness scale (r=.80), and the EAT "Bulimia and Food Preoccupation" factor correlated highly with the EDI Bulimia scale (r=.85). In other samples, the authors found that the EDI Drive for Thinness scale correlated highly with the total EAT score (r=.88), and there were no differences between bulimics and anorexics on the Drive for Thinness scale (Garner et al., 1983).

The EAT has been reported to have good discriminant and predictive validity, and appears to be sensitive to recovery (Garner & Garfinkel, 1979). Internal consistency for a sample of anorexic subjects was .79 and for a sample including both anorexics and normal controls was .94. Internal

reliability for the current sample, as measured by Cronbach's alpha, was .91 (See Table 2 for internal reliability data on all scales in this study).

The Parent Eating Attitudes Scale (Frank, Jackson-Walker, & Monestere, 1992; unpublished measure) already described for Sample 1 was administered to obtain participants' perceptions of their parents' preoccupation with eating and weight.

Autonomy

Participants completed four questionnaire measures and an interview designed to assess the three aspects of autonomy discussed previously: individuation, mutuality, and anxieties about separation.

The 5-item Deidealization subscale from the Emotional Autonomy Scale (Steinberg & Silverberg, 1986) was used to assess the adolescent's level of awareness of parental fallibility. It is measured by items such as "Even when my mother and I disagree, my mother is always right" (negatively scored), and "My father hardly ever makes mistakes" (negatively scored). This scale was completed separately for mother and for father, and items were answered on a 4-point Likert scale ranging from strongly disagree to strongly agree. The Emotional Autonomy Scale has been used in a number of studies with early and middle adolescents (Lamborn & Steinberg, 1990; Ryan & Lynch, 1989; Steinberg & Silverberg, 1986) and late adolescents (Frank, Pirsch & Wright, 1990; Frank & Jackson-Walker, in press), and the Deidealization subscale has been found to correlate with various aspects of adjustment in the late adolescent samples. Internal reliability for the current sample was .69 for relationships with fathers and .62 for relationships with mothers.

Table 2. Internal Reliability for Self-Report Measures

	Coefficient Alpha	
Individual Pathology Scales		
Eating Pathology	.91	
Self-Concept Problems	.92	
Depressive Symptoms	.85	
Autonomy Scales	**Mothers**	**Fathers**
Deidealization	.62	.69
Autonomy	.77	.86
Mutuality	.71	.67
Respect for Boundaries	.85	.78
Conflictual Dependence	.94	.91
Insecurity	.79	.79
Eating Preoccupation Scales		
Eating Preocc.-Self	.89	.84
Eating Preocc.-Child	.86	.79
Food as Nurturance	.66	.55

Three scales from Stutman & Lich's (1985) Parental Relationship Inventory were used to assess various aspects of autonomy. The 14-item Autonomy subscale measures self-governance or self-directedness (e.g. "I run my own life without needing my father's direction"). The 5-item Mutuality scale assesses the extent to which the respondent perceives the parent as recognizing her new adult status ("My mother doesn't seem to recognize that I have grown up") (negatively scored). The 9-item Respect for Intergenerational Boundaries scale assesses the extent to which the respondent perceives the parent as respecting her opinions, desires for autonomy, and need for separateness ("It's alright with my father if I disagree with him"). The items on the Parental Relationship Inventory were answered on a 4-point Likert scale ranging from strongly disagree to strongly agree. It was completed separately with regard to mother and to father. This measure has been used with both young adults and late adolescents, and associations have been found between its subscales and several measures of psychological health and personality dysfunction (Frank & Jackson-Walker, in press; Frank et al., 1990; Stutman & Lich, 1985). Internal consistencies for the current sample were as follows: Autonomy, .86 for relationships with fathers and .77 for relationships with mothers; Mutuality, .67 (fathers) and .71 (mothers); and Respect for Intergenerational Boundaries was .78 (fathers) and .85 (mothers).

The 50-item Conflictual Independence scale from the Psychological Separation Inventory (PSI) (Hoffman, 1984) was used to assess negative affect regarding separation from parents. Because items are worded to reflect lack of independence, this scale will be referred to in this study as Conflictual Dependence. The scale measures feelings of guilt, resentment, and anger in relation to parents, and conflicts and anxieties about

separation (e.g. "I feel uncomfortable keeping things from my mother"; "When I don't write my father often enough I feel guilty"). The measure is answered on a 5-point Likert scale, ranging from "Not at all true of me" to "Very true of me". Half of the items on this scale refer to mother and half to father, yielding separate conflictual dependence scores for each. This scale has been used in many studies using college student samples, and conflictual independence has been found to be positively associated with various measures of adjustment (Friedlander & Siegel, 1990; Hoffman, 1984; Rice et al., 1990). Alphas in this sample were .91 for dependence on fathers and .94 for dependence on mothers.

Ainsworth and Ainsworth's (1958) Familial Insecurity Scale assessed insecurity in the parent-adolescent relationship. This 12-item scale measures feelings of failure and inferiority, oversensitivity to parents' disapproval, and lack of self-confidence regarding separation from parents (e.g. "It makes me feel uneasy to think of being completely on my own"; "I sometimes worry about the future as a time when I will not get as much help from my parents as I do now"). This scale was completed separately for relationships with mother and father, and although the original measure used a true/false format, participants here responded to the items on a 4-point Likert scale, ranging from very false (or somewhat false) to very true (or somewhat true). This 4-point response format has been used successfully in a number of other studies, and relationships have been found between insecurity and other measures of attachment with parents (Frank et al., 1990; Frank & Poorman, 1993). Coefficient alphas in this study for relationships with both fathers and mothers were .79.

The Young Adult/Parent Relationship Interview (Frank, Avery, & Laman, 1988) is a 1 1/2 hour semi-structured interview, completed

separately with regard to each parent. Five different dimensions measuring aspects of autonomy (decision making, independence, self-assertion, personal control, and self-other responsibility) are scored from the interviews, on a scale ranging from 1, indicating low autonomy, to 5, indicating high autonomy. (See Appendix L for interview and full description of the criteria for rating each level.)

The Decision Making dimension assesses the respondent's capacity to make her own decisions and choices and determine her own values, without depending on the parent to do so. The Independence scale measures the respondent's feelings of competence, and beliefs that she can cope with life difficulties without relying excessively on the parent. The Self-Other Responsibility scale refers to the adolescent's ability to resolve conflicts surrounding the parent's needs versus her own needs, as well as the ability to develop attachments and investments outside of the parent-adolescent relationship. The Personal Control scale refers to the adolescent's ability to control her behavior and regulate her feelings (particularly negative feelings) in the relationship with the parent. The Self-Assertion scale assesses the extent to which the respondent is uninhibited by feelings of shame or guilt in the relationship with the parent, and relies on her own standards or expectations of behavior, rather than evaluating her behavior based on the parent's standards.

This interview was developed on a young adult sample, ages 22-33, but has also been used in other studies with college students (Frank, Avery & Laman, 1988; Wright, 1992; Pirsch, 1993). Interrater reliabilities for this sample are reported in Table 3; they ranged from .75 (Self-Other Responsibility) to .90 (Decision Making), with a mean of .82. The following autonomy subscales described above were expected to measure aspects of

Table 3. Interrater Reliability for the Young Adult/Parent Relationship Interview

	Pearson r
Decision Making	.90
Independence	.81
Self-Assertion	.78
Personal Control	.87
Self-Other Responsibility	.75

individuation: deidealization, autonomy, decision making, and independence. Mutuality, respect for intergenerational boundaries, and self-other responsibility were expected to assess aspects of mutuality. Finally, conflictual dependence, insecurity, personal control, and self-assertion were intended to measure anxieties about separation (see Table 4 for summary chart).

Adjustment

The Offer Self-Image Questionnaire (Offer, Ostrov, & Howard, 1989) measures various aspects of psychological health. Three scales (34 items) were combined to provide a measure of emotional adjustment, or more specifically, self-concept: emotional tone, mastery of the external world, and absence of psychopathology. The measure reportedly has adequate concurrent validity and discriminates between normal and disturbed adolescents (Offer et al., 1989). Internal consistency for the combined scales for this sample was .92.

A number of items from the Health History questionnaire (described above in the Eating Attitudes and Behavior section) were used to assess depressive symptoms, in order to provide another measure of emotional adjustment. Respondents were asked to indicate how frequently they experience several symptoms of depression (depression, anxiety, difficulty getting up in the morning, crying episodes, irritability, fatigue, and difficulty falling asleep) on a 5-point scale ranging from "Never" to "Always". Factor analysis of these items resulted in one "depressive symptoms" factor. Internal consistency for this sample was .85.

Table 4. Predicted Factors for the Autonomy Scales

Individuation	Measure
Deidealization	Emotional Autonomy Scale
Autonomy	Parental Relationship Inventory
Decision-Making	YAPR
Independence	YAPR
Mutuality	
Mutuality	Parental Relationship Inventory
Respect for Boundaries	Parental Relationship Inventory
Self-Other Responsibility	YAPR
Anxieties about Separation	
Conflictual Dependence	Psychological Separation Inventory
Insecurity	Familial Insecurity Scale
Personal Control	YAPR
Self-Assertion	YAPR

Note: YAPR=Young Adult/Parent Relationship Interview

Procedure

Participants were recruited from the introductory psychology subject pool at a large midwestern university, and were given research credit for their psychology course in exchange for their participation. Participants were part of a larger group of students who completed a battery of questionnaires, administered in random order, during group testing sessions lasting approximately one to two hours. They were told that the purpose of the research was to study the relationship between the family environment and various health attitudes and behaviors. During the testing sessions, students were requested to complete a Recontact form if they wished to be considered for participation in the second phase of the study. On the Recontact form, they were asked to provide a code name by which they would be identified, along with their phone number. They were told they would receive additional research credits if chosen to continue. They were also told that only a small percentage of the total group would be recontacted, and that even if they signed the form, they were not obligated to participate in the second phase.[1]

The majority of students participating in phase one completed the Recontact form (74%), and the present sample was chosen from this group. Of women meeting the criteria for the eating disorder group (those who had scores of 30 or above on the EAT), 79% agreed to be recontacted (as opposed to 72% of the women who did not meet criteria for the eating disorder

[1] The procedure for Samples 1 and 2 was virtually identical, with the only exception being that Sample 1 was administered all of the questionnaires but the Health History in the group testing session. Sample 1 was given the option of participating in Phase 2 of the study, in order to test the success of using this method to recruit subjects for the interview phase. Although the primary goal was collecting questionnaire data for Sample 1, 10 subjects were also administered the interview and included in Sample 2. Hence, 10 subjects were included in both Samples 1 and 2.

group), indicating that women with disordered eating were no less likely to agree to be recontacted than other women. Students who met the criteria for the comparison group (had scores of 20 or less on the EAT) were matched to an eating disorder subject based on age and socioeconomic status. Women meeting the criteria for the disordered eating or comparison groups were recontacted by an interviewer, identified only by the code name they had provided, and were requested to take part in the interview phase. Unfortunately, statistics on the women who declined to participate further in the study at this point were not kept. However, the primary reason for not continuing was having already received the maximum number of required and extra credit research credits, and this generally occurred only towards the end of the semester.

Participants who agreed to complete the second phase of the study were administered the interview in either one 3 hour session or two 1 1/2 hour sessions, depending on participant preference. The order in which mother and father interviews were administered was alternated. Participants were also given additional questionnaires to fill out at home prior to the interview. The first 10 participants completed all but one of the questionnaires (the Health History) in the initial testing session. The remaining 70 were given half of the questionnaires in the initial session and half as part of the interview phase of the study. One participant did not complete the additional questionnaires, reducing the total number of participants to 79.

Two primary interviewers (who together completed 80% of the interviews) and four secondary interviewers (who administered 20% of the interviews) were trained to administer the Young Adult/Parent Relationship Interview by its author (Susan Frank). Interviewers were all

female; five were clinical psychology graduate students and one was a senior psychology student. In the large majority of cases, interviewers were blind to the status of the participant (i.e. disordered eating group or comparison group); however, in a few cases, the primary investigator was aware of the status of the interviewee.

Two clinical psychology graduate students (the primary investigator and a secondary interviewer), who had prior experience in coding the YAPR, coded the autonomy scales using detailed manuals developed by Susan Frank. The manuals provided criteria for scoring each dimension on a 5-point scale. The primary investigator "blocked" the interviews by printing only the responses that pertained to each autonomy dimension on separate sheets of paper, so that coders were only reading items that specifically addressed the dimension they were coding. Although there was still some overlap in content, this process maximized the likelihood that each autonomy dimension would be scored without information about other dimensions. Coders were blind to the status (i.e. disordered eater or comparison) of the participant, as protocols were identified only by subject numbers.

Coders practiced scoring the autonomy dimensions using interview protocols from prior studies by Susan Frank and colleagues. The coders' interrater reliability was measured using a sample of 20 protocols from a prior study with college students. Scores for the reliability sample were established by Susan Frank and a secondary investigator (who had attained adequate reliability on other protocols); both coders independently scored the protocols, then discussed them and resolved any differences. The resulting scores were used as the standard to which the coders' scores in

this study were compared. Once reliability was established, the coders scored the protocols from the current study.

Results

Preliminary Analyses

Participants ranged in weight from 95 to 180 pounds (M=129.6, SD=15.86), and ranged in height from 60 to 71 inches (M= 65.49, SD=2.57). The mean weight of the disordered eating group was 133.35 pounds and the mean height was 65.92 inches, while the mean weight of the comparison group was 126.22 pounds, and mean height was 65.22 inches. Analyses of variance revealed that although there were not significant group differences on height, disordered eaters weighed significantly more than controls, $F(1,74)=3.97$, $p<.05$. However, a calculation of body mass index (BMI) (weight in kilograms/height in meters^2) revealed no differences between disordered eaters and controls. Participants' scores on the Eating Attitudes Test ranged from 6 to 78.

The mean scores for this sample on the scales completed separately with regard to mothers and fathers are presented in Table 5. Paired t-tests indicated that in a number of cases, there were significant differences between daughters' experiences of their relationships with mothers versus fathers. Where differences existed on measures of separation-individuation, daughters generally experienced higher levels of autonomy from fathers than from mothers. In particular, daughters had higher scores with regard to fathers on the autonomy, $t(77)=2.83$, $p<.01$, decision-making, $t(77)=2.00$, $p<.05$, and self-other responsibility scales, $t(77)=6.58$, $p<.001$. However, they reported higher levels of mutuality in relationships with their mothers, $t(77)=3.52$, $p<.001$. On the parent eating preoccupation

Table 5. Means (and Standard Deviations) on Autonomy and Eating Preoccupation Scales for Mothers and Fathers

	Mothers	Fathers	t
Autonomy Scales			
Deidealization	2.86 (.47)	2.85 (.49)	.10
Autonomy	2.36 (.39)	2.50 (.49)	2.83[b]
Mutuality	3.11 (.56)	2.89 (.59)	3.52[c]
Respect for Boundaries	2.97 (.54)	2.97 (.47)	.13
Conflictual Dependence	1.92 (.70)	1.80 (.62)	1.76
Insecurity	2.05 (.55)	2.08 (.56)	.59
Decision Making	2.33 (1.18)	2.65 (1.25)	2.00
Independence	2.37 (1.06)	2.49 (1.15)	1.01
Self-Assertion	2.20 (1.22)	2.00 (1.02)	1.33
Personal Control	3.43 (1.18)	3.41 (1.19)	.08
Self-Other Responsibility	1.97 (1.03)	2.99 (1.22)	6.58[c]
Eating Preoccupation Scales			
Eating Preocc.-Self	1.84 (.77)	1.50 (.64)	3.33[c]
Eating Preocc.-Child	1.61 (.69)	1.29 (.59)	3.91[c]
Food as Nurturance	2.00 (.66)	1.60 (.54)	5.59[c]

[a] $p<.05$. [b] $p<.01$. [c] $p<.001$.

scales, the adolescents perceived their mothers as being more preoccupied with both their own weight and eating, $t(78)=3.33$, $p<.001$, as well as their daughter's, $t(78)=3.91$, $p<.001$. Mothers were also perceived as being more likely to use food as a means of providing nurturance, $t(78)=5.59$, $p<.001$.

Comparisons between Disordered and Non-Disordered Eaters

Eating Behavior

Preliminary analyses were conducted in order to determine whether disordered eaters (as defined by scores on the EAT) were significantly different from comparisons on eating-related variables (from the Health History). Results of chi square analyses conducted on the two groups indicated, as would be expected, that disordered eaters were more likely than comparisons to report having dieted, $x^2(1, N=78)=12.71$, $p<.001$. Analyses of variance indicated that disordered eaters also began dieting at a younger age ($M=14.28$ vs. 16.64 years), $F(1,51)=18.68$, $p<.001$, and started more diets in their first year of dieting ($M=4.34$) than did comparisons ($M=2.18$), $F(1,51)=10.32$, $p<.002$. Disordered eaters were more likely to report having binged, $x^2(1, N=78)=20.86$, $p<.001$, and having vomited after eating in order to get rid of the food eaten, $x^2(1, N=78)=11.76$, $p<.001$. Of the women who reported binging, disordered eaters felt more out of control during binges, $F(1, 44)=10.38$, $p<.002$, felt more miserable or annoyed after binges, $F(1, 44)=16.95$, $p<.001$, were more likely to binge eat in private, $F(1, 44)=7.92$, $p<.007$, and were more uncomfortable with their binge eating, $F(1, 39)=4.91$, $p<.03$. However, differences were not found on reports of eating rapidly during binges, consuming large amounts of food during binges, or eating until feeling physically ill. The two groups did not differ significantly on whether they had used laxatives to control weight or "get rid of food".

However, the fact that this relationship was not significant is likely due to the very low rate of endorsement of this item (only 9 participants endorsed this item, 8 of whom were disordered eaters).

Adjustment

Analyses of variance indicated that disordered eaters reported more depressive symptoms, $F(1,70)=5.01$, $P<.03$, and poorer self-concepts, $F(1,69)=13.11$, $P<.001$, than comparisons. In addition, disordered eaters were more likely to have been involved in outpatient mental health treatment, $x^2(1, N=78)=5.01$, $p<.03$. The groups did not differ on reports of attempted suicide, or attempts to physically hurt oneself. They also did not differ on history of hospitalization for eating or emotional problems or history of taking psychiatric medication, although, again, this was probably due to the low frequency with which these variables were endorsed: Only two participants had been hospitalized, both of whom were disordered eaters, and five had taken psychiatric medication, including 4 disordered eaters and 1 comparison subject.

Comparisons between Three Groups

Participants were also separated into three groups, based on their EAT scores, which were defined as "no or mild eating pathology" (score <30), "moderate eating pathology" (score ≥ 30 and < 40) and "severe eating pathology" (score ≥ 40), in order to determine whether differences existed based on extent or severity of eating pathology. For the most part, results of comparisons between the three groups were similar to the comparisons between two groups, in that women with both moderate and severe eating pathology reported more disturbed eating patterns and poorer emotional adjustment than those with little to no eating pathology. However, there

were several differences between the women with moderate and severe eating pathology. Although there were no differences in body mass between disordered eaters and comparisons, women with moderate eating pathology had higher body mass index scores than both women with no eating pathology and women with severe eating pathology, $F(2,75)=3.51$, $P<.04$. In addition, women with severe eating pathology reported significantly more depressive symptoms, $F(2,70)=4.85$, $P<.01$, and were more likely to have been hospitalized for eating or emotional problems than those with no or moderate pathology, $x^2(2, N=78)=5.95$, $p<.05$.

Factor Analyses

Parent Eating Attitudes Scale

A factor analysis of the Parent Eating Attitudes Scale was conducted, using Sample 1 (N=272). First, I discarded very low frequency items, i.e., items to which 90% or more of the sample responded "very false". This resulted in discarding one item for the "mother" scale and four items for the "father" scale. I then factor analyzed the scales using the remaining items pertaining to eating and weight. Five factors were obtained for perceptions of mother and six were obtained for perceptions of father (the sixth was a single item); the solutions were very similar for mothers and fathers, except that for fathers the third and fourth factors were reversed. For perceptions of mothers' eating attitudes, 48% of the variance was explained by the first three factors, and for perceptions of fathers, 53% of the variance was explained by the first four factors. Because the three primary factors were very similar for perceptions of mothers and fathers, I used the "mother" solution as the standard in computing three scales, by averaging scores for PEATS items with loadings greater than .45 on each of the

factors. Factor 1 described daughters' reports of parents' preoccupation with their own (the parents') weight and eating, Factor 2 described daughters' perceptions of parents' preoccupation with the daughter's weight and eating, and Factor 3 described daughters' perceptions of parents' use of food as a source of nurturance or reinforcement. These three scales were then computed for Sample 2.

Autonomy Scales

Separate factor analyses of the autonomy scales using a varimax solution resulted in three somewhat different factors for autonomy from mothers and autonomy from fathers[1]. The factor solutions for autonomy from mothers and fathers are shown in Tables 6 and 7, respectively (factor loadings greater than .50 are in boldface). Taking relationships with mothers first, it can be seen that the first two factors obtained were similar to the predicted factors. The first factor included aspects of both the predicted Mutuality and Anxieties about Separation factors. Scores for five subscales loaded on this factor: conflictual dependence (positive), respect for boundaries (negative), insecurity (positive), mutuality (negative), and personal control (negative). This factor appears to describe Anxieties about Separation because it indicates negative affect regarding separation, a perceived lack of respect by the mother for the adolescent's independence strivings, and a lack of control over negative emotions in the relationship with mother.

The second factor describes Individuation, and is very similar to the predicted individuation factor. It consists of deidealization, autonomy,

[1] One participant was not used in the analyses regarding relationship with fathers because she was missing too many variables.

Table 6. Factor Loadings for Autonomy Scales on the Three Factors Obtained for Relationship with Mothers

	Anxiety about Separation	Individuation	Disengagement
Autonomy Scale			
Conflictual Dependence	**.90**	.11	-.02
Respect for Boundaries	**-.88**	-.12	-.06
Insecurity	**.87**	.21	-.12
Mutuality	**-.78**	-.12	-.37
Personal Control	**-.64**	.23	.01
Decision-Making	.15	**.75**	.29
Independence	.10	**.71**	.28
Self-Assertion	-.24	**.71**	-.40
Deidealization	.35	**.67**	.03
Autonomy	-.22	**.55**	.50
Self-Other Responsibility	.06	.17	**.86**

Table 7. Factor Loadings for Autonomy Scales on the Three Factors Obtained for Relationship with Fathers

	Anxiety about Separation	Autonomy with Overt Conflict	Independence
Autonomy Scale			
Respect for Boundaries	**-.83**	.25	-.11
Conflictual Dependence	**.81**	.16	-.01
Insecurity	**.80**	-.02	-.13
Mutuality	**-.78**	-.23	-.19
Autonomy	-.04	**.84**	.27
Self-Other Responsibility	-.05	**.73**	.05
Deidealization	.31	**.66**	.39
Personal Control	**-.54**	**-.56**	.14
Independence	.07	-.03	**.76**
Decision-Making	.16	.43	**.71**
Self-Assertion	-.12	.14	**.54**

independence, decision-making, and self-assertion, and most clearly reflects a healthy form of autonomy. It describes self-governing behavior, feelings of competence, and an ability to independently evaluate one's own self-worth. In addition, it reflects a recognition on the adolescent's part of her mother's fallibility, as opposed to continuing to hold to highly idealized views of her, and a willingness to assert one's standards, even if they differ from mother's.

The strongest variable loading on the third factor was self-other responsibility; however, it is important to note that self-assertion as well as autonomy also had sizeable loadings, with self-assertion in a negative direction. This factor appears to reflect a defensive type of autonomy that is often associated with intrapsychic conflict. Although a high score on this dimension suggests that the daughter has made investments and attachments outside of the mother-daughter relationship and also experiences a certain degree of behavioral autonomy from her mother, she may be unable to assert herself in their relationship, be inhibited by feelings of shame and guilt, and continue to need her mother's approval in order to feel good about herself. Because of its associations with intrapsychic (but not overt) conflict, this factor is labeled Disengagement. Factors were computed by averaging scores for scales with loadings greater than .50 on each of the factors.

The first factor obtained for relationship with fathers was similar to that found for relationship with mothers. It included respect for boundaries, mutuality, conflictual dependence, and insecurity, and was also labeled Anxieties about Separation. However, the second and third factors were different from those regarding relationship with mothers. The second factor consisted of autonomy, self-other responsibility,

deidealization, and personal control. Personal control had approximately equivalent loadings on the first and second factors, but was included on the second factor because its loading was slightly stronger. Notably, personal control had a negative loading on factor two, which deserves some comment. The fact that high levels of autonomy (as defined on this factor) are associated with low levels of personal control suggests that factor two describes autonomy which is achieved in the context of a conflicted relationship with father. It indicates self-governance, a recognition of father's weaknesses and fallibilities, and an ability to distinguish between one's own and one's father's needs. However, it also suggests a degree of alienation from father, as it indicates a lack of emotional control, and an inability to regulate one's negative feelings in the relationship with father; therefore, it is labeled Autonomy with Overt Conflict. Although this factor is similar in some ways to the Disengagement factor found for relationship with mothers, the conflict with fathers is overt, rather than intrapsychic.

The third factor found for relationship with fathers consists of independence, decision-making, and self-assertion. It describes behavioral or functional independence and feelings of competence, and appears to best reflect healthy autonomy in relation to fathers. This factor was labeled Independence. Again, factors were computed by averaging scores for scales with loadings greater than .50, with the exception of personal control, which had high loadings on both factors one and two (.54 and .56 respectively). It was only included on factor two, in order to maintain the independence of the factors.

Regression Analyses

Multiple regression analyses assessed whether separation-individuation difficulties and perceptions of parent eating preoccupation would predict eating pathology and adjustment problems (poor self-concept and depressive symptoms), and also whether separation-individuation experiences would moderate the relationships between parent eating preoccupation and disordered eating or problems in adjustment. Separate analyses tested main and interaction effects for relationships with mothers and relationships with fathers.

In order to reduce the number of variables in the analyses, I combined the three parent eating preoccupation scales (parent's preoccupation with own weight and eating, parent's preoccupation with daughter's weight and eating, and use of food as nurturance) for mothers and for fathers, creating global mother eating preoccupation and father eating preoccupation variables. Correlations among the eating preoccupation scales for each parent were, for the most part, relatively high (see Table 8), although fathers' use of food as nurturance was unrelated to fathers' preoccupation with their own eating, and mothers' use of food as nurturance was unrelated to mothers' preoccupation with their daughters' eating. The pattern of results for the regression analyses were very similar whether the parent eating preoccupation variables were combined or entered separately, although effect sizes were slightly weaker for the combined scores.

I first regressed eating pathology (defined by EAT scores) on parent eating preoccupation and each of the autonomy variables (Anxieties about Separation, Individuation, and Disengagement for relationships with

Table 8. Correlations among PEATS Scales

		1	2	3	4	5	6
1	F. Self Pre.	1.00					
2	F. Child Pre.	.38[c]	1.00				
3	F. Food/Nurt.	.08	.27[a]	1.00			
4	M. Self Pre.	.22[a]	.25[a]	.14	1.00		
5	M. Child Pre.	.12	.37[c]	.10	.29[b]	1.00	
6	M. Food/Nurt.	.13	.19	.43[c]	.41[c]	.08	1.00

[a] $p<.05$. [b] $p<.01$. [c] $p<.001$.

F.=Father; M.=Mother; Self-Pre.=Preoccupation with own eating; Child Pre.=Preoccupation with daughter's eating; Food/Nurt.=Using food as nurturance.

mothers, and Anxieties about Separation, Independence, and Autonomy with Overt Conflict for relationships with fathers); I then used a stepwise procedure to test for possible interactions, which were computed as cross-products, between parent eating preoccupation and each of the autonomy factors. For the analyses predicting self-concept problems and depressive symptoms, I first entered daughter's eating pathology, in order to partial out the effect of disordered eating on adjustment problems; this was because there were strong relationships between poor adjustment and disordered eating. I then regressed each of the adjustment variables (negative self-concept and depressive symptoms) on the autonomy variables and parent eating preoccupation, and used a stepwise procedure to test the interactions between parent eating preoccupation and each of the autonomy factors.

Table 9 shows correlations among the variables in the analyses. As can be seen, there were strong correlations among the measures of individual pathology (eating pathology, self-concept problems, and depressive symptoms), with r's from .40 to .67. There were also relatively strong and significant correlations between each of the individual pathology variables and a) perceptions of mothers' and fathers' eating preoccupation (r's from .33 to .46), as well as b) reports of anxiety about separation from both mothers and fathers (r's from .23 to .56). In addition, perceptions of mothers' eating preoccupation were associated with anxieties about separation from mothers ($r=.52$, $p<.001$), and perceptions of fathers' eating preoccupation were associated with anxieties about separation from fathers ($r=.43$, $p<.001$). Although reports of individuation from mothers were correlated with reports of disengagement in the relationship with mothers

Table 9. Correlations among Eating and Adjustment Problems, Parents' Eating Preoccupation, and Experiences of Autonomy

		1	2	3	4	5	6	7	8	9	10	11
1	Eating Pathology	1.00										
2	Self-Concept Problems	.43[c]	1.00									
3	Depressive Symptoms	.40[c]	.67[c]	1.00								
4	M. Eating Preoccupation	.46[c]	.39[c]	.33[b]	1.00							
5	F. Eating Preoccupation	.43[c]	.40[c]	.35[b]	.43[c]	1.00						
6	M. Individuation	-.13	-.17	-.03	-.00	-.10	1.00					
7	F. Independence	.07	-.12	.03	-.08	-.03	.52[c]	1.00				
8	M. Disengagement	.03	.12	-.12	-.08	-.06	.31[b]	.11	1.00			
9	F. Autonomy w/OC	-.14	-.07	-.04	-.13	.00	.40[c]	.45[c]	.22[a]	1.00		
10	M. Anxiety/Separation	.23[a]	.56[c]	.52[c]	.52[c]	.15	.15	-.03	.16	-.08	1.00	
11	F. Anxiety/Separation	.36[c]	.44[c]	.46[c]	.42[c]	.43[c]	.02	.11	.02	.16	.53[c]	1.00

[a] $p<.05$. [b] $p<.01$. [c] $p<.001$.

M.=Mother; F.=Father; OC=Overt Conflict.

(r=.31, p<.01), and reports of autonomy with overt conflict in relationships with fathers were correlated with reports of independence from fathers (r=.45, p<.001), none of these measures of autonomy were associated with measures of individual pathology, parents' eating preoccupation, or anxieties about separation.

Beta coefficients derived from the regression analyses for relationships with mothers are shown in Table 10. As can be seen, adolescents' perceptions of mothers' eating preoccupation was the strongest predictor of daughters' eating pathology, accounting for 25% of the variance. Contrary to predictions, separation-individuation difficulties in the relationship with mother were not significantly associated with disordered eating. However, one autonomy variable, disengagement, did moderate the relationship between mothers' eating preoccupation and eating pathology (See Figure 1). That is, among adolescents reporting high levels of disengagement in the relationship with their mothers, perceptions of mothers' weight and eating preoccupations were more strongly related to daughter's eating pathology than among adolescents reporting low levels of disengagement.

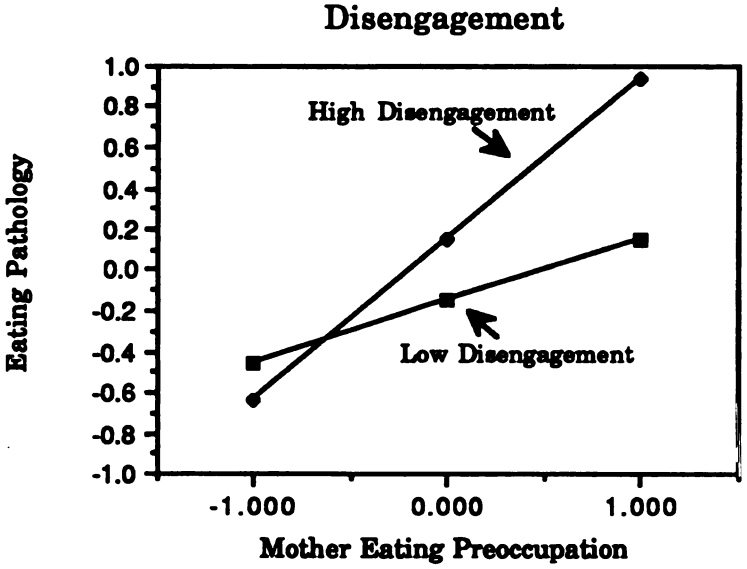
In contrast to the results for eating pathology, separation-individuation difficulties in the relationship with mothers predicted emotional maladjustment. In particular, adolescents' reports of anxieties about separation from mothers and lack of individuation from mothers accounted for an additional 27% of the variance in self-concept problems, after controlling for daughter's eating pathology. Similarly, adolescents' anxieties about separation and low levels of disengagement in the

Table 10. Regression Analyses for Relationship with Mothers

EATING PATHOLOGY	r	b	R^2
Step 1			
Eating Preocc.	.46[c]	.48[c]	.25[c]
Step 2			
Eating Preocc. x Disengagement		.24[a]	.06[a]
SELF-CONCEPT PROBLEMS			
Step 1			
Eating Pathology	.43[c]	.43[c]	.18[c]
Step 2			
Anxieties about Separation	.56[c]	.51[c]	.27[c]
Individuation	-.17	-.24[b]	
DEPRESSIVE SYMPTOMS			
Step 1			
Eating Pathology	.40[c]	.40[c]	.16[c]
Step 2			
Anxieties about Separation	.52[c]	.55[c]	.25[c]
Disengagement	-.12	-.23[a]	

[a] $p<.05$. [b] $p<.01$. [c] $p<.001$.

Figure 1. Interaction between Disengagement and Mother Eating Preoccupation in Predicting Eating Pathology



relationship with mothers accounted for 25% of the variance in predicting depressive symptoms. As expected, none of the interactions between separation-individuation difficulties and mothers' eating preoccupation were significant.

Results regarding relationships with fathers were somewhat different than those found for mothers. Beta coefficients from the analyses for relationships with fathers are shown in Table 11. Like the results for relationships with mothers, adolescents' perceptions of fathers' eating preoccupation was a direct predictor of adolescents' eating problems. However, unlike the results for mothers, both reports of anxieties about separation from fathers and low levels of autonomy with overt conflict in the relationship with fathers also accounted for significant variance in adolescents' eating pathology, with the three variables together accounting for 28% of the variance. None of the interactions between separation-individuation and father eating preoccupation were significant.

With regard to adjustment, the results were essentially the same for poor self-concept and depressive symptoms. As predicted, after controlling for the effects of daughter's eating pathology, anxieties about separation from fathers accounted for significant additional variance in adjustment problems (14% for self-concept problems and 13% for depressive symptoms). However, the interaction between autonomy with overt conflict and father eating preoccupation was also significant for both measures of adjustment problems (see Figures 2 and 3). That is, among adolescents describing high levels of autonomy with overt conflict in their relationships with their fathers, degree of self-concept problems or depressive symptoms was increased when daughters reported that their fathers were highly

Table 11. Regression Analyses for Relationship with Fathers

EATING PATHOLOGY	r	b	R^2
Step 1			
Eating Preoccupation	.43[c]	.33[b]	.28[c]
Aut. w/OC	-.12	-.28[b]	
Anxieties about Separation	.36[c]	.28[a]	
SELF-CONCEPT PROBLEMS			
Step 1			
Eating Pathology	.43[c]	.43[c]	.18[c]
Step 2			
Anxieties about Separation	.44[c]	.29[b]	.14[b]
Step 3			
Eating Preocc. by Aut. w/OC		.23[a]	.05[a]
DEPRESSIVE SYMPTOMS			
Step 1			
Eating Pathology	.40[c]	.40[c]	.16[c]
Step 2			
Anxieties about Separation	.46[c]	.36[b]	.13[a]
Step 3			
Eating Preocc. by Aut. w/OC		.30[b]	.08[b]

[a] $p<.05$. [b] $p<.01$. [c] $p<.001$.

Aut. w/OC=Autonomy with Overt Conflict.

Figure 2. Interaction between Autonomy with Overt Conflict and Father Eating Preoccupation in Predicting Self-Concept Problems

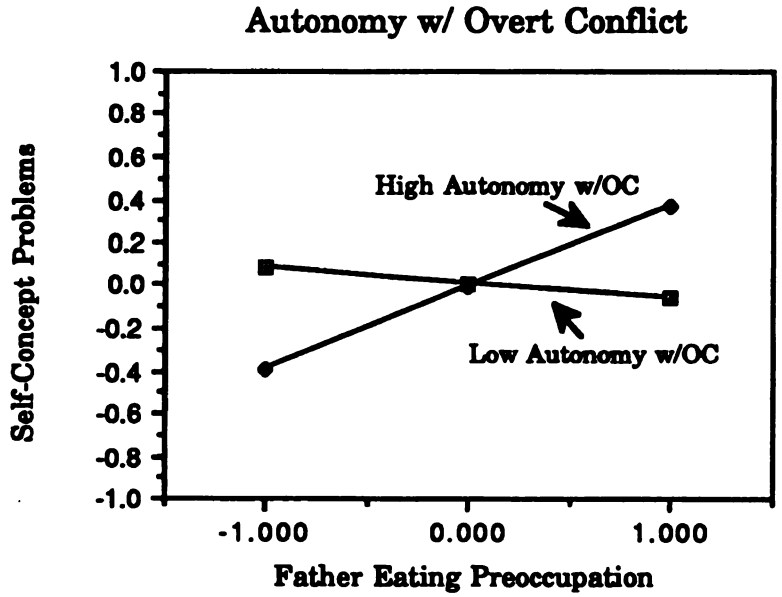
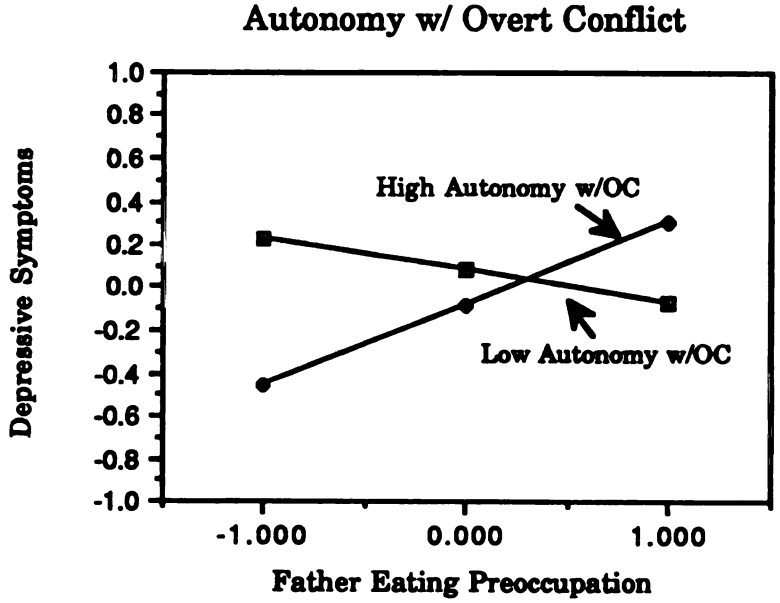


Figure 3. Interaction between Autonomy with Overt Conflict and Father Eating Preoccupation in Predicting Depressive Symptoms



preoccupied with eating and weight. On the other hand, among adolescents describing low levels of autonomy with overt conflict in their relationships with their fathers, there was little to no relationship between daughters' adjustment problems and reports of fathers' eating preoccupation.

Discussion

Overall, these results strongly demonstrate the importance of separation-individuation processes and parent eating preoccupation in the development of eating pathology in late adolescent women. Interestingly, the results regarding relationships with mothers versus fathers were quite different, and they indicated that, despite the fact that fathers have frequently been overlooked in the eating disorders literature as well as the literature on adolescent female autonomy development, both parents have a substantial impact on daughters' adjustment.

A factor analysis of a variety of aspects of autonomy resulted in quite different factors for relationships with mothers versus fathers, suggesting that daughters may become increasingly autonomous from their parents in unique ways. First, in relation to both mothers and fathers, an "anxieties about separation" factor was obtained. The affective experience regarding separating from parents appears to be a salient component of the separation-individuation process, and negative feelings about the process have consistently been found to have negative implications for late adolescent adjustment (Holmbeck & Wandrei, 1993; Kenny & Donaldson, 1991; Rice et al., 1990). In this study, anxiety about separation was defined by feelings of insecurity, guilt, shame, and resentment related to separating from parents, as well as an inability to control these negative feelings. It also described a perceived lack of mutuality in the relationship with the parent, including feeling that the parent does not respect the late

adolescent's status as an adult, or her need to become independent and make her own decisions.

What appeared to be a "healthy autonomy" factor was also obtained in relation to both parents. However, this factor was somewhat different for mothers and fathers, and they were therefore given different labels (Individuation and Independence, respectively). The decision making, independence, and self-assertion scales loaded on both healthy autonomy factors, indicating that the ability to make one's own decisions, to cope with life difficulties, and to rely on one's own standards of behavior are important in becoming independent from mothers and fathers. However, deidealization and autonomy, often referred to as aspects of "individuation" in the psychoanalytic literature, also loaded with these scales on the factor for relationships with mothers. This indicates that, in addition to being behaviorally independent from mothers, late adolescent women scoring high on "individuation" were able to see their mothers as fallible and had given up childish notions of her omnipotence.

For relationships with fathers, deidealization and autonomy loaded on a third factor along with self-other responsibility and low personal control. This suggests that there is an element of conflict and negativity involved in deidealizing and separating from fathers. Adolescents scoring high on this variable (autonomy with overt conflict) were able to see their fathers' weaknesses, distinguish between their own needs and their fathers' needs, and develop new investments outside of this relationship. However, they also experienced overt conflict in the relationship, and had difficulty controlling their negative feelings regarding fathers. Without longitudinal data, it is impossible to know if daughters begin to deidealize and separate from fathers <u>because of</u> the conflict in their relationship, or

whether separating from fathers and relinquishing idealized notions of them leads to overt conflict.

Women who received high scores on the third factor obtained for relationships with mothers, disengagement, appeared to have defensively developed a level of behavioral autonomy and separateness, in order to compensate for an inability to assert themselves in the mother-daughter relationship. Unlike the third factor obtained with regard to fathers, the conflict that appears to exist in the mother-daughter relationship is intrapsychic rather than overt. In order to gain a better understanding of this construct, it is helpful to look at self-other responsibility, the variable with the strongest loading on this factor, more closely. Self-other responsibility appears to be a more difficult aspect of autonomy to attain in the mother-daughter relationship, for late adolescent women. Late adolescents in this sample averaged a lower score on this variable than on any of the other interview variables, and it was the only interview variable on which they scored significantly lower than they did within the father-daughter relationship. On average, these women fell at level 2, which is defined by clear overinvolvement by the parent in the child's life. At this level, late adolescents may make weak, ineffective attempts to deinvest in the parent-child relationship, or may resist pressures to deinvest in it. This suggests that lack of separateness in the mother-daughter relationship is relatively normative among late adolescents, at least in this sample of college women. This finding is not altogether unexpected, as others have found that relationships between mothers and adolescent or young adult daughters are characterized by less distinct boundaries and higher levels of emotional intensity than other parent-child dyads (Chodorow, 1978; Frank, et al., 1988). However, this makes it important to identify the correlates and

issues involved for women who experience high levels of self-other responsibility.

The major thrust of this research was to explore factors which place late adolescent females at risk for developing disordered eating, and to distinguish between factors which lead to eating disorders versus other problems of adjustment. First, it is important to point out that women with eating pathology described more individual dysfunction than women who did not exhibit disturbed eating patterns. As would be expected, disordered eaters reported earlier histories of concern over weight (i.e., they began dieting earlier and more frequently), and they reported more severely maladaptive eating patterns, including binging and purging. Although some women in the comparison group reported binge eating, disordered eaters experienced their binge eating as more troublesome and out of control. In addition to differences in eating behavior, the disordered eaters also had more negative self-concepts and reported more depressive symptoms than women without eating problems. Moreover, severity of eating pathology was related to the severity of depression.

The correlational data revealed, like a number of other studies of college student populations, that anxieties about separation from parents were strongly correlated with measures of individual dysfunction, including eating pathology, poor self-concept, and depressive symptoms. In addition, daughters' perceptions of parent eating preoccupation were associated with each of the individual pathology variables, and perceptions of parent eating preoccupation were strongly associated with anxieties about separation in relation to mothers and fathers. It is conceivable that when parents are preoccupied with their own and their daughter's eating and weight, the daughter perceives her parents as being critical of both

themselves and of her, leading to feelings of insecurity, anger and resentment. The following excerpt from an interview of a woman in the disordered eating group exemplifies this concept. Madison states: "She'll make a suggestion and she doesn't think she's doing anything - but it hurts. When your mom's always saying something like 'Shouldn't you lose a few pounds? Don't you want to get down a pants size?' Finally I'm like 'Mom, quit telling me! I know I'm fat!' And in retaliation to that I get mad at her. And then my friends come over and say 'You're so mean to your Mom' and I feel terrible."

Another possible explanation for the relationship between perceptions of parent eating preoccupation, anxieties about separation, and individual pathology goes back to the discussion of early separation-individuation processes. It is easy to imagine that parents who are caught up in issues surrounding eating and food will be unable to respond appropriately to their infant's cues regarding hunger and feeding, causing disruptions for the child in the development of trust, interoceptive awareness, and separateness. These characteristics, in turn, may lead to anxieties about separation and eating pathology. In addition, if parents' preoccupations with food and weight are attributable to their own struggles with interoceptive confusion and insecurity, they are likely to transmit these messages across generations through their responses to their children.

The regression analyses offered rich, and somewhat unexpected, findings. For example, the notion that parent eating preoccupation would be a significant factor in the development of disordered eating in late adolescents was strongly supported by these data. However, it turned out that perceptions of parent eating preoccupation were far more important

than was expected. Although it was predicted that perceptions of parent eating preoccupation would have relevance for disordered eating only in the context of problems with separation-individuation, perceptions of both mother's and father's eating preoccupation were actually direct predictors of daughter's eating pathology. The results regarding perceptions of fathers' eating preoccupation are especially noteworthy, as fathers have typically been neglected in explorations of influences on daughters' body image and eating pathology.

Contrary to predictions, parent eating preoccupation superseded the role of separation-individuation problems in eating pathology, in the relationship with mothers. That is, although perceptions of mothers' eating preoccupation had a direct effect on daughters' eating pathology, none of the autonomy constructs were significant predictors of disordered eating. However, there was a significant interaction, in the opposite direction of that expected, between mothers' eating preoccupation and disengagement in predicting eating pathology. In particular, among late adolescents reporting high levels of disengagement from mothers, perceptions of mothers' weight and eating preoccupation were more strongly related to daughters' eating pathology than among late adolescents reporting low levels of disengagement. It appears that the defensive aspect involved in disengagement from mothers may be responsible for the increased association between perceptions of mothers' eating preoccupation and daughters' disordered eating. In addition, the intrapsychic conflict that was associated with disengagement may help to explain this relationship. When daughters have defensively adopted a level of separateness from their mothers, but are not able to assert themselves in the relationship and need their mothers' approval to feel good about

themselves, they are more likely to be susceptible to mothers' pressures and criticisms surrounding weight.

It was predicted that autonomy problems would moderate the relationship between perceptions of parent eating preoccupation and daughter's eating pathology, but not between perceptions of parent eating preoccupation and adjustment problems. In relation to mothers, perceptions of parent eating preoccupation did not directly predict adjustment problems (either negative self-concept or depressive symptoms), nor was the relationship between mother eating preoccupation and adjustment moderated by autonomy problems. This suggests that mother's preoccupation with her own and her daughter's weight and eating was a specific risk factor for eating pathology.

Somewhat surprisingly, problems with autonomy in relation to mothers were more likely to lead to general adjustment problems than to disordered eating. Unlike the results for eating pathology, anxieties about separation from mothers predicted both negative self-concept and depressive symptoms. In addition, lack of individuation from mothers led to problems with self-concept, and low levels of disengagement were predictive of depressive symptoms. These findings suggest that disengagement is somewhat of a "double-edged sword". Although high levels of disengagement increased risk for eating pathology when mothers were perceived as being preoccupied with their own and their daughters' weight and eating, low levels were associated with increased depression. Again, it is plausible that the defensive component of disengagment increased daughters' vulnerability to mothers' weight preoccupation, while the lack of differentiation from mother and inability to develop a life separate from her led to depression.

Taken together, these results provide evidence that late adolescent women who are overly dependent on their mothers (as defined by each of the aspects of autonomy measured here) are more likely to have problems in adjustment than women who are more autonomous from their mothers. These findings run counter to contentions (e.g. Ryan & Lynch, 1989) that individuation reflects detachment and alienation, and is associated with negative outcomes for adolescents. It is particularly noteworthy that separation-individuation problems in the relationship with mother led to general maladjustment, rather than to eating disorders.

The findings were quite different for relationships with fathers. Again, perceptions of parent eating preoccupation was a direct predictor of daughters' eating pathology. However, unlike results for mothers, anxieties about separation and inability to disengage from fathers (along with low levels of conflict) made independent contributions to eating pathology, suggesting that separation-individuation problems with fathers are more relevant for disturbed eating than with mothers. Looking next at adjustment problems, after controlling for eating pathology, anxieties about separation also predicted both poor self-concept and depressive symptoms. Independence (which appeared to describe "healthy" autonomy) was not related to either eating pathology or adjustment problems. This raises the question of whether functional or behavioral autonomy is, in fact, a "healthy" type of autonomy. However, this type of autonomy has been found to correlate with <u>other</u> measures of adjustment, including more mature identity statuses and success in intimate relationships (Frank et al., 1990).

Although none of the interactions between experiences of autonomy and perceptions of father eating preoccupation were significant in predicting eating pathology, a significant interaction was found between

perceptions of father eating preoccupation and autonomy with overt conflict in predicting adjustment problems. That is, there was a stronger association between perceptions of father's eating preoccupation and daughter's self-concept problems or depressive symptoms, among late adolescents who experienced high levels of separateness and conflict in the relationship with father.

Like disengagement from mothers, autonomy with overt conflict in the father-daughter relationship appears to have both pros and cons. However, the direction of the effect is the exact opposite for fathers, and it is not altogether clear why this is the case. The results suggest that in the relationship with fathers, autonomy with overt conflict has a buffering effect for eating pathology; that is, women who experience high levels of separateness, even at the expense of a conflicted relationship with father, are less likely to have eating problems than those who experience low levels of separateness. However, this same type of autonomy appears to lead to problems in self-concept and depression, when fathers are perceived as being preoccupied with their own and their daughter's weight. It is conjectured that the daughter's perception of her father as being critical of her may be the most relevant component of father eating preoccupation in explaining the link between adjustment problems and perceptions of father eating preoccupation. In particular, daughters experiencing high levels of separateness and conflict in the father-daughter relationship are more vulnerable to poor self-concept or depression when they perceive their fathers as being critical of them than daughters who experience low levels of separateness and conflict. There is some sense that late adolescents who score high on the autonomy with overt conflict variable are "battling it out" with their fathers, rather than succombing to a lack of separateness or

differentiation. This may protect them from an eating disorder, but the high levels of separation and conflict may lead to feelings of depression or low self-esteem.

In sum, anxieties about separation with regard to both mothers and fathers most consistently predicted difficulty for daughters. However, it is important to note that low scores on autonomy, regardless of how it was defined (with the exception of "independence" in relationships with fathers), were associated with some type of problem for daughters, whether it was disordered eating, problems with self-concept, or depressive symptoms. In the relationship with fathers, the risks of lack of separateness (along with lack of conflict) appeared to be specific to eating pathology, while anxiety about separation was predictive of both eating and adjustment problems. In the relationship with mothers, separation-individuation difficulties were predictive of general adjustment problems, rather than disordered eating.

Most researchers who have considered parent attitudes about eating and weight as influential in the development of daughters' eating pathology have suggested that this variable would have an effect only in the context of significant family problems (Johnson & Flach, 1985; Pike & Rodin, 1991; Strober & Humphrey, 1987). In the current study, however, perceptions of parent eating preoccupation made an independent contribution to disordered eating, indicating that parents' attitudes about their own and their daughter's eating may be more important than was previously thought. In addition, neither perceptions of mother nor father eating preoccupation had an effect on adjustment problems, suggesting that it may be a specific risk factor for disordered eating. However, the significant interactions found between perceptions of father eating preoccupation and

autonomy in relation to fathers in predicting adjustment problems, suggests a somewhat more complex relationship. Although the physiological aspects of eating disorders were not the focus of this research, it is important to acknowledge the potential impact of biological and genetic factors. Particularly in attempting to understand the relationship between parents' eating preoccupation and daughter's eating pathology, it is essential to recognize the interaction between physiological and psychological factors.

An intriguing and significant result of this research is the impact of fathers on the development of disordered eating in late adolescent women, both with regard to fathers' attitudes towards eating and weight, and in the level of autonomy daughters experience in their relationships with their fathers. The findings regarding autonomy were consistent with Minuchin's family systems theory, in that the difficulty for daughters with eating pathology appears to lie in a lack of separation and an inability to disengage from fathers. This research did not support Maine's (1991) contentions that the problem for eating disordered girls is that their fathers are uninvolved and unavailable to them. Separation-individuation difficulties in relation to fathers appear to be even more pathognomic for eating disorders than similar difficulties with mothers, which seem to be more predictive of general adjustment problems. In light of this, the fact that daughters were somewhat more autonomous from fathers than mothers in certain areas lends support to the notion that fathers are instrumental in helping daughters separate from mothers. It appeared to be somewhat normative for late adolescent daughters to experience a lack of separateness from their mothers; however, when daughters were unable to differentiate from their fathers, they appeared to be at particular risk for

developing disordered eating. This suggests that fathers may play a key role in helping daughters to gain a sense of personal autonomy and self-governance.

Methodological Considerations

It is important to keep in mind the characteristics of this sample in interpreting these results. First, this is a predominantly Caucasian group of women from intact families, who are from middle to upper middle class backgrounds, which limits the generalizability of the findings to other populations. In particular, the findings regarding relationships with fathers might be very different for women from divorced families. In addition, although some women had severe levels of eating pathology, and had received treatment or even been hospitalized for their eating disorders, many others had more mild forms of disordered eating. These women were all enrolled in college, indicating that their eating disturbance was not so severe as to interfere significantly with daily functioning. This may partly account for the strong effect of perceptions of parent eating preoccupation on eating pathology. Perhaps in a sample of women with more severe eating disorders, separation-individuation problems would be the primary contributor, and perceptions of parent eating preoccupation would play a lesser, or moderating, role in the development of eating pathology. Nevertheless, these findings have major implications for understanding the potential effects of parent attitudes on the development of disordered eating. Moreover, they speak to the utility of the Parent Eating Attitudes Scale with eating disordered populations. Of course, the measure awaits further validation and replication of the results with larger samples. In addition, it will be important in future research to have

parents complete the questionnaire, in order to determine whether daughters' perceptions of parents' eating preoccupation are similar to parents' own perceptions of their eating preoccupation.

More generally, the inherent problems of using self-report measures are acknowledged. However, regarding autonomy, the interview measure provides some additional validation of the questionnaire measures, in that adolescents' perceptions of their experiences within the family are reflected in reported behavior. On the interview, the respondent must provide evidence for her perceptions of her independence. Unlike on questionnaire measures, stating "I am very independent from my mother" does not guarantee a high score; scores are based on the coders' clinical judgments regarding autonomy versus dependence and require examples or "proof". Nevertheless, a combination of observational and self-report measures (assessing both the adolescents' and parents' perceptions) would clearly provide a more complete test of the hypotheses.

Finally, longitudinal data would be helpful in gaining a better understanding of how daughters actually progress through the separation-individuation process, and become autonomous from each of their parents. For example, it is unclear if the negative feelings involved in some types of autonomy (i.e. autonomy with overt conflict from fathers and disengagement from mothers) are a result or by-product of gaining independence from parents, or whether the negative feelings allow separation to take place. An additional issue that must be addressed in longitudinal research, in order to better understand the implications of various factors for nonclinical versus clinical levels of eating disturbance, is whether in fact there is a continuum of disordered eating, such that less severe eating problems can become full-blown eating disorders, and what

factors account for the progression to more severe levels of eating pathology. However, despite these caveats, this research provides compelling evidence that parents' preoccupation with their own and their daughter's eating and weight, as well as difficulties in the separation-individuation process (at least with regard to fathers) have major implications for eating disturbance in late adolescent women.

APPENDICES

APPENDIX A

APPENDIX A

INFORMED CONSENT
HEALTH ATTITUDES AND FAMILY ENVIRONMENT
(PHASE I)

1. I understand that this study is part of a larger project examining development and behaviors during late adolescence and early adulthood, including patterns of alcohol use, eating habits, and different aspects of one's family environment.

2. My participation in this study will involve approximately one hour. I will attend one session at which time I will be asked to complete a series of questionnaires. At the end of my participation, I will be more fully debriefed about the purpose of this study. In exchange for my participation, I will receive 2 research credits.

3. Additionally, I have been told that I will be asked to disclose fairly personal information, for example, information about my own and my parents' alcohol use and health behaviors and attitudes. However, I also understand that I will at no time be asked to reveal my name and that my research records will be identified by code number only in order to protect my confidentiality and anonymity.

4. I understand that my participation is completely voluntary and I may withdraw from the study at any time. I also know that I have the right not to answer any item on any questionnaire that I do not wish to answer. However, I have been informed that all of my answers are valuable to this study and that my decision to omit various items may make it difficult or impossible to use the information I do provide.

5. I understand that I will not receive feedback on my individual responses but that I can obtain group results of this study, when they are available, upon request.

6. If I have any questions or concerns arising from my participation in this study, I know that I am encouraged to contact Dr. Susan Frank at 355-9561 in the Department of Psychology to discuss these concerns.

_____
Signature

_____
Date

INFORMED CONSENT
HEALTH ATTITUDES AND FAMILY ENVIRONMENT
(PHASE II)

1. I understand that I was chosen based on a number of my questionnaire responses from a larger number of volunteers who also participated in the first phase of this research.

2. I understand that the purpose of this phase of the study is to gain a more indepth understanding of adolescents' and young adults' feelings about their parents and to examine possible differences in feelings about mothers versus fathers. I also understand that this information will be related to other information on my personal adjustment and health attitudes and behaviors that I reported in the first phase of this study.

3. My participation in this study will involve completing, at my convenience, a packet of questionnaires that takes approximately one and one-half hours to complete. In addition, I will complete an interview that will take approximately three hours. I have been told that these questionnaires and this interview session ask for information about my perceptions of and my relationship with one or both of my parents, my perception of my relationships with my peers, my feelings about intimate relationships, my health history, and my behaviors and my views of myself in a variety of different life areas. At the end of my participation, I will be more fully debriefed about the purpose of this study. In exchange for my participation, I will receive 8 research credits (in addition to the credit I received from Phase I).

4. I understand that the investigators will contact me using the code name I provided during the first phase of this study. I also understand that my real name will not be associated with my responses and that my responses to both the questionnaires and interview will be identified by code number only.

5. My participation is completely voluntary and I may withdraw from the study at any time. However, I will only receive credit for this stage of the study if I complete all questionnaires and the interview. I also know that I have the right not to answer any question on the questionnaires or during the interview that I do not wish to answer. I understand, however, that all of my answers are valuable to this study and that my decision to omit particular items may make it difficult or impossible to use the information I do provide.

6. I understand that I will not receive feedback on my individual responses but that I can obtain group results of this study, when they are available, upon request.

7. If I have any questions or concerns arising from my participation in this study, I know that I am encouraged to contact Dr. Susan Frank at 355-9561 in the Department of Psychology to discuss these concerns.

_____ _____

Signature **Date**

APPENDIX B

APPENDIX B

RECONTACT FORM

I wish to be considered for participation in Phase II of this research study on health attitudes and family environment. When you contact me, please ask for the code name indicated below. I understand that I may not be contacted, but if I am, I may decide at that time not to participate without any penalty. I am aware that in exchange for my participation in Phase II I will receive additional research credits beyond those I received for participating in Phase I. I have read the informed consent agreement for Phase II and understand its content.

The name I wish to be identified by is _____.

The code number from my questionnaire packet in Phase I is _____.

My daytime phone number is _____.

In the evenings I can be reached at _____.

Please let your roommates know that we may be calling and asking for someone with your code name.

APPENDIX C

APPENDIX C

PERSONAL BACKGROUND QUESTIONNAIRE

Demographic Information:

1) What is your sex? male _____ female _____

2) Class: Freshman _____ Sophmore _____ Junior _____

Senior _____ 5th Year Senior _____

3) What is your age? _____

4) What is your major? _____

5) What are your future career plans? _____

---

6) What is your GPA? _____

7) What was your high school GPA? _____

8) Are you: Black: _____ White: _____ Hispanic: _____

Asian: _____ Native American: _____ Other: _____

9) What is your religion?

Protestant (please specify denomination) _____

Roman Catholic _____ Greek Orthodox _____ Jewish _____

None _____ Other (please specify) _____

10) Are you currently married? yes _____ no _____

11) Were you ever married? yes _____ no _____

12) How many children do you have? none _____ one _____

two _____ three _____ more than three _____

13) Were you adopted? yes _____ no _____

14) Are your biological (or adoptive) parents:

a) married to each other? yes _____ no _____

b) separated from each other? yes _____ no _____

If yes, how old were you? _____
What was the month and year they separated? month _____
year _____

c) divorced from each other? yes _____ no _____

If yes, how old were you? _____
What was the month and year they divorced? month _____
year _____

15a) What is your father's occupation? (Be as specific as possible; e.g. what sort of responsibilities are included with his job?) _____

15b) What was your father's highest level of education?

a) less than high school
b) high school degree
c) some college
d) 4 year college degree
e) Masters degree
f) Ph.D., J.D., M.D., D.D.S., etc.

16a) What is your mother's occupation? (Be as specific as possible; e.g. what sort of responsibilities are included with her job?) _____

16b) What was your mother's highest level of education?

a) less than high school
b) high school degree
c) some college
d) 4 year college degree
e) Masters degree
f) Ph.D., J.D., M.D., D.D.S., etc

17) If your mother works, has she worked full time (35 hours per week) since you entered elementary school?

yes _____ no _____ (if yes, skip to # 18)

My mother worked part time when I was between the ages of

1) _____ and _____ years old
2) _____ and _____ years old
3) _____ and _____ years old

My mother worked full time when I was between the ages of
1) _____ and _____ years old
2) _____ and _____ years old
3) _____ and _____ years old

18) List your siblings (including step-siblings):

	sex	age	where they live
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			
10.			
11.			
12.			
13.			
14.			

19a) Do you live at home during summers and vacations?
yes _____ no _____

19b) Do you live at home during the school year?
yes _____ no _____ (if yes, skip to #21)

20) What is the average number of phone contacts you have with your parents each month?
With biological (or adoptive) mother: _____
With biological (or adoptive) father: _____

What is the average number of visits you have with your parents each month?

With biological (or adoptive) mother: _____
With biological (or adoptive) father: _____

21) How many miles away from MSU do your parents live? _____

22) My father is _____ years old. My mother is _____ years old.

23) If there are any additional situations in your family which are pertinent, please explain them here (and on the back of this sheet):

APPENDIX D

APPENDIX D

PARENT EATING ATTITUDES SCALE - FATHER

The following questions refer to your father's attitudes about health and eating while you were growing up. For each of the statements please indicate whether they are very true (4), somewhat true (3), somewhat false (2), or very false (1). Circle the number which corresponds to the answer which is most correct for you.

When I was growing up...		Very True	Somewhat True	Somewhat False	Very False
1.	My father thought it was very important for me to be thin.	4	3	2	1
2.	My father nagged me to lose weight.	4	3	2	1
3.	My father exercised vigorously to stay thin.	4	3	2	1
4.	My father greatly discouraged me from drinking alcohol.	4	3	2	1
5.	My father was hurt if I did not like the food that he made.	4	3	2	1
6.	My father rewarded me with food.	4	3	2	1
7.	My father put the food on my plate at meals; I did not serve myself.	4	3	2	1
8.	My father thinks fat people are disgusting.	4	3	2	1
9.	My father often drank too much.	4	3	2	1
10.	My father took diet pills.	4	3	2	1
11.	My father was always worried about gaining weight or being too fat.	4	3	2	1
12.	My father thought it was very important for me to be attractive.	4	3	2	1
13.	My father felt that it was okay if I drank alcohol.	4	3	2	1
14.	My father dieted constantly.	4	3	2	1

15.	When I was upset, my father gave me food to comfort me.	4	3	2	1
16.	My father skipped meals to lose weight.	4	3	2	1
17.	My father got upset if I used marijuana.	4	3	2	1
18.	My father was considerably underweight.	4	3	2	1
19.	My father was very overweight.	4	3	2	1
20.	My father got upset when I drank too much.	4	3	2	1
21.	My father sometimes ate too much and then threw up.	4	3	2	1
22.	My father put me on diets to control my weight.	4	3	2	1
23.	My father was a problem drinker.	4	3	2	1
24.	My father criticized me for being overweight.	4	3	2	1
25.	My father often complained about my mother's weight.	4	3	2	1
26.	My father was always gaining and losing weight.	4	3	2	1
27.	I often felt that my father was watching everything that I ate.	4	3	2	1
28.	My father felt that it was okay if I used marijuana.	4	3	2	1
29.	My father smoked cigarettes.	4	3	2	1
30.	My father tried out a number of fad diets.	4	3	2	1
31.	Dieting was one of my father's favorite topics of conversation.	4	3	2	1

32. My father sometimes used drugs to cheer him up.	**4**	**3**	**2**	**1**

PARENT EATING ATTITUDES SCALE - MOTHER

The following questions refer to your mother's attitudes about health and eating while you were growing up. For each of the statements please indicate whether they are very true (4), somewhat true (3), somewhat false (2), or very false (1). Circle the number which corresponds to the answer which is most correct for you.

When I was growing up...		Very True	Somewhat True	Somewhat False	Very False
1.	My mother thought it was very important for me to be thin.	4	3	2	1
2.	My mother nagged me to lose weight.	4	3	2	1
3.	My mother exercised vigorously to stay thin.	4	3	2	1
4.	My mother greatly discouraged me from drinking alcohol.	4	3	2	1
5.	My mother was hurt if I did not like the food that she made.	4	3	2	1
6.	My mother rewarded me with food.	4	3	2	1
7.	My mother put the food on my plate at meals; I did not serve myself.	4	3	2	1
8.	My mother thinks fat people are disgusting.	4	3	2	1
9.	My mother often drank too much.	4	3	2	1
10.	My mother took diet pills.	4	3	2	1
11.	My mother was always worried about gaining weight or being too fat.	4	3	2	1
12.	My mother thought it was very important for me to be attractive.	4	3	2	1
13.	My mother felt that it was okay if I drank alcohol.	4	3	2	1
14.	My mother dieted constantly.	4	3	2	1
15.	When I was upset, my mother gave me food to comfort me.	4	3	2	1

16.	My mother skipped meals to lose weight.	4	3	2	1
17.	My mother got upset if I used marijuana.	4	3	2	1
18.	My mother was considerably underweight.	4	3	2	1
19.	My mother was very overweight.	4	3	2	1
20.	My mother got upset when I drank too much.	4	3	2	1
21.	My mother sometimes ate too much and then threw up.	4	3	2	1
22.	My mother put me on diets to control my weight.	4	3	2	1
23.	My mother was a problem drinker.	4	3	2	1
24.	My mother criticized me for being overweight.	4	3	2	1
25.	My mother often complained about my father's weight.	4	3	2	1
26.	My mother was always gaining and losing weight.	4	3	2	1
27.	I often felt that my mother was watching everything that I ate.	4	3	2	1
28.	My mother felt that it was okay if I used marijuana.	4	3	2	1
29.	My mother smoked cigarettes.	4	3	2	1
30.	My mother tried out a number of fad diets.	4	3	2	1
31.	Dieting was one of my mother's favorite topics of conversation.	4	3	2	1
32.	My mother sometimes used drugs to cheer her up.	4	3	2	1

APPENDIX E

APPENDIX E

EATING ATTITUDES TEST

On the line beside each item, please write the number which applies best to each of the numbered statements. All of the results will be strictly confidential. Most of the questions directly relate to food or eating, although other types of questions have been included. Please answer each question carefully. Thank you.

1	2	3	4	5	6
Always	Very Often	Often	Sometimes	Rarely	Never

_____ 1. Like eating with other people

_____ 2. Prepare foods for others, but do not eat what I cook

_____ 3. Become anxious prior to eating

_____ 4. Am terrified about being overweight

_____ 5. Avoid eating when I am hungry

_____ 6. Find myself preoccupied with food

_____ 7. Have gone on eating binges where I feel that I may not be able to stop

_____ 8. Cut my food into small pieces

_____ 9. Am aware of the calorie content of foods that I eat

_____ 10. Particularly avoid foods with a high carbohydrate content (e.g. bread, potatoes, rice, etc.)

_____ 11. Feel bloated after meals

_____ 12. Feel that others would prefer if I ate more

_____ 13. Vomit after I have eaten

_____ 14. Feel extremely guilty after eating

_____ 15. Am preoccupied with a desire to be thinner

_____ 16. Exercise strenuously to burn off calories

_____ 17. Weigh myself several times a day

_____ 18. Like my clothes to fit tightly

_____ 19. Enjoy eating meat

_____ 20. Wake up early in the morning

_____ 21. Eat the same foods day after day

_____ 22. Think about burning up calories when I exercise

_____ 23. Have regular menstrual periods

_____ 24. Other people think that I am too thin

_____ 25. Am preoccupied with the thought of having fat on my body

_____ 26. Take longer than others to eat my meal

_____ 27. Enjoy eating at restaurants

_____ 28. Take laxatives

_____ 29. Avoid foods with sugar in them

_____ 30. Eat diet foods

_____ 31. Feel that food controls my life

_____ 32. Display self control around food

_____ 33. Feel that others pressure me to eat

_____ 34. Give too much time and thought to food

_____ 35. Suffer from constipation

_____ 36. Feel uncomfortable after eating sweets

_____ 37. Engage in dieting behavior

_____ 38. Like my stomach to be empty

_____ 39. Enjoy trying new rich foods

_____ 40. Have the impulse to vomit after meals

APPENDIX F

APPENDIX F

EMOTIONAL AUTONOMY SCALE - FATHER

Please read the following statements and decide if you strongly disagree, disagree, agree, or strongly agree. Circle the appropriate number.

1 = Strongly disagree
2 = Disagree
3 = Agree
4 = Strongly agree

		Strongly Disagree	Disagree	Agree	Strongly Agree
1.	My father and I agree on everything.	1	2	3	4
2.	I go to my father for help before trying to solve a problem myself.	1	2	3	4
3.	I have often wondered how my father acts when I'm not around.	1	2	3	4
4.	Even when my father and I disagree, my father is always right.	1	2	3	4
5.	It's better for kids to go to their best friend than to their father for advice on some things.	1	2	3	4
6.	When I've done something wrong, I depend on my father to straighten things out for me.	1	2	3	4
7.	There are some things about me that my father doesn't know.	1	2	3	4
8.	My father acts differently when he is with his parents from the way he does at home.	1	2	3	4
9.	My father knows everything there is to know about me.	1	2	3	4
10.	I might be surprised to see how my father acts at a party.	1	2	3	4

11.	I try to have the same opinions as my father.	1	2	3	4
12.	When he is at work, my father acts pretty much the same way he does when he is at home.	1	2	3	4
13.	If I was having a problem with one of my friends, I would discuss it with my father before deciding what to do about it.	1	2	3	4
14.	My father would be surprised to know what I'm like when I'm not with him.	1	2	3	4
15.	When I become a parent, I'm going to treat my children in exactly the same way that my father has treated me.	1	2	3	4
16.	My father probably talks about different things when I am around from what he talks about when I'm not.	1	2	3	4
17.	There are things that I will do differently from my father when I become a parent.	1	2	3	4
18.	My father hardly ever makes mistakes.	1	2	3	4
19.	I wish my father would understand who I really am.	1	2	3	4
20.	My father acts pretty much the same way when he is with his friends as he does when he is at home with me.	1	2	3	4

EMOTIONAL AUTONOMY SCALE - MOTHER

Please read the following statements and decide if you strongly disagree, disagree, agree, or strongly agree. Circle the appropriate number.

1 = Strongly disagree
2 = Disagree
3 = Agree
4 = Strongly agree

		Strongly Disagree	Disagree	Agree	Strongly Agree
1.	My mother and I agree on everything.	1	2	3	4
2.	I go to my mother for help before trying to solve a problem myself.	1	2	3	4
3.	I have often wondered how my mother acts when I'm not around.	1	2	3	4
4.	Even when my mother and I disagree, my mother is always right.	1	2	3	4
5.	It's better for kids to go to their best friend than to their mother for advice on some things.	1	2	3	4
6.	When I've done something wrong, I depend on my mother to straighten things out for me.	1	2	3	4
7.	There are some things about me that my mother doesn't know.	1	2	3	4
8.	My mother acts differently when she is with her parents from the way she does at home.	1	2	3	4
9.	My mother knows everything there is to know about me.	1	2	3	4
10.	I might be surprised to see how my mother acts at a party.	1	2	3	4
11.	I try to have the same opinions as my mother.	1	2	3	4

12.	When she is at work, my mother acts pretty much the same way she does when she is at home.	1	2	3	4
13.	If I was having a problem with one of my friends, I would discuss it with my mother before deciding what to do about it.	1	2	3	4
14.	My mother would be surprised to know what I'm like when I'm not with her.	1	2	3	4
15.	When I become a parent, I'm going to treat my children in exactly the same way that my mother has treated me.	1	2	3	4
16.	My mother probably talks about different things when I am around from what she talks about when I'm not.	1	2	3	4
17.	There are things that I will do differently from my mother when I become a parent.	1	2	3	4
18.	My mother hardly ever makes mistakes.	1	2	3	4
19.	I wish my mother would understand who I really am.	1	2	3	4
20.	My mother acts pretty much the same way when she is with her friends as she does when she is at home with me.	1	2	3	4

APPENDIX G

APPENDIX G

PARENTAL RELATIONSHIP INVENTORY - FATHER

Instructions:

The following questions refer to your current relationship with your father. If you were not reared by your natural father, please respond in terms of the person who primarily raised you until you were 18 in the role of a father. If your father is no longer living, answer in terms of how you remember the relationship to have been as well as how you imagine the relationship would be today if your father was living.

Please circle the number which best describes your agreement or disagreement with each statement.

		Strongly Agree	Agree	Disagree	Strongly Disagree
1.	It is fun to be with my father.	4	3	2	1
2.	I can still feel good about myself, even when my father is upset with me.	4	3	2	1
3.	My father treats me as if I were the most important person in his life.	4	3	2	1
4.	When I'm trying to reach a goal, I can't depend on my father for encouragement.	4	3	2	1
5.	My father doesn't seem to recognize that I've grown up.	4	3	2	1
6.	If I were in financial trouble, I would feel comfortable asking my father to lend me money.	4	3	2	1
7.	My father needs me to keep him from being lonely.	4	3	2	1
8.	Many times when something happens to my father, I feel like it's happening to me.	4	3	2	1

9.	I generally consult my father before making important decisions.	4	3	2	1
10.	My father respects my desire to be an independent person.	4	3	2	1
11.	My father does not need me to make him feel proud of his own life.	4	3	2	1
12.	When I'm having trouble making a decision, it really helps to have my father provide direction for me.	4	3	2	1
13.	My father frequently lets me know that his generation knows best.	4	3	2	1
14.	My father accepts my need for privacy.	4	3	2	1
15.	I feel that my father tries to make me responsible for his happiness.	4	3	2	1
16.	My father wants to know all my thoughts.	4	3	2	1
17.	I am able to put my own needs before my father's.	4	3	2	1
18.	In my relationship with my father, I don't feel like an "orphan".	4	3	2	1
19.	I don't feel it's my job to make my father happy.	4	3	2	1
20.	I avoid asking my father for his emotional support.	4	3	2	1
21.	I run my own life without needing my father's direction.	4	3	2	1
22.	When I am feeling bad, my father shows little interest in my feelings.	4	3	2	1
23.	My father doesn't try to influence the decisions I make.	4	3	2	1
24.	It's hard not to feel like a child when I'm with my father.	4	3	2	1

25.	It is alright with my father if I disagree with him.	4	3	2	1
26.	My father and I feel like strangers to one another.	4	3	2	1
27.	I feel happy when I'm with my father.	4	3	2	1
28.	My father feels most useful when he is in the "father" role.	4	3	2	1
29.	When I'm ill, I avoid asking my father for sympathy.	4	3	2	1
30.	I often don't do things my way because it would upset my father.	4	3	2	1
31.	When I'm feeling bad, I can count on my father to remind me of my worth.	4	3	2	1
32.	I feel uncomfortable keeping secrets from my father.	4	3	2	1
33.	My father can only feel successful if I am doing well.	4	3	2	1
34.	The relationship I have with my father feels like a relationship between equals.	4	3	2	1
35.	It is important to me that my father approves of the way I am handling my life.	4	3	2	1
36.	If I needed practical help, I would prefer not to go to my father for it.	4	3	2	1
37.	I feel tense when I am around my father.	4	3	2	1
38.	My father doesn't try to tell me how to run my life.	4	3	2	1
39.	I can't rely on emotional support from my father.	4	3	2	1

40.	My father relies more on others for companionship than he does on me.	4	3	2	1
41.	I don't need to tell my father all about what is happening in my life.	4	3	2	1
42.	When my father gives me things there are generally "strings attached".	4	3	2	1
43.	My father is able to talk to me as one adult to another.	4	3	2	1
44.	I feel that my father tries to interfere with my personal business.	4	3	2	1
45.	I feel comfortable having different beliefs and values than my father.	4	3	2	1
46.	If my father feels sad or disappointed about something, it's hard for me to enjoy myself.	4	3	2	1
47.	My father and I don't seem to have very much in common with each other.	4	3	2	1
48.	I find it hard to go against my father's advice.	4	3	2	1
49.	My father often insists on making me see things his way.	4	3	2	1
50.	I feel very warm towards my father.	4	3	2	1

PARENTAL RELATIONSHIP INVENTORY - MOTHER

Instructions:

The following questions refer to your current relationship with your mother. If you were not reared by your natural mother, please respond in terms of the person who primarily raised you until you were 18 in the role of a mother. If your mother is no longer living, answer in terms of how you remember the relationship to have been as well as how you imagine the relationship would be today if your mother was living.

Please circle the number which best describes your agreement or disagreement with each statement.

		Strongly Agree	Agree	Disagree	Strongly Disagree
1.	It is fun to be with my mother.	4	3	2	1
2.	I can still feel good about myself, even when my mother is upset with me.	4	3	2	1
3.	My mother treats me as if I were the most important person in her life.	4	3	2	1
4.	When I'm trying to reach a goal, I can't depend on my mother for encouragement.	4	3	2	1
5.	My mother doesn't seem to recognize that I've grown up.	4	3	2	1
6.	If I were in financial trouble, I would feel comfortable asking my mother to lend me money.	4	3	2	1
7.	My mother needs me to keep her from being lonely.	4	3	2	1
8.	Many times when something happens to my mother, I feel like it's happening to me.	4	3	2	1
9.	I generally consult my mother before making important decisions.	4	3	2	1
10.	My mother respects my desire to be an independent person.	4	3	2	1

11.	My mother does not need me to make her feel proud of her own life.	4	3	2	1
12.	When I'm having trouble making a decision, it really helps to have my mother provide direction for me.	4	3	2	1
13.	My mother frequently lets me know that her generation knows best.	4	3	2	1
14.	My mother accepts my need for privacy.	4	3	2	1
15.	I feel that my mother tries to make me responsible for her happiness.	4	3	2	1
16.	My mother wants to know all my thoughts.	4	3	2	1
17.	I am able to put my own needs before my mother's.	4	3	2	1
18.	In my relationship with my mother, I don't feel like an "orphan".	4	3	2	1
19.	I don't feel it's my job to make my mother happy.	4	3	2	1
20.	I avoid asking my mother for her emotional support.	4	3	2	1
21.	I run my own life without needing my mother's direction.	4	3	2	1
22.	When I am feeling bad, my mother shows little interest in my feelings.	4	3	2	1
23.	My mother doesn't try to influence the decisions I make.	4	3	2	1
24.	It's hard not to feel like a child when I'm with my mother.	4	3	2	1
25.	It is alright with my mother if I disagree with her.	4	3	2	1
26.	My mother and I feel like strangers to one another.	4	3	2	1

27.	I feel happy when I'm with my mother.	4	3	2	1
28.	My mother feels most useful when she is in the "mother" role.	4	3	2	1
29.	When I'm ill, I avoid asking my mother for sympathy.	4	3	2	1
30.	I often don't do things my way because it would upset my mother.	4	3	2	1
31.	When I'm feeling bad, I can count on my mother to remind me of my worth.	4	3	2	1
32.	I feel uncomfortable keeping secrets from my mother.	4	3	2	1
33.	My mother can only feel successful if I am doing well.	4	3	2	1
34.	The relationship I have with my mother feels like a relationship between equals.	4	3	2	1
35.	It is important to me that my mother approves of the way I am handling my life.	4	3	2	1
36.	If I needed practical help, I would prefer not to go to my mother for it.	4	3	2	1
37.	I feel tense when I am around my mother.	4	3	2	1
38.	My mother doesn't try to tell me how to run my life.	4	3	2	1
39.	I can't rely on emotional support from my mother.	4	3	2	1
40.	My mother relies more on others for companionship than she does on me.	4	3	2	1
41.	I don't need to tell my mother all about what is happening in my life.	4	3	2	1

42.	When my mother gives me things there are generally "strings attached".	4	3	2	1
43.	My mother is able to talk to me as one adult to another.	4	3	2	1
44.	I feel that my mother tries to interfere with my personal business.	4	3	2	1
45.	I feel comfortable having different beliefs and values than my mother.	4	3	2	1
46.	If my mother feels sad or disappointed about something, it's hard for me to enjoy myself.	4	3	2	1
47.	My mother and I don't seem to have very much in common with each other.	4	3	2	1
48.	I find it hard to go against my mother's advice.	4	3	2	1
49.	My mother often insists on making me see things her way.	4	3	2	1
50.	I feel very warm towards my mother.	4	3	2	1

APPENDIX H

APPENDIX H

PSYCHOLOGICAL SEPARATION INVENTORY
CONFLICTUAL INDEPENDENCE SCALE

Instructions: The following list of statements describes different aspects of students' relationships with both their mother and father. Imagine a scale ranging from 1 to 5 that tells how well each statement applies to you. In the space next to the statement, please enter a number from "1" (Not at all true of me) to "5" (Very true of me). If the statement does not apply, enter "1". Please be completely honest. Your answers are entirely confidential and will be useful only if they accurately describe you.

____ 1. Sometimes my mother is a burden to me.

____ 2. I feel like I am constantly at war with my mother.

____ 3. I blame my mother for many of the problems I have.

____ 4. I wish I could trust my mother more.

____ 5. I have to be careful not to hurt my mother's feelings.

____ 6. I sometimes feel like I'm being punished by my mother.

____ 7. I wish my mother wasn't so overprotective.

____ 8. I wish my mother wouldn't try to manipulate me.

____ 9. I wish my mother wouldn't try to make fun of me.

____ 10. I feel that I have obligations to my mother that I wish I didn't have.

____ 11. My mother expects too much from me.

____ 12. I wish I could stop lying to my mother.

____ 13. I often wish that my mother would treat me more like an adult.

____ 14. I am often angry at my mother.

____ 15. I hate it when my mother makes suggestions about what I do.

____ 16. Even when my mother has a good idea I refuse to listen to it because she made it.

____ 17. I wish my mother wouldn't try to get me to take sides with her.

____ 18. I argue with my mother over little things.

____ 19. My mother is sometimes a source of embarassment to me.

____ 20. I am sometimes ashamed of my mother.

____ 21. I get angry when my mother criticizes me.

____ 22. When I don't write my mother often enough I feel guilty.

____ 23. I feel uncomfortable keeping things from my mother.

____ 24. I often have to make decisions for my mother.

____ 25. I sometimes resent it when my mother tells me what to do.

____ 26. Sometimes my father is a burden to me.

____ 27. I feel like I am constantly at war with my father.

____ 28. I blame my father for many of the problems I have.

____ 29. I wish I could trust my father more.

____ 30. I have to be careful not to hurt my father's feelings.

____ 31. I sometimes feel like I'm being punished by my father.

____ 32. I wish my father wasn't so overprotective.

____ 33. I wish my father wouldn't try to manipulate me.

____ 34. I wish my father wouldn't try to make fun of me.

____ 35. I feel that I have obligations to my father that I wish I didn't have.

____ 36. My father expects too much from me.

____ 37. I wish I could stop lying to my father.

____ 38. I often wish that my father would treat me more like an adult.

____ 39. I am often angry at my father.

____ 40. I hate it when my father makes suggestions about what I do.

____ 41. Even when my father has a good idea I refuse to listen to it because he made it.

____ 42. I wish my father wouldn't try to get me to take sides with him.

____ 43. I argue with my father over little things.

____ 44. My father is sometimes a source of embarassment to me.

____ 45. I am sometimes ashamed of my father.

____ 46. I get angry when my father criticizes me.

____ 47. When I don't write my father often enough I feel guilty.

____ 48. I feel uncomfortable keeping things from my father.

____ 49. I often have to make decisions for my father.

____ 50. I sometimes resent it when my father tells me what to do.

APPENDIX I

APPENDIX I

FAMILIAL INSECURITY SCALE - FATHER

Read the following statements and decide whether they are true or false for you. Under column A, circle T for true or F for false.

		A		B
1.	Although I value the affection my father holds for me, I feel that I do not need it to make me feel confident in myself.	T	F	
2.	I feel on very good terms with my father, despite the fact that I no longer rely on him for help or advice.	T	F	
3.	I feel so close to my father that I feel that he will always be my closest friend.	T	F	
4.	The nagging I get from my father sometimes irritates me very much.	T	F	
5.	I enjoy the comfortable feeling that I can handle any problem that might come my way without help from my father.	T	F	
6.	I feel very much at home with my father, more so than with anyone else I have ever met.	T	F	
7.	I am concerned that my relationship with my father is not all that it might be.	T	F	
8.	I often feel very regretful that I have not fulfilled my obligations to my father.	T	F	
9.	When the going gets tough I often wish that I were back in the happy days of my childhood.	T	F	
10.	Although I get on very well with my father, I do not feel that loss or separation would make any great difference to my life in general.	T	F	
11.	It is a great comfort to me to realize that I can	T	F	

always count on my father to get me out of a jam.

12. I often get a troubling feeling from wondering if my father might disapprove of what I am doing. T F

13. My father is very kind to me, but I am sorry that I do not have a real warm relationship with him. T F

14. It is a great comfort to me that my father helps me to make up my mind. T F

15. I feel comfortably free to make my own arrangements with my friends without talking it over with my father. T F

16. I feel discouraged that it is so difficult to live up to what my father expects of me. T F

17. It makes me feel uneasy to think of being completely on my own. T F

18. It is a great comfort to have my father help me such a lot. T F

19. I am happy to fall back on my father to do the many little things for me that tend to make life more comfortable. T F

20. I often feel a sense of regret that I have not had as happy a family life as other people have had. T F

21. One of the most important factors in helping me decide on something is whether or not it will please my father. T F

22. It bothers me that my father does not allow me to be more on my own. T F

23. It discourages me that my father interferes so much in my life. T F

24. I sometimes worry about the future as a time I will not get as much help from my father as I do now. T F

25.	I would feel guilty if I felt that I were letting my father down in any way.	T	F
26.	I would feel very hesitant to embark on a course of action which my father might consider wrong.	T	F
27.	One of the reasons that I get along with my father is that I never feel held in by his disapproval.	T	F

Now re-read each statement and decide how true or false each is for you.

If you circled True, decide whether the statement is Very True or Somewhat True for you.

If you circled False, indicate whether the statement is Very False or Somewhat False for you.

Indicate your response by writing under column B:

For items to which you previously responded true, either
VT (Very True) or
ST (Somewhat True)

For items to which you previously responded false, either
VF (Very False) or
SF (Somewhat False)

FAMILIAL INSECURITY SCALE - MOTHER

Read the following statements and decide whether they are true or false for you. Under column A, circle T for true or F for false.

		A		B
1.	Although I value the affection my mother holds for me, I feel that I do not need it to make me feel confident in myself.	T	F	
2.	I feel on very good terms with my mother, despite the fact that I no longer rely on her for help or advice.	T	F	
3.	I feel so close to my mother that I feel that she will always be my closest friend.	T	F	
4.	The nagging I get from my mother sometimes irritates me very much.	T	F	
5.	I enjoy the comfortable feeling that I can handle any problem that might come my way without help from my mother.	T	F	
6.	I feel very much at home with my mother, more so than with anyone else I have ever met.	T	F	
7.	I am concerned that my relationship with my mother is not all that it might be.	T	F	
8.	I often feel very regretful that I have not fulfilled my obligations to my mother.	T	F	
9.	When the going gets tough I often wish that I were back in the happy days of my childhood.	T	F	
10.	Although I get on very well with my mother, I do not feel that loss or separation would make any great difference to my life in general.	T	F	
11.	It is a great comfort to me to realize that I can always count on my mother to get me out of a jam.	T	F	

12.	I often get a troubling feeling from wondering if my mother might disapprove of what I am doing.	T	F
13.	My mother is very kind to me, but I am sorry that I do not have a real warm relationship with her.	T	F
14.	It is a great comfort to me that my mother helps me to make up my mind.	T	F
15.	I feel comfortably free to make my own arrangements with my friends without talking it over with my mother.	T	F
16.	I feel discouraged that it is so difficult to live up to what my mother expects of me.	T	F
17.	It makes me feel uneasy to think of being completely on my own.	T	F
18.	It is a great comfort to have my mother help me such a lot.	T	F
19.	I am happy to fall back on my mother to do the many little things for me that tend to make life more comfortable.	T	F
20.	I often feel a sense of regret that I have not had as happy a family life as other people have had.	T	F
21.	One of the most important factors in helping me decide on something is whether or not it will please my mother.	T	F
22.	It bothers me that my mother does not allow me to be more on my own.	T	F
23.	It discourages me that my mother interferes so much in my life.	T	F
24.	I sometimes worry about the future as a time I will not get as much help from my mother as I do now.	T	F
25.	I would feel guilty if I felt that I were letting my mother down in any way.	T	F

26.	I would feel very hesitant to embark on a course of action which my mother might consider wrong.	T	F
27.	One of the reasons that I get along with my mother is that I never feel held in by her disapproval.	T	F

Now re-read each statement and decide how true or false each is for you.

If you circled True, decide whether the statement is Very True or Somewhat True for you.

If you circled False, indicate whether the statement is Very False or Somewhat False for you.

Indicate your response by writing under column B:

For items to which you previously responded true, either
VT (Very True) or
ST (Somewhat True)

For items to which you previously responded false, either
VF (Very False) or
SF (Somewhat False)

APPENDIX J

APPENDIX J

OFFER SELF-IMAGE QUESTIONNAIRE

1- Describes me very well
2- Describes me well
3- Describes me fairly well
4-Does not quite describe me
5-Does not really describe me
6-Does not describe me at all

____ 1. I carry many grudges.

____ 2. When I am with people I am afraid that someone will make fun of me.

____ 3. Most of the time I think that the world is an exciting place to live in.

____ 4. I would not hurt someone just for the "heck of it".

____ 5. The recent changes in my body have given me some satisfaction.

____ 6. I am going to devote my life to helping others.

____ 7. I "lose my head" easily.

____ 8. The opposite sex finds me a bore.

____ 9. If I would be separated from all the people I know, I feel that I would not be able to make a go of it.

____ 10. I feel tense most of the time.

____ 11. I usually feel out of place at picnics and parties.

____ 12. I feel that working is too much responsibility for me.

____ 13. It is very hard for a teenager to know how to handle sex in a right way.

____ 14. At times I have fits of crying and/or laughing that I seem unable to control.

____ 15. I am going to devote my life to making as much money as I can.

____ 16. If I put my mind to it, I can learn almost anything.

____ 17. Only stupid people work.

____ 18. I am confused most of the time.

____ 19. I feel inferior to most people I know.

____ 20. I do not like to put things in order and make sense of them.

____ 21. In the past year I have been very worried about my health.

____ 22. Dirty jokes are fun at times.

____ 23. I often blame myself even when I am not at fault.

____ 24. I would not stop at anything if I felt I was done wrong.

____ 25. The size of my sex organs is normal.

____ 26. Most of the time I am happy.

____ 27. I am going to devote myself to making the world a better place to live in.

____ 28. I can take criticism without resentment.

____ 29m. (for males only)
My work, in general, is at least as good as the work of the guy next to me.

____ 29f. (for females only)
My work, in general, is at least as good as the work of the girl next to me.

____ 30. Sometimes I feel so ashamed of myself that I just want to hide in a corner and cry.

____ 31. I am sure that I will be proud about my future profession.

____ 32. My feelings are easily hurt.

____ 33. When a tragedy occurs to one of my friends, I feel sad too.

____ 34. I blame others even when I know that I am at fault too.

____ 35. When I want something, I just sit around wishing I could have it.

____ 36. The picture I have of myself in the future satisfies me.

____ 37. I am a superior student in school.

____ 38. I feel relaxed under normal circumstances.

____ 39. I feel empty emotionally most of the time.

____ 40. I would rather sit around and loaf than work.

____ 41. Even if it were dangerous, I would help someone who is in trouble.

____ 42. Telling the truth means nothing to me.

____ 43. Our society is a competitive one and I am not afraid of it.

____ 44. I get violent if I don't get my way.

____ 45. I think that other people just do not like me.

____ 46. I find it very difficult to establish new friendships.

____ 47. I am so very anxious.

____ 48m. (for males only)
Working closely with another fellow never gives me pleasure.

____ 48f. (for females only)
Working closely with another girl never gives me pleasure.

____ 49. I am proud of my body.

____ 50. At times I think about what kind of work I will do in the future.

____ 51. Even under pressure I manage to remain calm.

____ 52. I often feel that I would rather die than go on living.

____ 53. I find it extremely hard to make friends.

____ 54. I would rather be supported for the rest of my life than work.

____ 55. I do not mind being corrected, since I can learn from it.

____ 56. I feel so very lonely.

____ 57. I do not care how my actions affect others as long as I gain something.

____ 58. I enjoy life.

____ 59. I keep an even temper most of the time.

____ 60. A job well done gives me pleasure.

____ 61. I seem to be forced to imitate the people I like.

____ 62. For me good sportsmanship in school is as important as winning a game.

____ 63. I prefer being alone than with kids my age.

____ 64. When I decide to do something, I do it.

____ 65m. (for males only)
I think that girls find me attractive.

____ 65f. (for females only)
I think that boys find me attractive.

____ 66. Other people are not after me to take advantage of me.

____ 67. I feel that there is plenty I can learn from others.

____ 68. I do not attend sexy shows.

____ 69. I fear something constantly.

____ 70. Very often I think that I am not at all the person I would like to be.

____ 71. I like to help a friend whenever I can.

____ 72. If I know that I will have to face a new situation, I will try in advance to find out as much as is possible about it.

____ 73. If others disapprove of me I get terribly uspset.

____ 74. Being together with other people gives me a good feeling.

____ 75. Whenever I fail in something, I try to find out what I can do in order to avoid another failure.

____ 76. I frequently feel ugly and unattractive.

____ 77. Sexually I am way behind.

____ 78. If you confide in others you ask for trouble.

____ 79. Even though I am continuously on the go, I seem unable to get things done.

____ 80. When others look at me they must think that I am poorly developed.

____ 81. I believe I can tell the real from the fantastic.

____ 82. Thinking or talking about sex frightens me.

____ 83. I am against giving so much money to the poor.

____ 84. I feel strong and healthy.

____ 85. Even when I am sad I can enjoy a good joke.

____ 86. There is nothing wrong with putting oneself before others.

____ 87. I find life an endless series of problems--without solution in sight.

____ 88. At times I feel like a leader and feel that other kids can learn something from me.

____ 89. I feel that I am able to make decisions.

____ 90. I am certain that I will not be able to assume responsibilities for myself in the future.

____ 91. When I enter a new room I have a strange and funny feeling.

____ 92. I feel that I have no talent whatsoever.

____ 93. I do not rehearse how I might deal with a real coming event.

____ 94. When I am with people I am bothered by hearing strange noises.

____ 95. I do not have a particularly difficult time in making friends.

____ 96. I do not enjoy solving difficult problems.

____ 97. School and studying mean very little to me.

____ 98. Eye for an eye and tooth for a tooth does not apply for our society.

____ 99. Sexual experiences give me pleasure.

____ 100m. (for males only)
Having a girlfriend is important to me.

____ 100f. (for females only)
Having a boyfriend is important to me.

____ 101. I would not like to be associated with those kids who "hit below the belt".

____ 102. Worrying a little about one's future helps to make it work out better.

____ 103. I often think about sex.

____ 104. Usually I control myself.

____ 105. I enjoy most parties I go to.

____ 106. Dealing with new intellectual subjects is a challenge for me.

____ 107. I do not have many fears which I cannot understand.

____ 108. No one can harm me just by not liking me.

____ 109. I am fearful of growing up.

____ 110. I repeat things continuously to be sure that I am right.

____ 111. I frequently feel sad.

APPENDIX K

APPENDIX K

HEALTH HISTORY

I. Weight History

Current Weight ___lbs. Current Height ___in. Desired Weight ___lbs.

Adult Years:

Highest weight since age 18 ___lbs. at age ___

Lowest weight since age 18 ___ at age ___

How long did you remain at your highest adult weight?

___days ___months ___years

How long did you remain at your lowest adult weight?

___days ___months ___years

Adolescent Years:

Highest weight between ages 12 and 18 ___lbs. at age ___

Lowest weight between ages 12 and 18 ___lbs. at age ___

II. Dieting Behavior

Have you ever been on a diet? Yes ___ No ___

If no, skip to section III.

At what age did you begin to restrict your food intake due to concern over your body size?

___years old

In your first year of dieting how many times did you start a diet?

___ # of times

Over the last year how often have you begun a diet?

___ # of times

Please rank from 1-9 your preferred way of dieting (1=most preferred, 9=least preferred).

skip meals	___	reduce portions	___
total fast	___	go on fad diets	___
restrict carbohydrates	___	reduce calories	___
restrict sweets	___	other	___
restrict fats	___		

If you have ever been encouraged to diet, please rank from 1-10 the people that encouraged you to diet the most (1=most encouraged, 10=least encouraged).

boyfriends	___	sister	___
girlfriends	___	employer	___
mother	___	teacher/coach	___
father	___	other relative	___
brother	___	other (specify)	___

III. Binge Eating Behavior

Have you ever had an episode of eating a large amount of food in a short space of time (an eating binge)?

Yes ___ No ___

If you answered no, skip to section IV.

Please circle on the scales below, how characteristic the following are of your binge eating.

I consume a large amount of food during a binge.

1	2	3	4	5
Never	Rarely	Sometimes	Often	Always

I eat very rapidly.

1	2	3	4	5
Never	Rarely	Sometimes	Often	Always

I feel out of control when I eat.

1	2	3	4	5
Never	Rarely	Sometimes	Often	Always

I feel miserable or annoyed after a binge.

1	2	3	4	5
Never	Rarely	Sometimes	Often	Always

I get uncontrollable urges to eat and eat until I feel physically ill.

1	2	3	4	5
Never	Rarely	Sometimes	Often	Always

I binge eat in private.

1	2	3	4	5
Never	Rarely	Sometimes	Often	Always

How long does a binge usually last?

Less than one hour ___ 1-2 hours ___ More than 2 hours ___

Please rank 1-9 the times of day that you are most likely to binge (1=most likely, 9=least likely)

8 am - 10 am	___	6 pm - 8 pm	___
10 am - 12 pm	___	8 pm - 10 pm	___
12 pm - 2 pm	___	10 pm - 12 am	___
2 pm - 4 pm	___	after midnight	___
4 pm - 6 pm	___		

Please rank 1-6 the places where you are most likely to binge (1=most likely, 6=least likely).

Home ___ Work ___ Restaurant ___ Car ___

Party ___ Other (specify) _____

Please rank from 1-5 how likely you are to binge eat in the presence of the following people (1=most likely, 5=least likely).

Friends ___ Parents ___ Children ___ Alone ___

Spouse/significant other ___

How old were you when you began binge eating?

___years old

How long have you had a problem with binge eating?

___days ___months ___years

What is the longest period you have had without binge eating since the onset of the problem?

___days ___months ___years

What were the circumstances that helped you to not binge eat for that period of time? (If more than one event is applicable, please rank order the importance of the event with 1=most important).

began dieting	___	started exercising	___
sought professional help	___	began romantic relationship	___
developed illness	___	left romantic relationship	___
left home	___	divorce	___
marriage	___	pregnancy	___
work	___	vacation	___

Please rank from 1-7 the foods that you are most likely to binge on (1=most likely, 7=least likely).

bread/cereal/pasta	___	cheese/milk/yogurt	___
fruit	___	meat/fish/poultry/eggs	___
salty snack foods	___	sweets	___
vegetables	___		

Please rank from 1-7 the foods that you are most likely to eat when you are not binging (1=most likely, 7=least likely).

bread/cereal/pasta	___	cheese/milk/yogurt	___
fruit	___	meat/fish/poultry/eggs	___
salty snack foods	___	sweets	___
vegetables	___		

Were there any particular events in your life, either positive or negative, which preceded or coincided with the onset of your binge eating (Check as many as applicable).

death of significant other	___	leaving home	___

illness or injury to self	___	failure at school or work	___
difficult sexual experience	___	family problems	___
problems with romantic relationship	___	illness or injury to family member or significant other	___
teasing about appearance	___	prolonged periods of dieting	___
marriage	___	pregnancy	___
work transition	___	other (specify)	___

Using the scale below, please select the number which indicates the intensity of each of the following feelings BEFORE a binge.

1 Extremely Intense	2 Very Intense	3 Moderately Intense	4 Slightly Intense	5 Not at all Intense

Calm	___	Bored	___
Empty	___	Frustrated	___
Confused	___	Panicked	___
Excited	___	Relieved	___
Angry	___	Guilty	___
Spaced Out	___	Depressed	___
Inadequate	___	Nervous	___
Disgusted	___	Other (specify)	___
Lonely	___		

Using the scale below, please select the number which indicates the intensity of each of the following feelings AFTER a binge.

1 Extremely Intense	2 Very Intense	3 Moderately Intense	4 Slightly Intense	5 Not at all Intense

Calm	___	Bored	___
Empty	___	Frustrated	___
Confused	___	Panicked	___
Excited	___	Relieved	___
Angry	___	Guilty	___
Spaced Out	___	Depressed	___
Inadequate	___	Nervous	___
Disgusted	___	Other (specify)	___
Lonely	___		

Have you noticed a relationship between the frequency of your binge eating and your menstrual cycle?

Yes ___ No ___

If yes, please indicate when during your cycle you feel most vulnerable to binge eating.

During menstruation ___
11-14 days prior to menstruation ___
7-10 days prior to menstruation ___
3-6 days prior to menstruation ___
1-2 days prior to menstruation ___
After menstruation ___

How uncomfortable are you with your binge eating behavior?

1	2	3	4	5
Extremely Uncomfortable	Very Uncomfortable	Uncomfortable	Somewhat Uncomfortable	Not at all Uncomfortable

How willing would you be to gain 10 pounds in exchange for not binge eating anymore?

1	2	3	4	5
Extremely Willing	Very Willing	Moderately Willing	Somewhat Willing	Not at all Willing

IV. Purging Behavior

Have you ever vomited or spit out food after eating in order to get rid of the food eaten?

Yes ___ No ___

How old were you when you induced vomiting for the first time?

___years old

How long have you been using self-induced vomiting?

___days ___months ___years

Have you ever used laxatives to control your weight or "get rid of food"?

Yes ___ No ___

How old were you when you first took laxatives for weight control?

___years old

How long have you been using laxatives for weight control?

___days ___months ___years

How often are you now able to eat a "normal" meal without "binge eating" and without vomiting?

Never	___	Several meals a week	___
Less than one meal a week	___	One meal a day	___
About one meal a week	___	More than one meal a day	___

How soon after eating do you induce vomiting?

0-15 minutes	___
16-30 minutes	___
31-45 minutes	___
46-60 minutes	___
One hour or longer	___

Which of the behaviors, "binge eating" or vomiting after meals came first?

Binge eating came first.	___	Vomiting came first.	___
They both occurred at the same time.	___	Neither came first, I have never had binge eating or vomiting episodes.	___
Neither came first. I have only binge eating episodes.	___		
Neither came first. I have only vomiting episodes.	___		

During the entire last month, what is the average frequency that you have engaged in the following behaviors? (Check one for each behavior.)

(0=Never; 1=Once a month or less; 2=Several times a month; 3=Once a week; 4=Several times a week; 5=Once a day; 6=More than once a day)

	0	1	2	3	4	5	6
Binge eating	___	___	___	___	___	___	___
Vomiting	___	___	___	___	___	___	___
Laxative use	___	___	___	___	___	___	___
Use of diet pills	___	___	___	___	___	___	___
Use of water pills	___	___	___	___	___	___	___
Use of enemas	___	___	___	___	___	___	___
Exercise to control weight	___	___	___	___	___	___	___

Fasting (Skipping meals for a day) ___ ___ ___ ___ ___ ___ ___

Using the scale below, please select the number which indicates the intensity of each of the following feelings BEFORE a purge.

1 Extremely Intense	2 Very Intense	3 Moderately Intense	4 Slightly Intense	5 Not at all Intense

Calm	___	Bored	___
Empty	___	Frustrated	___
Confused	___	Panicked	___
Excited	___	Relieved	___
Angry	___	Guilty	___
Spaced Out	___	Depressed	___
Inadequate	___	Nervous	___
Disgusted	___	Other (specify)	___
Lonely	___		

Using the scale below, please select the number which indicates the intensity of each of the following feelings AFTER a purge.

1 Extremely Intense	2 Very Intense	3 Moderately Intense	4 Slightly Intense	5 Not at all Intense

Calm	___	Bored	___
Empty	___	Frustrated	___
Confused	___	Panicked	___
Excited	___	Relieved	___
Angry	___	Guilty	___
Spaced Out	___	Depressed	___
Inadequate	___	Nervous	___
Disgusted	___	Other (specify)	___
Lonely	___		

V. Exercise and Other Behavior

How many minutes a day do you currently exercise (including going on walks, riding bicycle, etc.)?

___minutes

Have you ever competed in any of the following physical activities? (Check as many as are applicable.)

Distance running	___	Weight lifting	___
Dancing	___	Gymnastics	___
Wrestling	___	Tennis	___
Swimming	___	Other (Specify)	___

Have you ever made a suicide attempt?

Yes ___ No ___

Have you ever tried to physically hurt yourself (i.e. cut yourself, hit yourself with intent to hurt, burn yourself with cigarettes)?

Yes ___ No ___

Since the onset of any eating problem, have you been involved in stealing?

Yes ___ No ___

VI. Sexual History

Have you ever engaged in sexual intercourse? Yes ___ No ___

If your answer is yes, at what age did you first engage in sexual intercourse?

Age ___

Please indicate on the line below your interest in sex before the onset of any eating problem:

1	2	3	4	5
No interest	Somewhat Interested	Interested	Very Interested	Extremely Interested

Please indicate on the scale below whether there has been a change in your sexual interest since the onset of any eating problem:

1	2	3	4	5
Much less Interested	Somewhat less Interested	Equally Interested	Somewhat more Interested	Much more Interested

Please check your sexual preference:

Exclusively heterosexual	___	Primarily heterosexual, some homosexual	___
Bisexual	___	Autosexual (prefer masturbation to sex with others)	___
Primarily homosexual, some heterosexual	___	Asexual (no sexual pref.)	___
Exclusively homosexual	___		

How satisfied are you with the quality of your sexual activity?

1	2	3	4	5
Extremely Satisfied	Very Satisfied	Satisfied	Moderately Satisfied	Not at all Satisfied

VII. Menstrual History

Age at onset of menses (if you have never gotten your period, please mark 0)

___years

Since you began dieting, purging, or binge eating, how many times have you stopped menstruating for 3 months or more (which were unrelated to pregnancy)?

___# of times

Before you began dieting, purging, or binge eating, how many times have you stopped menstruating for 3 months or more (which were unrelated to pregnancy)?

___# of times

Since you began dieting, purging, or binge eating, what is the total number of months that you have not menstruated (months unrelated to pregnancy?)

___months

Before you began dieting, purging, or binge eating, what is the total number of months that you have not menstruated (months unrelated to pregnancy)?

___ months

Approximate regularity of the cycles before onset of any eating difficulties (Check one).

Fairly regular (Same number of days +3) ___
Somewhat irregular (Variation 4-10 days) ___
Very irregular (Variation greater than 10 days) ___
Never menstruated ___

How many times in the past have you had episodes of loss of menstrual periods lasting 3 months or more associated with significant weight loss when you were not "binge eating" or pregnant?

___ # of times

VIII. Medical and Psychiatric History

Have you ever had any serious medical difficulties?

Yes ___ No ___

If yes, please explain:

Please indicate any prior hospitalizations for eating or emotional problems.

	Most Recent	Second Prior	Third Prior	Fourth Prior
Date Admitted	_____	_____	_____	_____
Date Discharged	_____	_____	_____	_____
Duration	_____	_____	_____	_____
Age	_____	_____	_____	_____
Primary reason for admission*	_____	_____	_____	_____

*** Use number code: 1=bulimia; 2=anorexia nervosa; 3=chemical dependency; 4=depression; 5=psychiatric problem other than depression; 6=other**

Prior outpatient treatment for eating or emotional problems (i.e., a logically continuous series of treatments).

	Most Recent	Second Prior	Third Prior	Fourth Prior
Date Admitted	_____	_____	_____	_____
Date Discharged	_____	_____	_____	_____
Duration	_____	_____	_____	_____
Age	_____	_____	_____	_____

Primary reason _____ _____ _____ _____

for admission*

* Use number code: 1=bulimia; 2=anorexia nervosa; 3=chemical dependency; 4=depression; 5=psychiatric problem other than depression; 6=other

Please indicate the types of treatment* you have been involved with:

Most Recent Second Prior Third Prior Fourth Prior

_____ _____ _____ _____

* Use number code: 1=individual psychotherapy; 2=group psychotherapy; 3=psychiatric medication

Are you currently on any medication?

Yes ___ No ___

If yes, please identify: _____

What physical problems have you had since the onset of any eating problems? (If more than one response is applicable please rank order your answers with 1=most troublesome, 8=least troublesome).

sore throat	___	sores or calluses on fingers	
weakness or tiredness	___	due to induction of vomiting	___
seizures	___	dental problems	___
feeling bloated	___	other	___
stomach pains	___		

Have you ever taken any psychiatric medication?

Yes ___ No ___

If yes, please identify: _____

Please circle on the scale below how frequently you experience the following symptoms:

	Never	Rarely	Sometimes	Often	Always
Depression	1	2	3	4	5
Anxiety	1	2	3	4	5
Difficulty getting up in the morning	1	2	3	4	5
Crying episodes	1	2	3	4	5
Irritability	1	2	3	4	5
Fatigue	1	2	3	4	5
Difficulty falling asleep	1	2	3	4	5

APPENDIX L

APPENDIX L

YOUNG ADULT/PARENT RELATIONSHIP INTERVIEW

General Rating Instructions for Coding the Young Adult/ Parent Relationship Dimensions

This manual describes the criteria for rating protocols describing a dimension of the young adult's relationship with his or her parent on a 5 point rating scale. There are one or more criteria listed under each of the 5 points on the scale (referred to in the manual as "LEVELS" that will guide you in determining the appropriate rating for each protocol. In some cases, only one criterion listed under a particular level will fit a particular protocol and will determine the rating for that protocol. More often several of the criteria listed under a level will fit the protocol you are rating. Regardless, it is only necessary to have a clear fit on one criterion to rate a protocol at a particular level. The difficult decisions are when criteria at two different levels seem to apply. To rate the protocol you will have to make a weighted judgment as to which level best describes the protocol. If several criteria at one level apply but only one criterion at the other level applies the protocol is probably best rated at the level at which it meets the largest number of criteria. This is not a hard and fast rule; you may have to make a judgment call.

The coding manual cannot cover every case. It is important to understand the conceptual distinctions between each level so that when a protocol is not addressed directly by the stated criteria, it is possible to make a clinical judgment as to the best level. In a sense, the rater should imagine adding another instance to a particular level that at a more

abstract level gets at the same issues raised by the other examples, albeit with somewhat different content. It is also helpful to remember that a scale consists of a range from low to high. A protocol may be "between" a lower and a higher level (e.g. it seems like a 4 because there is "more" than what is at level 3 and "less" than what is described at level 5) even though it does not meet the specific criteria of the level in the middle. This is a valid criterion for rating a protocol, but should only be used after considering the specific criteria contained in the manual.

YOUNG ADULT/PARENT RELATIONSHIP INTERVIEW

Introduction: WE TALKED A LITTLE ABOUT THIS ON THE PHONE... WHAT KINDS OF CONTACTS DO YOU HAVE WITH YOUR PARENTS NOW, SUCH AS VISITS, WRITING LETTERS, TELEPHONE CALLS AND SUCH. LET'S START WITH YOUR MOTHER/FATHER.

1. What kinds of contacts do you have with your mother/father? (List below) FOR EACH ONE MENTIONED, ASK: About how often do you do this?

   IF THE YOUNG ADULT IS LIVING IN THE PARENTAL HOME, ASK: About how much time do you spend with your mother/father?

2. What kinds of things do you do when you're together with your mother/father?
3. What do you enjoy about your contacts with your mother/father?
4. What does your mother/father enjoy about these contacts?
5. Of course, there's usually something we don't enjoy about others... what might these things be about your mother/father?
6. What do you think might not be so enjoyable about these contacts for your mother/father?
7. Who initiates the contacts between you and your mother/father? (Can you give me an example?)
8. Do you wish you had more or less contact with your mother/father?

   IF MORE OR LESS: Why would you prefer (more/less) contact?

   IF SAME: What makes it seem about right?

9. In general, how much does your mother/father talk about his/her personal concerns with you? What kinds of things does s/he discuss? (How do you feel about that?)

10. And how much do you talk about your personal concerns with her/him? What kinds of things do you discuss? (How do you feel about that?

11a. Are there things that you avoid talking about with your mother/father? What kinds of things?

11b. What do you think makes you avoid these topics? (Can you give me one or two examples? How do you feel about that?)

12. In what ways do you feel close to your mother/father? What kinds of things bring you together? And how do you and your mother/father express closeness?

13a. Are there any feelings of tenseness when you and your mother/father are together?

13b. How often does that occur?

13c. What do you think that feeling of tenseness is about?

14. In what ways would you like to be closer to your mother/father? (Can you give me an example?)

15. What gets in the way of closeness between you and your mother/father?

16a. At what point were you closest to your mother/father?

16b. At what point were you most distant from your mother/father?

16c. TAKE THE LATEST REFERENT POINT, OR AGE, WHETHER CLOSE OR DISTANT AND ASK: Your relationship has changed since (age... or time...). How do you account for the difference?

17. In what ways are you like your mother/father? (What does that tell you about yourself?)

18. In what ways are you different from your mother/father? (What does that tell you about yourself?)

19a. In what ways does your mother/father show concern for your needs or welfare? (Can you give me a few examples? How do you feel about this?)

19b. Do you think s/he should be more or less responsive to your needs? (How would that affect your relationship?)

20. In what ways do you show concern for your mother/father's needs or welfare? Do you think s/he gets the message? IF NO: What makes you say that? Do you wish it were different? IF YES: How do you know?

21. Can you think of a time recently when you felt conflicted about your mother/father's needs and your needs? What was that about? (How did you handle it? How did you feel about the way it was handled?)

22a. Which parent do you feel closer to? (PROBE: Lots of people feel closer to one parent than the other. IF SAYS NEITHER: What makes this so?)

22b. In what ways are you closer to _____ than to _____?

22c. How do you think it came about (that you are closer to _____?)

23a. To change to focus somewhat... Can you think of a time that you talked over an important decision with your mother/father? IF SAYS NEVER: Imagine what would happen if you did... what might happen? IF SAYS CAN'T IMAGINE: What makes that impossible to imagine?

23b. What other kinds of decisions do you discuss with your mother/father... for example, your financial affairs, personal relationships, work or career choices?

24. Can you think of a time that you and your mother/father disagreed about something very important? Tell me about that. (How did you

handle that? How did you feel about your response? How did it get resolved? Is that how disagreements usually get resolved between you and your mother/father?)

25a. In what ways are your values different from those of your mother/father?

25b. In what ways are your values similar to those of your mother/father?

25c. We've talked about things that you discuss with your mother/father. Besides advice, what other kinds of things does s/he help you with? (Do you ask for help or does s/he offer?--Who initiates?--How do you think s/he feels about doing that for you? How do you feel?)

26. What happens when your mother/father is not available. (IF SAYS NOTHING, ASK: Imagine...)

27. Are there ways in which you wish you could rely more on your mother/father... or maybe less? (How do you expect that to come about?)

28. What are some of your mother/father's weaknesses? What do you think makes her/him that way?

29. In what ways would you like her/him to change? Do you think s/he ever will? (How will that come about?) IF SAYS, I DON'T KNOW: What do you think s/he might do to change?) IF SAYS NO: What might prevent her/him from changing?

30. In what ways has s/he let you down?

31. What kinds of things about your mother/father make you feel proud? What are some of her/his strengths?

DECISION MAKING

DEFINITION: This definition has to do with the young adult's ability to make important decisions and life choices without undue influence from the parent. This includes the young adult's ability to make decisions in accordance with his or her own values and preferences as well as the ability to make decisions as to the nature of those values and preferences.

Note 1: Young adults who are generally able to make their own decisions may occasionally seek advice from the parent; these young adults should be rated as high on decision making if a) the parent's input does not appear to be essential (e.g. the young adult indicates that he or she often makes decisions without consulting the parent) and b) the parent's advice is viewed as input for self-determined decisions rather than as the final word as to what the young adult ought or ought not to do. These distinctions are made more explicit in the descriptions of the criteria for rating the various points on the scale.

Note 2: If the young adult does not consult the parent because of negative feelings towards the parent or because of a lack of respect for the parent and the young adult makes his or her decisions without relying on the parent's standards he or she should probably be coded as high on decision making. The negative feelings about the parent are coded elsewhere and should not be confused with the decision making dimension.

Note 3: Some young adults rely on a spouse, close friend, etc. rather than the parent in making decisions. This should not affect the rating. Only rate how much the young adult relies on and is influenced by the parent.

SPECIFIC RATING CRITERIA

The young adult's decision making abilities in relation to the parent are coded on a 5 point scale with 1 referring to "low" decision making abilities and 5 referring to "high" decision making abilities. The criteria for rating a protocol as 1, 2, 3, 4, or 5 on the Decision Making Scale are described below.

Indicators of LEVEL 1:

a) The young adult generally relies on the parent in making decisions or in deciding on his or her values; if there are any differences at all, the young adult is extremely susceptible to the parent's pressures to conform to the parent's beliefs and/or he or she feels very uncertain about his or her own views.

b) If and when the young adult makes decisions that are different from what the parent wants or thinks the young adult should do, the young adult feels guilty, ashamed, afraid, etc.

c) The young adult feels guilty, afraid, hurt, abandoned, etc. if the parent does not agree with and/or support the young adult's decision.

Indicators of LEVEL 2:

a) There is some evidence that the young adult is at least trying to make his or her own decisions, but he or she has relatively little success or

he or she is still heavily influenced by the parent and continues to experience self-doubts about his or her own decisions.

b) The young adult seems to feel like he or she makes his or her own decisions, but these claims are largely unsubstantiated and there is clear evidence to the contrary.

c) The young adult is very reliant on the parent for help in making decisions in some important areas of his or her life, but there are at least a few areas where they do not seek or feel that they need the parent's advice.

d) At this level there is little or only minimal evidence that the young adult's decisions are based on self- chosen values, standards, or preferences.

Indicators of LEVEL 3:

a) The young adult clearly makes his or her own decisions in some important areas of his or her life, but is still clearly influenced by the parent in others.

b) There is clear evidence that the young adult is attempting to make his or her own decisions, but at the same time he or she is susceptible to and at times swayed by the parent's influence; this experience is viewed negatively by the young adult and sometimes leads him or her to act against his or her own wishes.

c) The young adult tries to avoid discussing his or her decisions with the parent in order not to be swayed, influenced, or coerced into taking the parent's point of view.

d) The young adult attempts to make his or her own decisions, but generally relies on the parent as a sounding board in thinking out what to

do; the parent acts as a frequent counselor and advisor who bolsters the young adult's confidence in his or her final decision.

Indicators of LEVEL 4:

a) The young adult clearly makes his or her own decisions in life but his or her values (or what he or she values) are less clearly differentiated from those of the parent than at Level 5. For example, the young adult identifies with (and there is little or no evidence of having questioned) the parent's values, but he or she may implement these values in a different way.

b) The young adult's values are clearly differentiated from those of the parent but he or she tends to consult the parent on a wider range of issues than at level 5.

Indicators of LEVEL 5:

a) The young adult has a clear sense of conviction about what he or she believes, values, etc.; these standards or preferences are at least in part differentiated from those of the parent, and he or she uses these self-determined criteria to make his or her own decisions. At this level, the young adult has identified areas where decisions differ from the parent and is satisfied with these differences. In addition, he or she is able to evaluate and choose whether or not to accept the parent's advice.

INDEPENDENCE

DEFINITION: This dimension focuses on the young adult's experience of competence in the relationship with the parent, and on his or her belief that he or she can cope with the challenges and setbacks in his or her life without having to rely on the parent.

Note: If the young adult does not rely on the parent because of negative feelings towards the parent or because of a lack of respect for the parent he or she probably should be coded as high if it is clear that he or she is able to cope with his or her own life without fear of repeating the parent's perceived failures. Those negative feelings about the parent that do not directly affect the young adult's perception of his or her coping abilities should not be confounded with the rating for this dimension; these feelings will be coded elsewhere.

SPECIFIC RATING CRITERIA

The young adult's independence from and competence in the relationship with the parent is coded on a 5 point scale with 1 referring to "low" independence and 5 referring to "high" independence. The criteria for rating a protocol as 1, 2, 3, 4, or 5 on the Independence Scale are described below.

Indicators of LEVEL 1:

a) The young adult generally relies on the parent to cope with challenges and difficulties in his or her own life. Young adults at this level often experience themselves as helpless and unable to cope without the

parent's support and may feel frustrated or angry when the parent is unable to help.

b) The young adult may realize and feel badly about his or her dependency but in spite of desires or wishful thinking about being more self-reliant he or she is unable or unwilling to give up this dependency and face the world on his or her own.

c) The young adult feels inferior to or like a failure in the parent's eyes and either accepts or feels conflicted about that definition. The young adult may have difficulty accepting the parent's help without feeling inferior, ashamed, angry or resentful.

Indicators of LEVEL 2:

a) The young adult provides some minimal evidence of competence, for example, he or she at times feels able to cope with the world, but these feelings are often transitory, are based on thin denials of insecurities, and/or are accompanied by clear examples of strong dependencies on the parent. The young adult may vacillate between feelings of competence and inferiority or may express serious conflicts and self-doubts in spite of some minimal acknowledgment of his or her competence.

b) The young adult has some sense that he or she can be of help to the parent, but retains strong doubts about his or her ability to cope with life in the world outside the family.

c) The young adult indicates some competencies that are not being used because of strong and pervasive dependencies on the parent.

d) The young adult makes some weak attempts to be more independent but is inhibited by strong ambivalences and fears of feeling helpless or deprived if the parent's help were not available.

Indicators of LEVEL 3:

a) There are clearly some important areas in the young adult's own life in which he or she feels able to cope without the parent's assistance, but there are just as clearly other areas in which they feel insecure and unable to cope without relying on the parent for advice and guidance.

b) The young adult feels like he or she is in a student relationship with the parent/teacher, although he or she has some abilities or expertise to offer the parent. The young adult sees the parent as a positive role model and is working towards but has not yet achieved that ideal.

c) The young adult describes some feelings of inferiority but these feelings are not all-pervasive or overwhelming; there is a definite sense that the young adult is moving towards becoming more independent, and in some areas may even feel that he or she has strengths the parent does not have.

Indicators of LEVEL 4:

a) The young adult clearly feels he or she can cope without the parent's help but this sense of competence is not as pronounced as in Level 5; there is greater emphasis on not being dependent than on active goal-oriented coping.

b) There is no clear evidence that the young adult is especially proud of his or her abilities nor direct evidence that he or she is seen by the parent as especially capable.

c) In spite of an overall sense of competence the young adult reveals some isolated but obvious areas of concern or self-doubt that may be of relatively minimal importance to their daily or overall functioning.

Indicators of LEVEL 5:

a) The young adult feels at least on an equal par with the parent in evaluating his or her ability to cope and deal effectively with challenges and difficulties in his or her life. The young adult may identify with the parent's strengths and/or sees differences in a positive light and feels able to pick and choose in emulating the parent's qualities.

b) The young adult has a strong sense of confidence in his or her ability to cope, a perception they often feel is shared by the parent (or an evaluation that clearly is unshaken in spite of the parent's skepticism).

c) The young adult can maintain a sense of competence even when accepting help from the parent and is able to draw on other sources when the parent is not available.

d) In addition to being able to function independently the young adult describes areas in which his or her expertise is helpful to the parent.

PERSONAL CONTROL

DEFINITION: This dimension refers to the young adult's ability to control his or her behavior and feelings in the relationship with the parent.

Note: This dimension does not refer to and should not be confounded with how much the young adult likes or does not like the parent (although the two may be correlated). The key issue rated in this dimension is how the young adult handles his or her needs and feelings (including negative feelings) in the relationship with the parent. If the young adult is overwhelmed by or has little control over his or her needs or feelings they would be identified as low in personal control; however, a young adult who has some negative feelings about a parent but who is undistressed by, has some psychological distance from, and is able to keep those feelings from spilling into inappropriate behaviors could conceivably be rated as high on personal control.

SPECIFIC RATING CRITERIA

The young adult's degree of personal control in the relationship with the parent is coded on a 5 point scale with 1 referring to "low" personal control and 5 referring to "high" personal control. The criteria for rating a protocol as 1, 2, 3, 4, or 5 on the Personal Control Scale are described below.

Indicators of LEVEL 1:

a) The young adult behaves in very inappropriate ways (e.g. yells, flees the scene, loses his or her temper, argues incessantly, says very hostile things to the parent that may be regretted later, cries uncontrollably,

etc.) in the relationship with the parent because he or she is unable to control intense feelings of anger, frustration, or shame.

Indicators of LEVEL 2:

a) The young adult is overwhelmed by and/or has to be constantly on guard against intense feelings of unresolved ambivalence, hatred, rage, shame, or guilt that are often distressful to the young adult.

b) The young adult expresses highly intense feelings of rage, dependency, shame, etc.; although the young adult appears to be unashamed or untroubled by these feelings, their intensity indicates a lack of control and/or constricted rage that is serious enough to be coded at Level 2.

c) The young adult appears to have very little tolerance for frustration in the relationship with the parent. For example, the young adult acknowledges extreme dependency needs that are inappropriate in adulthood; although the parent may be meeting these needs, the young adult indicates that if his or her needs were not met by the parent this would result in feelings of anger, deprivation, or extreme frustration.

Indicators of LEVEL 3:

a) The young adult is irritated by often seemingly minor conflicts or behaviors on the part of the parent.

b) The young adult occasionally gets into mild arguments with, is sarcastic towards, or feels mildly ashamed or guilty in the relationship with the parent; these negative feelings toward the parent and the ways in which they are expressed are less intense and more controlled than at the previous levels.

c) The young adult is disturbed or ashamed by the parent's weaknesses, relationships, or behaviors even when these do not directly affect the young adult.

d) The young adult acknowledges mild ambivalence toward the parent that creates conflict for the young adult, but is (potentially) resolvable or at least sufficiently under control so as not to be overly distressing.

Indicators of LEVEL 4:

a) The young adult experiences minor irritation or discomfort in the relationship with the parent; although these feelings are mostly under control or of relatively little importance to the young adult, they are notable because they indicate that the young adult has not altogether resolved parent/child issues. For example, these feelings may be stimulated by situations that would not result in conflicts if the other person involved were not a parent (e.g. the young adult feels infantilized when the parent attempts to give advice that probably would be well received from someone else).

Indicators of LEVEL 5:

a) The young adult experiences little or no tension, distress, anger, etc. in the relationship with the parent; in some cases the relationship is described in a positive way and may be characterized by mutual enjoyment and pleasure.

b) The young adult has developed effective coping strategies for dealing with potentially tense interactions or negative feelings; these ways of coping allow the young adult to master negative perceptions of the parent

or to deal successfully with difficult situations that might otherwise create discomfort in the relationship.

SELF-ASSERTION

DEFINITION: This dimension refers to the extent to which the young adult's behavior in the relationship with the parent is inhibited by feelings of shame or guilt. At the low end of the scale young adults implicitly or explicitly use the parent as a superego or ego ideal; these young adults' standards for evaluating and monitoring their behaviors vis a vis the parent are insufficiently differentiated or confused with perceived parental expectations. At the high end of the scale young adults are uninhibited by feelings of shame or guilt, are able to rely on their own standards in relating to the parent, and are able to assert themselves in the relationship when failure to do would compromise these standards.

SPECIFIC RATING CRITERIA

The young adult's self assertion in the relationship with the parent is coded on a 5 point scale with 1 referring to "low" self-assertion and 5 referring to "high" self-assertion. The criteria for rating a protocol as 1, 2, 3, 4, or 5 on the Self-Assertion Scale are described below.

Indicators of LEVEL 1:

a) The young adult is clearly inhibited by feelings of shame and guilt in the relationship with the parent and/or monitors his or her behavior in order to avoid the parent's negative evaluation, disapproval, contempt, anger, or retribution. If the use of the parent as an ego ideal or superego figure is mostly ego syntonic, the young adults' excessive self-abnegation may be relatively untroublesome to the young adult even though it is painfully evident from the perspective of an outsider.

b) The young adult's self-abnegation in the relationship with the parent is so glaring that even minimal attempts at self-assertion appear futile or ineffective in view of the larger context of the relationship.

Indicators of LEVEL 2:

a) The young adult, as in Level 1, is constrained in the relationship by feelings of shame or guilt, perceives the parent as an appropriate evaluator of his or her behavior and/or is inhibited by the parent's judgment or disapproval of his or her actions; however, there is some evidence that the young adult is beginning to assert him or herself in the relationship with the parent and is questioning or reevaluating his or her perceptions of the parent's power or authority.

b) The young adult is able to assert him or herself in a few isolated areas in the relationship with the parent, although overall the young adult is still inhibited by shame or guilt and/or uses the parent to evaluate and monitor his or her behavior.

c) The young adult projects his or her own discomfort about being him or herself onto the parent (e.g. "he can not take it when I let him know who I really am") and/or denies or does not acknowledge that he or she is concerned about or fears the parent's disapproval; however, this denial is difficult to believe in the face of obvious clues to the contrary. For example, the young adult has tremendous tension or anxiety about opening up with the parent or is still emotionally involved with the experiences of guilt or shame in response to memories of past conflicts. Alternatively, the young adult may be constrained in the relationship because he or she is intensely ashamed of or embarrassed by the parent; the parent functions as a negative ego ideal, detracting from and constraining the young adult's

ability to be him or herself in the relationship with the parent and implicitly or explicitly diminishing the young adult's own feelings of self-worth.

Indicators of LEVEL 3:

a) In some areas the young adult appears to be uninhibited by shame or guilt in the relationship with the parent (e.g., he or she can discuss potentially shameful experiences or assert and maintain his or her own standards when these differ from those of the parent); however, in other important areas the young adult appears to be constrained in the relationship by feelings of shame or guilt (be it shame about his or her own or the parent's characteristics) and these areas compromise the young adult's feelings of self-worth.

b) In some significant areas the young adult implicitly or explicitly uses the parent to set standards for his or her behavior in the relationship and/or indicates that he or she continues to need the parent's approval; in other areas, however, he or she is more able to be a self-evaluator.

Indicators of LEVEL 4:

a) The young adult generally is uninhibited by feelings of shame and uses his or her own standards to monitor his or her behavior in the relationship with the parent. However, there is a fairly isolated area in which he or she continues to be inhibited and implicitly or explicitly seeks or desires the parent's approval.

b) Although the young adult generally is comfortable being him or herself in the relationship with the parent he or she admits to an important but isolated area in the relationship in which he or she is unable to be him or herself. Although the constraints are mostly outside of the young adult's

control the tensions in some way detract from the young adult's feelings of self-worth; implicitly if not explicitly, the young adult appears to need the parent's acknowledgment or approval to alleviate feelings of self-doubt, rejection, etc. Alternatively, the young adult may be ashamed of the parent and while these feelings are relatively isolated they detract in some way from the young adult's feeling of self-worth and from a generally high level of self-assertion in the relationship with the parent.

c) While it is evident that the young adult has developed his or her own standards and is not inhibited by guilt or shame in the relationship with the parent, repeated statements about not needing the parent's approval suggest that his or her sense of being a self-evaluator is not on as firm ground as at Level 5.

Indicators of LEVEL 5:

a) The young adult is able to assert him or herself and express his or her needs, values and interests in the relationship with the parent even when these needs or values clash with those of the parent. The young adult gives no evidence that he or she views the parent as an authority figure or as an appropriate judge of the young adult's self-worth or behavior.

b) The young adult clearly has his or her own standards for evaluating his or her behavior and these can be clearly distinguished from those of the parent. The young adult does not sacrifice these standards in the relationship with the parent although at times he or she may avoid certain issues that might lead to unnecessary tensions. At Level 5, not bringing up these issues does not in any way detract from the young adult's feelings of self-worth and is rather an indication that he or she does not need the parent's approval.

c) The young adult's relationship with the parent is limited more by the parent's conflicts, inhibitions, etc. than by the young adult's lack of assertiveness. Although the young adult may openly confront the parent in an attempt to change the relationship, he or she is able to acknowledge and accept that, given the parent's limitations, he or she will "never" be him or herself with the parent. This knowledge does not compromise the young adult's standards nor detract from his or her feelings of self-worth.

SELF/OTHER RESPONSIBILITY

DEFINITION: This dimension describes how the young adult resolves conflicts and pulls between obligations and needs created by his or her own life circumstances and the needs of and the obligations to the parents. Conflicts about where and with whom to spend holidays and vacations often provide information on this dimension. Self/other responsibility is similar to what other theorists have described as the parent's ability to allow the child to develop relationships and interests outside of the parent/child dyad; however, here it is coded from the young adult's perspective and describes his or her ability to make attachments and investments outside of the relationship with the parent.

Note: Most young adults who are high on this dimension should be able to make new investments without totally denying the needs of or breaking contact with the parent. However, a young adult may have a very negative relationship with the parent and still score high on self/other responsibility if he or she has developed new sources outside of the parent/young adult relationship for finding love and affection, fulfillment, stimulation, efficacy, etc. A young adult who continues to rely heavily on the parent for these psychological resources or who fails to make psychological investments outside of the dyad because he or she continues to be embroiled in unresolved conflicts with the parent would be rated as low on self/other responsibility. The quality of the parent/young adult relationship that to a greater or lesser extent is left behind is irrelevant in coding this dimension and will be rated elsewhere.

SPECIFIC RATING CRITERIA

The young adult's self/other responsibility in the relationship with the parent is coded on a 5 point scale with 1 referring to "low" self/other responsibility and 5 referring to "high" self/other responsibility. The criteria for rating a protocol as 1, 2, 3, 4, or 5 on the Self/Other Responsibility Scale are described below.

Indicators of LEVEL 1:

a) The young adult is unable to leave home in the psychological sense. The young adult has not transferred his or her loyalties and investments to new sources of affection, stimulation, fulfillment, etc.: rather, he or she relies heavily on the relationship with the parent for stimulation, affection, fulfillment, etc. and feels lonely or abandoned without constant contact.

b) The parent is involved in the minute details of the young adult's life. The young adult may have excessive responsibility for or involvement in the parent's life or concerns and/or is responsible for involving the parent in his or her own life concerns.

c) The young adult is often triangulated in the parent's marital or family relationships and/or is unable to keep the parent from interfering in his or her own relationships or efforts to make an independent life for him or herself.

Indicators of LEVEL 2:

a) As in Level 1, there are clear indications that the parent is overinvolved in significant areas of the young adult's life and vice versa, but the enmeshment is not as intense, emotionally compelling, or all-pervasive

as in a Level 1 protocol. The young adult may view the enmeshment positively, may not exert any effort to separate, or else might make weak but mostly ineffective attempts to deinvest in the dyad.

b) The young adult resists pressures to deinvest in the dyad or yearns to increase his or her involvements at the expense of separation even though these efforts may be resisted by the parent.

Indicators of LEVEL 3:

a) The young adult makes clear attempts to resist the parent's intrusiveness, but constantly has to be on guard against inner pulls (e.g., guilt or dependency needs) and/or parental pressures that may interfere with or encroach on involvements and relationships outside of the dyad or family of origin.

b) The young adult's overinvolvement in the dyadic relationship with the parent and/or inner pulls towards excessive involvement are moderated by investments in other important areas (e.g., other close relationships, career, etc.); these other investments are relevant for rating self/other responsibility if they serve as alternate sources of support, affection, fulfillment, etc. and help to deintensify involvements with the parent.

Indicators of LEVEL 4:

a) The young adult describes minor instances of overinvolvement or minimal conflicts about separating from the parent, but for the most part the young adult has make satisfying or fulfilling investments outside of the parent/young adult relationship.

b) Although the parent attempts to triangulate or remain excessively involved in the young adult's life, the young adult for the most part actively and successfully fends off these attempts by the parent.

c) There is some evidence that the young adult has in some ways given in to his or her own or to the parent's desires for triangulation, overinvolvement, etc., but these compromises only minimally affect the young adult's generally successful attempts to make satisfying investments outside of the dyadic relationship.

Indicators of LEVEL 5:

a) The young adult clearly has made satisfying, stable, and fulfilling investments outside of the dyadic relationship with the parent and is able to regulate the relationship so that contacts with the parent do not intrude on his or her relationships outside of the dyad.

b) The young adult is able to share in the parent's life or to share their life with the parent (if this is viewed as desirable) without fear of triangulation, overinvolvement or enmeshment.

c) If the young adult does not directly address the issue of self/other responsibility but there is no indication of overinvolvement, triangulation, or enmeshment, code the protocol as a 5.

Questions Invariably Coded for Specific Autonomy Issues

Decision Making:

17. In what ways are you like your mother/father? (What does that tell you about yourself?)

18. In what ways are you different from your mother/father? (What does that tell you about yourself?)

23a. Can you think of a time that you talked over an important decision with your mother/father? IF SAYS NEVER: Imagine what would happen if you did... what might happen? IF SAYS CAN'T IMAGINE: What makes that impossible to imagine?

23b. What other kinds of decisions do you discuss with your mother/father... for example, your financial affairs, personal relationships, work or career choices?

24. Can you think of a time that you and your mother/father disagreed about something very important? Tell me about that. (How did you handle that? How did you feel about your response? How did it get resolved? Is that how disagreements usually get resolved between you and your mother/father?)

25a. In what ways are your values different from those of your mother/father?

25b. In what ways are your values similar to those of your mother/father?

Independence:

9. In general, how much does your mother/father talk about his/her personal concerns with you? What kinds of things does s/he discuss? (How do you feel about that?)

10. And how much do you talk about your personal concerns with her/him? What kinds of things do you discuss? (How do you feel about that?

17. In what ways are you like your mother/father? (What does that tell you about yourself?)

18. In what ways are you different from your mother/father? (What does that tell you about yourself?)

19a. In what ways does your mother/father show concern for your needs or welfare? (Can you give me a few examples? How do you feel about this?)

19b. Do you think s/he should be more or less responsive to your needs? (How would that affect your relationship?)

20. In what ways do you show concern for your mother/father's needs or welfare? Do you think s/he gets the message? IF NO: What makes you say that? Do you wish it were different? IF YES: How do you know?

25c. We've talked about things that you discuss with your mother/father. Besides advice, what other kinds of things does s/he help you with? (Do you ask for help or does s/he offer?--Who initiates?--How do you think s/he feels about doing that for you? How do you feel?)

26. What happens when your mother/father is not available. (IF SAYS NOTHING, ASK: Imagine...)

27. Are there ways in which you wish you could rely more on your mother/father... or maybe less? (How do you expect that to come about?)

<u>Personal Control</u>:

3. What do you enjoy about your contacts with your mother/father?

4. What does your mother/father enjoy about these contacts?

5. Of course, there's usually something we don't enjoy about others... what might these things be about your mother/father?

6. What do you think might not be so enjoyable about these contacts for your mother/father?

11a. Are there things that you avoid talking about with your mother/father? What kinds of things?

11b. What do you think makes you avoid these topics? (Can you give me one or two examples? How do you feel about that?)

13a. Are there any feelings of tenseness when you and your mother/father are together?

13b. How often does that occur?

13c. What do you think that feeling of tenseness is about?

24. Can you think of a time that you and your mother/father disagreed about something very important? Tell me about that. (How did you handle that? How did you feel about your response? How did it get resolved? Is that how disagreements usually get resolved between you and your mother/father?)

28. What are some of your mother/father's weaknesses? What do you think makes her/him that way?

29. In what ways would you like her/him to change? Do you think s/he ever will? (How will that come about?) IF SAYS, I DON'T KNOW: What do you think s/he might do to change?) IF SAYS NO: What might prevent her/him from changing?

30. In what ways has s/he let you down?

31. What kinds of things about your mother/father make you feel proud? What are some of her/his strengths?

Self-Assertion:

9. In general, how much does your mother/father talk about his/her personal concerns with you? What kinds of things does s/he discuss? (How do you feel about that?)

10. And how much do you talk about your personal concerns with her/him? What kinds of things do you discuss? (How do you feel about that?

11a. Are there things that you avoid talking about with your mother/father? What kinds of things?

11b. What do you think makes you avoid these topics? (Can you give me one or two examples? How do you feel about that?)

13a. Are there any feelings of tenseness when you and your mother/father are together?

13b. How often does that occur?

13c. What do you think that feeling of tenseness is about?

16a. At what point were you closest to your mother/father?

16b. At what point were you most distant from your mother/father?

16c. TAKE THE LATEST REFERENT POINT, OR AGE, WHETHER CLOSE OR DISTANT AND ASK: Your relationship has changed since (age... or time...). How do you account for the difference?

17. In what ways are you like your mother/father? (What does that tell you about yourself?)

18. In what ways are you different from your mother/father? (What does that tell you about yourself?)

24. Can you think of a time that you and your mother/father disagreed about something very important? Tell me about that. (How did you handle that? How did you feel about your response? How did it get

resolved? Is that how disagreements usually get resolved between you and your mother/father?)

Self-Other Responsibility:

1. What kinds of contacts do you have with your mother/father? (List below) FOR EACH ONE MENTIONED, ASK: About how often do you do this?

   IF THE YOUNG ADULT IS LIVING IN THE PARENTAL HOME, ASK: About how much time do you spend with your mother/father?

7. Who initiates the contacts between you and your mother/father? (Can you give me an example?)

8. Do you wish you had more or less contact with your mother/father?

   IF MORE OR LESS: Why would you prefer (more/less) contact?

   IF SAME: What makes it seem about right?

16a. At what point were you closest to your mother/father?

16b. At what point were you most distant from your mother/father?

16c. TAKE THE LATEST REFERENT POINT, OR AGE, WHETHER CLOSE OR DISTANT AND ASK: Your relationship has changed since (age... or time...). How do you account for the difference?

21. Can you think of a time recently when you felt conflicted about your mother/father's needs and your needs? What was that about? (How did you handle it? How did you feel about the way it was handled?)

LIST OF REFERENCES

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