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THE PSYCHODYNAMICS OF ANOREXIA NERVOSA AND BULIMIA

By

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ABSTRACT

THE PSYCHODYNAMICS OF ANOREXIA NERVOSA AND BULIMIA

By

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Anorexia nervosa and bulimia are severe eating disorders commonly reported among college aged women. While their symptomatic behavioral profiles have been well documented, less is known about the psychodynamics of these syndromes. This study explored conscious and unconscious dynamics associated with anorexia nervosa, bulimia, and more normal eating patterns, as measured by a self-report questionnaire and the Thematic Apperception Test (TAT). Subjects were 50 undergraduate women, selected from a larger subject pool on the basis of reported eating patterns. Ten women reported histories of restrictive anorexia nervosa, 20 binged and purged, 10 dieted occasionally and 10 were free from such psychological involvement with food. Although TAT data did not reveal differences in unconscious, internal conflicts as a function of eating pathology, several important differences emerged in conscious feelings about men in general and father in specific. Bulimics tended to perceive father as critical and controlling, although they respected and admired him. In contrast to bulimics, anorexics expressed more conflicted and ambivalent feelings towards father. Members of both eating disordered groups were afraid of adult heterosexual

relationships, fearing the destructive potential of closeness with men, but expecting men to depart unscathed from their encounters with women. Comparing feelings of isolation, feelings about mother, and issues around pleasing one's parents, no differences were found across groups. These results are discussed from a psychodynamic viewpoint, and conclusions are drawn regarding normative patterns of eating, dieting and purgation among young American women. While bizarre and physiologically destructive eating patterns may be prevalent in this population, the statistically normal preoccupation with food and weight reduction should be carefully distinguished from the full clinical syndromes of anorexia nervosa and bulimia.

To James

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Food for Thought

Introduction

As society changes over time, psychopathology seems to keep current. Certain forms of psychological disturbance emerge, while others decrease in prevalence. Few clinicians still treat the conversion hysterias so common during Freud's time; the dynamics and conflicts which he observed now seem to emerge through new symptomatology, reflecting broad sociocultural changes. Two eating disorders, anorexia nervosa and bulimia, seem to be modern neuroses in this sense. Critical to both disorders is a relentless pursuit of thinness and an abject fear of fat which seem to coincide with mounting cultural pressure to be slim (Bruch, 1973; Garner, Garfinkle & Olmstead, 1983; Garner, Garfinkle, Schwartz & Thompson, 1980). The incidence rate of these disorders has reportedly risen exponentially over the last 25 years (Bemis, 1978; Duddle, 1973; Halmi, 1974, and others), spurring popular interest and scientific research in this previously uncharted region of psychopathology. Our knowledge and understanding of anorexia nervosa has increased dramatically, but research on bulimia is still in its incipient stages.

The diagnostic distinction between anorexia nervosa and bulimia is a recent and not yet explicit one, reflecting overlapping symptomatology and terminology. The self-induced starvation which is the cornerstone of anorexia nervosa was first identified and labelled by Gull in 1874. It was not until the seminal work of Boskind-Lodahl (1976) that such restrictive dieting was distinguished from the cycle of bingeing and

purging found among normal weight women. Boskind-Lodahl termed the latter disorder "bulimarexia", emphasizing both the uncontrolled bingeing and the self-punitive laxative abuse, vomiting or restrictive dieting which follows.

Palmer (1979) has addressed this diagnostic problem by coining the term "dietary chaos syndrome". This syndrome is characterized by 1) grossly disturbed eating patterns, including vomiting, binge-eating and abstinence, 2) a preoccupation with eating, food, and sometimes weight, which overrides other thoughts, and 3) rapid fluctuations of body weight in response to food intake and output. These features roughly match the criteria for bulimia established in the Diagnostic and Statistical Manual (DSM-III, American Psychiatric Association, 1980), which will be discussed in greater detail below. Other researchers have more casually referred to the binge-purge cycle as "bulimia", although the DSM-III allows for the diagnosis of bulimia in the absence of any attempts at purgation or dieting. For present purposes, the term "bulimia" will be used only in the more narrow sense of the binge-purge cycle.

Debate continues over whether anorexia nervosa and bulimia are discrete disorders or extremes along a continuum. Many anorexics binge and purge (Bruch, 1973; Casper, Eckert, Halmi, Goldberg & Davis, 1980; Szyrynski, 1973; Thoma, 1967), and either "true" or "cryptic" episodes of self-starvation may precede the development of bulimic symptomatology (Russell, 1979). Guiora (1967) argues that the psychological similarities of anorexia nervosa and bulimia, and the alternation of symptomatology within individuals indicate that these "are not separate dichotomous syndromes, but extreme ends of the same disorder" (p. 391).

Other researchers have pointed to incisive distinctions between anorexics who binge and purge and those who consistently restrict food intake (Strober, 1981; Strober, in press). Examining a range of demographic, clinical and psychometric variables, Garner, Garfinkle and O'Shaughnessy (in press) conclude that "as a group, the normal weight bulimics closely resemble anorexic-bulimics. . . Not only do these groups display many similarities, but also they both may be distinguished from the anorexic-restricters on many dimensions. Therefore, the presence or absence of bulimia, rather than the history of weight loss may be of greater diagnostic and etiological significance" (p. 8).

In sum, arguments can be made for both conjoint and separate consideration of anorexia nervosa and bulimia. What is known about one disorder may facilitate understanding of the other, but hasty equations of the psychodynamics of these two entities should clearly be avoided. They can only generate confusion and lead to inaccurate conclusions.

The Bulimic Cycle

In spite of this overlap in symptomatology, researchers have begun to identify behavioral features and psychosocial correlates of bulimia. Bulimia is characterized by recurrent episodes of binge-eating, accompanied by the fear of not being able to voluntarily control food intake. During the binge, large quantities of high-caloric food are rapidly ingested in a discrete period of time, usually less than two hours. Binges are usually private and inconspicuous, and are often followed by feelings of guilt, depression and panic. Behaviorally, the individual may induce vomiting, abuse laxatives, and/or initiate severe

diets after bingeing, in order to regain the feeling of being in control and to insure against morbidly feared weight gains. As noted above, the diagnosis of bulimia pivots upon difficulties with binge-eating; use of purgation techniques and attempts at weight loss are not necessary defining features of this disorder. See Table 1 for the DSM-III criteria for bulimia.

Bulimic individuals are usually women of normal weight, who are single, Caucasian and upper class (Garner, Olmstead & Polivy, 1983a; Halmi, Falk & Schwartz, 1981; Johnson, Stuckey, Lewis & Schwartz, 1982). The eating disorder typically emerges in early adulthood, and recent reports indicate that its incidence is dramatically high among college women with no history of anorexia or obesity (Boskind-Lodahl, 1976; Halmi et al., 1981; Pyle, Mitchell & Elke, 1981; Sinoway, 1982). Surveys at the State University of New York and at Pennsylvania State University indicate that as many as 13% of all college women experience the major symptoms of bulimia, as outlined in the DSM-III (Halmi et al., 1981; Sinoway, 1982). Other reports suggest a lower incidence rate, ranging from 2.5 to 3.5% of college women (Button & Whitehouse, 1981; Hawkins & Clement, 1980).

On the basis of her clinical observations, Boskind-Lodahl (1976) has described the women caught in this cycle as accommodating, dependent and passive. They uncritically embrace the traditional image of femininity, and obsessively strive to achieve this ideal. Such exaggerated esteem for the feminine role is at the expense of the development of the individual, and hence these women have little sense of personal identity or worth.

Table 1

DSM-III Criteria for Bulimia

A. Recurrent episodes of binge eating (rapid consumption of a large amount of food in a discrete period of time, usually less than two hours).

B. At least three of the following:

(1) consumption of high-caloric, easily ingested food during a binge
(2) inconspicuous eating during a binge
(3) termination of such eating episodes by abdominal pain, sleep, social interruption, or self-induced vomiting
(4) repeated attempts to lose weight by severely restrictive diets, self-induced vomiting, or use of cathartics or diuretics
(5) frequent weight fluctuations greater than ten pounds due to alternating binges and fasts

C. Awareness that the eating pattern is abnormal and fear of not being able to stop eating voluntarily.

D. Depressed mood and self-deprecating thoughts following eating binges.

E. The bulimic episodes are not due to Anorexia Nervosa or any known physical disorder.

Boskind-Lodahl traces these problems to childhood histories of dependence and submissiveness. These children are valued for their attractive appearance and praised for their compliance; they strive perfectionistically to please their parents, both through academic achievement and physical appearance. While many may consciously despise their controlling and manipulative mothers, others have close and intense mother-daughter relationships (Boskind-White & White, 1983). Generally they identify with mother and aspire to her role. Father is likewise idolized; he is an "object of hero worship, even though (he is) preoccupied, distant, or emotionally rejecting" (Boskind-Lodahl, 1976, p. 348). Often there is a secret yearning for greater intimacy with father, especially as this relationship seems to become more distant during adolescence (Boskind-White & White, 1983).

Such women approach adulthood with low self-esteem. They seek approval from men, but are unprepared for close heterosexual relationships. "These women have already learned a passive and accommodating approach to life from their parents and their culture. This accommodation is combined with two opposing tensions: the desperate desire for self-validation from a man and an inordinate fear of men and their power to reject" (Boskind-Lodahl, 1976, p. 354). Real or perceived rejections become critical events, generating intense concern about appearance. Embracing the media's message that thin and beautiful women are successful, happy, and most importantly, loved, they turn to dieting as a panacea for their problems and unhappiness. It is when dieting fails to deliver such bounties that these women enter the binge-purge cycle (Boskind-Lodahl, 1976; Sinoway, 1982).

The binge provides a release of tension from social pressures and the restrictions of dieting. All self-control is abdicated during the binge. "One gives one's self to the food, to the moment completely. There is a complete loss of control (ego). It is an absolute here-and-now experience, a kind of ecstacy" (Boskind-Lodahl, 1976, p. 352).

The ego regains tight control during the purge, undoing the damage of the binge-eating episode and the depression, shame and self-disgust it generated. The anger which originally fueled the episode is again submerged, until the next cycle begins.

Even when these women are not involved in the binge-purge cycle, they experience dramatic and rapid mood swings, and their moods are significantly more negative than those of normal women. Johnson and Larson (1982) propose that these women may be at risk for addictive behaviors because of their vulnerability to dysphoric and fluctuating moods. Their addiction is to food, which may modulate some of their psychological problems, but which creates new concerns about being overweight. Discovery of purging, "The Perfect Solution", leads to more binges and more purges.

The connection between bulimia, addictive behaviors and affective disorder has also been posited by other researchers (Strober, in press; Strober, Salken, Burroughs & Morrell, 1982). Relatives of bulimics have a high incidence rate for these disorders, suggesting that bulimics may also be at risk. These researchers posit that the ground may well be laid for such affective disorders among bulimics by childhood feelings of isolation and distance from one or both parents.

The Anorexic Profile

In contrast to the bulimic's chaotic eating habits, the anorexic "plays it straight". She consistently restricts her food intake, obsessively striving for thinness at all costs. Although bingeing and purging may accompany anorexia nervosa, the essential features of this disorder are: 1) a disturbance of body image and a body concept of delusional proportions, 2) a disturbance of perception or cognitive interpretation of stimuli arising from the body (e.g. bulimic behavior, overactivity and denial of fatigue), and 3) a paralyzing sense of ineffectiveness (Bruch, 1965). These young women physically resemble concentration camp survivors, but they claim not to suffer hunger; rather, they suffer "from the panicky fear of gaining weight" (Bruch, 1978, p. 4), and they report enjoyment of the feeling of emptiness. In spite of their miniscule food intake and their exaggerated level of activity, anorexics insist that there is nothing wrong with them; they take great pride in their thinness. They are not troubled by their continuous state of tension, nor by their hypersensitivity to light or sound.

According to Selvini Palazzoli (1971, p. 208), anorexics' "uncertainty is complete. They do not have an inner spontaneous awareness of needs, as the rest of us have. They never 'know' if and when they should eat, if they have eaten enough, and when they should stop. Every time they are overtaken by the fear, or terror, of not having controlled themselves. The history often reveals that the feeling of uncertainty first arose when departure for college or a vacation caused separation from the family environment, where an automatic and other-directed feeding ritual held sway." For many anorexics, controlling one's eating leads to new but spurious feelings of competency, of being in touch with

feelings, and of having a core to one's personality.

The clinical picture of anorexia nervosa includes not only restrictive eating patterns and their psychological correlates, but also marked physiological changes that cannot be attributed to any known medical illness, including loss of at least 25% of original body weight, amenorrhea, lanugo (growth of fine, baby-like hair on the body), and bradycardia (persistent resting pulse of 60 or less) (Feighner, Robbins, Guze, Woodruff, Winokur & Munox, 1972). These diagnostic criteria, compiled in Table 2, have been widely used in research investigations, although some modifications have been suggested. Rollins and Piazza (1970) argue that the loss of 25% of one's body weight is an arbitrary criterion dependent upon duration rather than severity of illness, which may eliminate from research anorexics who have been promptly identified and effectively treated. Investigators working with male anorexics have likewise challenged the usefulness of amenorrhea in diagnosis, because it has no clear analogue in the male (Beumont, Beardwood & Russell, 1972; Hogan, Huerta & Lucas, 1974). In the present study, anorexia nervosa is defined by the diagnostic criteria set forth in the DSM-III (See Table 3).

In the pre-anorexic's infancy, the essential food-related problem is the ritual nature of feeding (Selvini Palazzoli, 1971). The mother does not enjoy the relationship with her child, and "control prevails over signs of joy and tenderness" (p. 202). Feelings of personal ineffectiveness grow during childhood; "an impervious presence constantly interferes, criticizes, suggests, takes over the vital experiences and prevents them from being felt as one's own" (p. 202). The child enters adolescence with a close bond to her mother, and with poor peer

Table 2

Feighner et al. (1972) Diagnostic Criteria for Anorexia Nervosa

1. Age at onset less than 25 years.

2. Anorexia with weight loss of at least 25% of original body weight.

3. A distorted, implacable attitude toward eating, food, or weight overriding hunger, admonitions, reassurance, and threats, e.g. 1) denial of illness with a failure to recognize nutritional needs, 2) apparent enjoyment in losing weight with overt manifestation that food refusal is a pleasurable indulgence, 3) a desired body image of extreme thinness with overt evidence that it is rewarding to the patient to achieve and maintain this state, and 4) unusual hoarding or handling of food.

4. No known medical illness that could account for anorexia and weight loss.

5. No other known psychiatric disorder with particular reference to primary affective disorders, schizophrenia, obsessive-compulsive and phobic neuroses.

6. At least two of the following manifestations:

   1) Amenorrhea
   2) Lanugo - growth of fine, baby hair on body
   3) Bradycardia - persistent resting pulse of 60 or less
   4) Periods of overactivity
   5) Episodes of bulimia
   6) Vomiting (may be self-induced)

Table 3

DSM-III Criterias for Anorexia Nervosa

A. Intense fear of becoming obese, which does not diminish as weight loss progresses.

B. Disturbance of body image, e.g. claiming to "feel fat" even when emaciated.

C. Weight loss of at least 25% of original body weight or, if under 18 years of age, weight loss from original body weight plus projected weight gain expected from growth charts may be combined to make the 25%.

D. Refusal to maintain body weight over a minimal normal weight for age and height.

E. No known physical illness that would account for the weight loss.

relations. She experiences strong feelings of depression and hopelessness, leading to an acute oral helplessness.

Bruch (1978) emphasizes some of the more positive features of the pre-anorexic's family. These families often "look good"--they are characterized by stable marriages, high achievement, and upper-middle to upper class social positions. The parents tend to be older, the families are small (2.8 children), and the probands rarely have brothers. The fathers value their daughters for intellectual and athletic achievements but are likely to criticize them if they become plump. Often the mothers (and sometimes the fathers as well) are preoccupied with weight and dieting.

The child raised in such an environment typically feels an obligation because of family standards; much is expected of her and she strives to enact her role of perfect child. She devotes great amounts of time to predicting what her parents want to give and receive from her. "The distressing situation is to guess what the parents want to give and to accept it with enthusiastic gratitude" (Bruch, 1978, p. 43). Because their entire childhoods have been dedicated to outguessing others, "these youngsters appear to have no convictions of their own inner substance and value, and are preoccupied with satisfying the image others have of them" (p. 43).

Anorexics often excel in school, but their achievements are usually the results of extraordinary efforts. Bruch believes that the need for approval and recognition is so strong for these children that they struggle willfully against their own conceptual abilities.

An understanding of the family background of the anorexic leaves unanswered one essential question: why this disorder emerges so

regularly in the pre-adolescent or adolescent phases of development. Meyer (1971, p. 541) suggests this is because the mother's situation changes as her daughter approaches puberty. "She is searching for new values in a home once again childless, while her husband is becoming more and more absorbed in his professional commitments. Now the mother has to introduce her child into adult life, a very different task from what she has undertaken till then."

Other theorists emphasize a more basic fear of being a teenager. Galdston (1974) stresses that the onset of anorexia nervosa reflects the individual's efforts "to establish the dominance of her mind over her matter in anticipation of the developmental work of adolescence. The need for a mental confirmation of self-control is occasioned by an experience in disappointment which the patient takes to be a sign of intolerable personal fault, and which she seeks to remedy by regressing to reform herself anew" (p. 246).

Often the "sign of intolerable personal fault" is a remark that the pre-anorexic is filling out or growing chubby. She begins to diet, in much the same way as her peers diet. Bruch (1978, p. 19) claims that "not one of the patients I have known had intended to pursue the frightening road of life-threatening emaciation--and to sacrifice the years of youth to this bizarre goal. They had expected that to be slimmer would improve not only their appearance but their way of living. It seems that the way hunger is experienced accounts for the decisive difference."

In most cases the onset of anorexia nervosa is linked to early pre-pubertal bodily changes. Particular significance is attached to the development of breasts, which can be considered "signals" of sexual

maturity. According to Selvini Palazzoli (1971, p. 204), this is because puberty in the girl is a sudden and traumatic experience in which "narcissistic libido cathexis has to be withdrawn from the infantile body and directed toward the new body, the adult, curved body that also has to be considered as belonging (belongingness of the experience of one's body). This body, however, because of the permanent incorporation of the object, does not succeed in emerging as one's own and as distinct from the maternal object." From this perspective anorexia nervosa can be understood as a desperate attempt to distinguish oneself from the maternal object.

Bruch notes that most cases of anorexia are precipitated by external stresses, such as moving to a new neighborhood, leaving home for vacation or college, separation or loss of friends or siblings, or getting married. In such situations, the patient becomes "paralyzed with the fear of being unable to meet others on equal terms" (1978, p. 59). Casper and Davis (1977) suggest that in many other individuals, these same events might lead to depression. Loss of weight may be an active attempt to change one's appearance rather than submit to the depressive process.

The Feeling of Isolation

Strober's (1981) study of anorexic women and their families sheds light upon the issue of feeling distant or isolated from one's family. Subjects were classified according to whether they engaged in bulimic behaviors or continually restricted food intake. In comparison to the restricters, the premorbid functioning of the bulimics was characterized by unhappiness, crying easily, and clinging to parents. As young women,

the bulimics reported feeling less close to both their mothers and their fathers than did the restricters. Furthermore, scores on the Moos Family Environment Scale (Moos, 1974), which was administered to probands and their parents, indicated that bulimic families are characterized by less organization, more conflict, and less cohesion than families of restricters. Strober (in press) also reports that the families of bulimic anorexics are characterized by disequilibrium, turbulent interpersonal relations, affective lability and proneness to addictive behaviors.

While the families of bulimic-type anorexics appear quite disturbed, a number of researchers have found that the probands themselves are considerably more outgoing and socially integrated than are restricters (Beumont, 1977; Beumont, George & Smart, 1976; Garfinkle, Molodofsky & Garner, 1980). The consistency of this finding leads one to doubt the etiological significance of isolation in bulimia. However, there is no easy translation of findings concerning subtypes of anorexia nervosa to bulimic women of normal weight. Relative to anorexic dieters, bulimics may appear socially adjusted, but in comparison to normals they may have severe social handicaps. Brenner's (1981) comparison of the psychodynamics of obese, bulimic and normal women lends support to this thesis. Using projective tests, tachistoscopic procedures and a variety of self-report measures, she found that bulimics tended more toward fear and avoidance of others, while obese subjects tended more toward "need" toward others.

Aside from dynamic questions of predisposition, there is good evidence to suggest that the splurge-purge cycle is often triggered by social stress. As mentioned above, many young women report that their

first binges followed what they felt to be rejections by men. Once this pattern is established, it becomes the young woman's primary mechanism of defense. When she cannot physically escape stressful social situations, the binger reduces her anxiety and keeps herself separate by bingeing or contemplating bingeing. She takes refuge in her private orgy, trying to eat her problems away rather than cope with them.

As much as she may yearn for intimacy, especially with men, the fear of social integration propels the young woman into increasingly profound isolation. Being alone is almost always a prerequisite to bingeing and purging (Russell, 1979). As this pattern becomes entrenched, the bulimic moves further away from the social world and her problems seem only to worsen. Boskind-White and White (1983, p. 46) write that "it is not surprising that bulimarexics have few friends - so much of their time is spent in supporting their habit and in keeping others from knowing about it."

The clinical observations connecting bulimic behavior with the experience of isolation have also received empirical support. In an ingenious study, Johnson and Larson (1982) asked 15 bulimic women and 24 normal women to report on their current feelings and situations at various times of the day, when they were signaled by an electronic beeper. Bulimic women reported spending significantly more time alone, and their self-reports on a 7-point Likert scale indicated that they subjectively felt more lonely as well. Additionally, Johnson and Larson found that bulimics experience significantly more variability in mood, that bingeing and purging almost always occur when the bulimic is alone, and that more time in their daily lives is devoted to thoughts, preparation and eating of food.

Johnson and Larson's study does not address the issue of causality, but many of the women reported in post-trial interviews that "as they became increasingly involved with food they began to withdraw socially. Several of the bulimics, angrily and with some despair, mentioned that over the years food had become their closest companion, and that they would often opt to stay home and binge rather than be with friends or family" (p. 348). The powerful influence of eating difficulties has been further documented by Johnson et al., (1982) in a survey of 316 bulimic women. More than 90% of their subjects reported that their thoughts and feelings about themselves were "totally" or "very much" influenced by their eating behaviors. More than two-thirds of the subjects reported a similar degree of influence over their interpersonal relationships.

Among anorexic patients, social isolation also functions as an etiological factor and as a secondary elaboration of symptoms. The perception of social rejection often triggers anorexic dieting. In many cases the pre-adolescent interprets a remark about filling-out or growing chubby as an assasination of her character (Galdston, 1974); she begins dieting to make herself more socially acceptable, and to enhance her feelings of self-worth. Paradoxically, the outcome of her drive for thinness is withdrawl and social isolation (Bruch, 1973). One reason for retreat is that social interaction often entails eating, an activity that requires privacy for most anorexics (Levenkron, 1982). The anorexic may also withdraw because of starvation or low self-esteem, but the consequences of her withdrawl are other symptoms, including loneliness, isolation and poor social skills (Garfinkle & Garner, 1982). Furthermore, shyness and withdrawn behavior may persist after the

restoration of lost weight (Pillay & Crisp, 1977).

Taken together, these reports indicate that feelings of social isolation or rejection can trigger restrictive dieting as well as episodes of bingeing and purging; these behaviors, in turn, seem to perpetuate and aggravate the isolation which they were originally intended to combat. The connection between eating disorders and earlier experiences of isolation is less clear, although it can be conjectured that childhood feelings of isolation with regard to one's parents render the young woman exquisitely sensitive to rejection by others. Her consequent misperceptions may lead to a single-minded obsession with weight reduction, or to a destructive behavioral cycle wherein the immediate benefits of bingeing are offset by the long-term costs of increased depression and social isolation, as well as the medical complications which inevitably follow.

In the present study, it was predicted that the unconscious experience of isolation, as reflected in the TAT protocols of bulimics and anorexics, would differ significantly from that of normals. This difference at the unconscious level should reflect early experiences of feeling cut-off from parents, which are presumed to be of etiological significance in symptom formation. Differences between groups at the conscious level were also predicted, but the self-report of loneliness or isolation was expected to reflect the results of the eating disorder, that is, current rather than past experiences of isolation. Presumably the current and consciously felt isolation differs from buried and inaccessible feelings psychological distance from one's parents. It is because these dynamically critical feelings have not been allowed to enter into conscious awareness that the young woman resorts to

binge-eating and purgation to solve psychological problems. In contrast, the conscious report of loneliness should vary directly with the duration of the disorder and the frequency of episodes, the young woman feeling increasingly more isolated as her eating disorder progresses. Differences were expected on unconscious indices and conscious self-reports comparing young women with eating disorders to normal controls, but no differences were expected in the comparison of anorexics to bulimics.

Pleasing One's Parents

More specific hypotheses about early relationships with parents can be formulated to address the process by which anorexics and bulimics come to feel so isolated. Empirical exploration in this area has been minimal, although several specific dynamic patterns have begun to emerge.

Throughout the literature on anorexia nervosa and bulimia, there is repeated mention of perfectionistic strivings and the drive to please one's parents (Boskind-Lodahl, 1976; Bruch, 1973, and others). Women suffering from these disorders often excel in academics, music, athletics and art. They push themselves to achieve in these areas just as they force themselves to attain what they consider the ideal body size. However, "in most cases the drive to achieve (has) as its goal pleasing parents and marrying 'well'" (Boskind-Lodahl, 1976, p. 348).

For the eating disordered patient, compliance has become a way of life. Levenkron (1982, p. 7-8) sees this pathological drive to please other people as the response to a "depleted" family; the parents feel unable to cope with the problems of daily living, so they enlist the

daughter's help and support. "Depletion of the parent(s) often results in an implicit reversal of dependency between parent and child. The parent's message to the child has been 'You have more strength than I.' The child reacts by becoming the parent within the relationship. She assumes the role of assisting or supporting her parent(s) emotionally. She may become a high achiever, a pleaser of others. Such behavior is her contribution to raising family morale, or the morale of a depressed parent."

From a systems perspective, the anorexic family is enmeshed and undifferentiated. "The parents are typically unable to exert appropriate 'executive' leadership in that they are too dependent on their children's 'good' behavior as proof that they are good parents" (Stern, Whitaker, Hagemann, Anderson & Bargman, 1981). In such an environment the child must strive to make others happy and to confirm their expectations of her, for her failure would threaten her parents' self-esteem.

The anorexic's or bulimic's desire to pleease others may also be accompanied by the wish to cause her parents pain, to make them unhappy. She may resent the continual pressure for perfection, and the burden of nurturing her parents. In retaliation she may wish to punish her parents for their expectations.

On the TAT, the theme of displeasing one's parents was expected to emerge in stories wherein an older couple receives bad news from their child, which makes them both unhappy. This "bad news" may represent either a wish, a fear, or both for the young woman. While the anorexic or bulimic was expected to unconsciously feel that she makes her parents unhappy, no differences were predicted on the conscious self-report of such feelings comparing pathological and control subjects. As long as

the bulimic successfully hides her problems with people and with food, she is unlikely to be aware of deeper feelings of making others unhappy. And the anorexic dramatically escapes her internal feelings of interpersonal inadequacy through perfectionistic overkill. The young woman who strives to please others through achievement and accommodation may, in fact, be more likely to report that she makes her parents happy than her counterpart who is not pathologically involved with food.

Relationship With Mother

In traditional psychoanalytic theory, unconscious hatred for a domineering mother was posited as a major etiological factor in anorexia nervosa (Boskind-Lodahl, 1976; Boskind-Lodahl & Sirlin, 1977; Szyrnyski, 1973). Guiora (1967, p. 392) emphasizes that eating disorders stem from "an early deprivation in the mother-child relation that finds its expression in food intake." Hostility towards mother coupled with fixation at the oral stage precludes proper identification with mother, and hence blocks the emergence of womanhood and motherhood. While anger towards an aggressive and controlling mother can be viewed in the context of the anorexic's battle for independence, Wall (1959, p. 998) describes "a peculiar dependence upon the mother; a wish to hold her responsible and at the same time to be independent of her, mingled with resentment or strong feelings of envy and jealousy."

More recently psychodynamic theorists have shifted their emphasis away from drive disturbances, focusing instead upon early object relations. Selvini Palazzoli (1978), for example, suggests that the maternal object is permanently incorporated into the body of the anorexic. Although the young woman strives to separate from mother, the

maternal object remains incorporated because it is feared. This model hinges upon the behavior of the mother, who has been conceptualized as overprotective and unable to recognize the legitimate needs of her child. She rewards compliance and cannot allow her daughter to separate from her. "For these girls attachment means passive submission to the maternal object with a sense of dedifferentiation and fusion. Because of the mother's need to impose her wishes and wants upon the child this type of anorexia nervosa patient must withdraw and suppress all affect in order to feel separate" (Sours, 1974, p. 570). Along the same line, Bruch (1973) emphasizes the "robot-like compliance" that results from the mother's continual subversion of the child's needs to her own sense of propriety. Mother's omnipotence interferes with separation and individuation throughout the daughter's childhood; this attachment promotes fusion rather than nurturance, leading the daughter to suppress all affect and to feel as though she has no will independent of her mother (Sours, 1974). Kramer (1974) cautions, though, that the overemphasis on pathological and domineering mothering may obscure more subtle contributions of the child to the disturbed mother-child relationship.

Strober et al. (1982) have empirically addressed some of these personality features in the mothers of anorexics, comparing women whose daughters were restricters with the mothers of bulimic-type anorexics. Although no comparisons were made to the mothers of healthy young women, clear differences did emerge between eating disordered groups. The mothers of anorexics who binged and purged exhibited more pronounced depression, hostility and emotional dissatisfaction while character traits of mothers of restricters included submission, introversion, and

neurotic tension.

The mother-daughter relationship of bulimics of normal weight has been described in some detail by Boskind-Lodahl (1976). Her clinical impressions suggest that anger at mother is consciously felt; bulimics tend to view their mothers as demanding, controlling and manipulative. These mothers are bright and well educated, but they have devoted themselves entirely to family, at the expense of their other aspirations. As if to compensate for their lack of power outside the home, they reign supreme over their children. The bulimic daughters are well aware of their mothers' domineering qualities and feel duly angry and resentful, but they simultaneously emulate their mother's role.

The view of the bulimic's mother as stubborn and manipulative has received empirical support; Sinoway (1982) found these maternal qualities to be significant discriminant functions when comparing binger-purgers with women who binge-only and with nonbingers. However, the most recent work of Boskind-White and White (1983) suggests that the mother-daughter relationship may be best described as approach-avoidance. Mother is at once felt as controlling and is deeply loved. These authors caution that the view of mother as villain is myopic, missing the subtleties of the young woman's relationships with each of her parents.

The maze of contradictions regarding the mother-daughter relationship suggests that these findings may reflect conflicting aspects of a complex reality. Mother may be described positively, but still she may be felt negatively. If in fact the mothers of bulimics and anorexics are controlling, then these young women have good reason to feel angry and resentful. The expression of such negative feelings

may be blocked, though, by mother's firm control and/or by the young woman's caricatured endorsement of femininity. Angry expression is branded as unladylike, and hence is unacceptable. In any event, the young woman is unlikely to forget the benefits she gains from this "smothering" relationship; its destructive aspects are certainly not unmitigated.

If this hypothesized conflict exists between the experience and expression of feelings towards mother, then the false front of this ambivalent mother-daughter relationship sets the stage for feelings of social isolation. The young woman not only misses the essential experiences of honesty and freedom in closeness with her mother; she will probably view her other relationships in a similar manner. In the present study, the anorexic's and bulimic's views of older women, as projected in TAT stories, were hence expected to reflect control over younger women; older women would be described positively but would be felt negatively. The conscious description of mother was expected to be decidedly positive, in contrast, reflecting the socially desirable side of these ambivalent feelings. Differences were expected contrasting normal controls with these two pathological groups, although no differences were predicted between anorexic and bulimic subjects.

Relationship with Father

As mentioned above, bulimics and anorexics are unusually sensitive to the criticisms of men. Casual comments or requests may trigger obsessive dieting or ritual purging. Clearly, men are vested with great power by women with eating disorders. Both the corporal and psychological parts of the self are forced to fit whatever form is

requested by a male

The dependence upon male approval is exemplified by the bulimic cycle. The young woman strives to attain happiness by becoming what she thinks will be pleasing to men. When she feels rejected, or finds that her efforts fail to attract men and to improve her life, she feels cheated and angry, so she binges. After the binge, she tries even harder to solve her problems through beauty and thinness. Again and again she fails, because of her basic deficit in self-esteem and her overvaluation of male approval.

Certainly bulimics are not the only women who depend upon men for their happiness and gratification. Sociocultural values for women emphasize the joy derived from caring for husbands and children. Historically, women's value has been set not by what they do, but by the men with whom they keep company (deBeauvoir, 1952). The psychology of the bulimic seems an extreme caricature of such traditional femininity. The substance of ego does not exist, except to be injected or drained by men.

In dynamic terms, it is likely that the groundwork for this deification of men was laid in the early father-daughter relationship. Father was the first powerful man, because he could love and approve of his daughter, or criticize and reject her. How father wielded this power made him potentially dangerous and hurtful. Some of the women studied by Boskind-Lodahl reported the perception of their fathers as "more persistent in their demands for prettiness and feminine behavior" (1976, p. 348) than were their mothers. Because father is held in such high esteem, his criticisms cut sharply. Eventually the daughter learns that she is unacceptable as she is; she must become something other than

she is to gain her lifeblood, the approval of men. In her determination to succeed with other men where she has failed with father, the young woman redoubles her efforts to conform to feminine stereotypes. She is vigilant of men's criticisms and dissatisfactions, always feeling as if she is on the brink of failure, but desperately hoping for personal success.

In this regard, the anorexic experience seems quite different from that of the bulimic. Few investigators have detailed the dynamics or the father-daughter bond in anorexic families, and those who have describe it as eminently uninteresting. Szyrynski (1973, p. 496) points to a "passive and ineffectual father in the background," and Bruch (1973) suggests that the anorexic's father tends to feel inadequate, despite his considerable personal successes. He values his daughter's achievements, but his own weight-consciousness renders him likely to criticize his daughter should she become plump. More emphasis is laid upon the etiological role of the father by Levenkron (1982, p. 3), who attributes the anorexic's disinterest in sexuality in part to "the failure of the father to romance (his) daughter healthily, to offer affection and compliments."

Empirical validation of these clinically observed traits has been presented by Strober et al. (1982). On the MMPI, fathers of restricters tended towards greater reserve and passivity relative to their bulimic counterparts. The latter group was characterized more by hostility, immaturity, impulsiveness and dyscontrol.

As suggested in this review of the literature, the father-daughter relationship may play a critical role in the etiology of eating disorders, although its impact seems to differ across disorders. For

the bulimic, the idol status of father grants him, like the men who follow him, the power to criticize, wound and reject. Hence in the TAT stories of bulimics, it was predicted that father-figures would emerge as both critical or disapproving, and elevated in stature or revered. Again, the unconscious feelings about father were expected to be conflicted, but the consciously reported feelings were expected to be quite positive. While the TAT stories of bulimic women were expected to depict revered but feared father figures, self-reports were expected to reflect only the positive aspects of the father-daughter relationship. Anorexics, in contrast, were expected to describe father in more neutral terms at both the conscious and unconscious levels. Like the father of the bulimic, the anorexic's father was expected to emerge as critical on the TAT, but it was predicted that he would not be more feared or idolized than the fathers of healthy control subjects.

Heterosexual Relationships

Closely tied to the view of father as critical is the more general attitude towards men and heterosexuality. Although bulimics seem to have more mature heterosexual relationships than restricter-type anorectics (Beumont, 1977; Beumont, Abraham & Simpson, 1981; Beumont et al., 1976; Garfinkle et al., 1980), fear of closeness with men appears a major issue for individuals with both anorexia nervosa and bulimia. "Bulimic patients are sexually active, but usually feel misused and are unable to enjoy sex. They often report that a feeling of being out of control, sexually, exacerbates the bulimia" (Garfinkle & Garner, 1982, p. 50). Hence their greater sexual experience may reflect more upon their impulsive style than psychosexual maturity per se. This

hypothesis is supported by Crisp's (1967, p. 128) observation that bulimics "rushed into one relationship after another . . . in the mistaken belief that they would then feel secure and wanted."

Comparisons of anorexic subtypes indicate that restricters are less likely than bulimics to have engaged in sexual intercourse, to have taken oral contraceptives or to have ever had a steady boyfriend (Beumont, 1977; Beumont et al., 1976; Garfinkle et al., 1980). In a parallel manner, bulimics "act out" more impulsively in sex and in eating; the restricting anorexic shuns both bodily functions.

Anorexics seem to lose all interest in sex and to avoid interaction with the opposite sex (Bruch, 1973; Garfinkle & Garner, 1982). Psychodynamic theorists originally suggested that anorexics suffer from fears and fantasies of oral impregnation (Lindner, 1955; Szyrynski, 1973); the onset of anorexia nervosa was traced to alarming sexual experiences. For instance, Crisp (1970, p. 494) notes that the development of anorexic symptomatology was frequently marked by a "sexual misadventure ranging from some largely phantasized experience to a first guilty experience of sexual intimacy."

More recently theorists have attributed the anorexic's disinterest in sexuality to her general immaturity and fears of parental abandonment (Levenkron, 1982; Selvini Palazzoli, 1971, 1978). New interpretations of the bulimic pattern of heterosexual interaction have also been put forth. Boskind-Lodahl (1976) posits an extreme fear of failure in intercourse among bulimic women. Should they prove inferior as lovers, they expect to be rejected. Their fear of closeness with men hence stems from their reluctance to render themselves vulnerable to rejection. It has been suggested that such fears have been exacerbated

by the sexual revolution of recent years, as dating and heterosexual relationships have seemingly become synonomous with intercourse (Boskind-White & White, 1983).

Both anorexics and bulimics hence suffer from fears of adult heterosexuality and relationships with men, although their fears arise from different developmental conflicts and their behavioral manifestations are quite different. The bulimic's fear of men's power to reject in sex seems a likely result of the father-daughter relationship described above. With peers as with father, men are overvalued and feared; they have the power to hurt. The woman risks criticism, rejection, or personal injury, while the man leaves the encounter unscathed. This theme was predicted to emerge on the TAT in several forms: men are viewed as dangerous and hurtful to women, men are seen as "getting away with it" when they harm others, and on card 13MF, sex is equated with murder. The woman is killed or destroyed in sex, while the murderer escapes without reprimand. In contrast, the bulimic's consciously expressed image of heterosexual relationships was expected to be quite positive. While the theme of "sex equals murder" reflects unconscious fears about closeness and heterosexuality, the young woman consciously craves the affection and approval of men. She views relationships as the solution to her problems, unaware of the unconscious fears which bar her from succeeding in her attempts with men.

It was predicted that the anorexic subjects would likewise display considerable fear of men, but this was expected to emerge at both the conscious and unconscious levels. This postulate is grounded in the considerable evidence that anorexics actively avoid heterosexual

contact. Little dynamic conflict surrounds their internal fears about heterosexuality; the conflict, rather, is between the anorexic and those others who expect her to be interested in dating.

Projective Assessment of Eating Disorders

To date, few researchers have utilized projective measures to confirm their clinical observations about young women suffering from eating disorders. Such exploration of the binge-purge cycle is virtually nonexistent, although several researchers have reported on the projective assessment of anorexia nervosa.

Wall (1959, p. 1000) writes that anorexics "reacted with shock and disgust to male and female sexual symbols in the Rorschach. The Rorschach responses were similar to those seen in alcoholics and addicts: much oral preoccupation, simple responses and much reference to sea life." Their style of response was characterized by withdrawal and flatness of affect, and the underlying personality emerged as infantile and lacking in complex emotional responses.

Using the more specialized scoring technique developed by Singer and Wynne (1966), Selvini Palazzoli (1971) compared the cognitive styles of restricting and bulimic anorexics. She found a greater prevalence of disorganized thought among the anorexics who binged and purged, which correlated with poorer prognosis. This finding was not confirmed, though, in Bruch's (1973) replication of Selvini Palazzoli's study.

Although Blitzer, Rollins and Blackwell (1961) do not present a systematic analysis of their data, they noted several themes common to the TAT stories and Sentence Completions of anorexics. Among these were fears of relationships with men, and conflicts around the desire to grow

up, the fear of leaving mother, and the restraints imposed upon them by their mothers.

More empirical research is needed to clarify the unconscious dynamics that propel young women into bizarre eating patterns like anorexia nervosa and bulimia. While the clinical observations of psychotherapists may serve as guideposts in this endeavor, they are notoriously biased and demand more scientific confirmation. The objective test data available are also suggestive, as they indicate the individual's perceptions of her problems. Such data cannot, however, speak to the etiologically critical internal conflicts of which the individual is unaware. The role of the projective test is hence to systematically explore intrapsychic dynamic currents which by definition cannot be assessed by objective self-report instruments.

In such investigation, two methodological caveats must be remembered. First, claims about unconscious dynamic events must be accompanied by clear evidence that these themes are not readily accessible to conscious awareness. While conflicts circulating at both the conscious and unconscious levels are certainly troublesome in the psychological sense, more pathological states would be expected to result from internal conflicts of which the individual has little or no conscious awareness. Secondly, in order to substantiate claims that certain dynamic constellations are etiologically linked to psychopathological conditions, it must be demonstrated that these dynamics are absent in healthy individuals. Hence in the present investigation, assessments were made of psychological conflicts at the conscious level in concert with projective assessment, which is assumed to tap intrapsychic processes, comparing the psychological profiles of

identified anorexics and bulimics with young women who were free from such disturbed eating patterns.

The Pilot Study

Hypotheses and scoring criteria for the present investigation were developed on the basis of prior research reports and an informal pilot study. TAT protocols were collected from four female college students. Two were bulimic women who had been administered the TAT by their psychotherapists. The comparison subjects were undergraduates who had taken the TAT for extra credit in their introductory psychology classes.

Protocols of the bulimic women were carefully studied by two psychologists trained in psychodynamic theory and projective assessment. The aim here was to extract dynamic themes common to both bulimic protocols, but absent in the protocols of comparison subjects.

This exploration led to the generation of 14 hypotheses regarding the intrapsychic and interpersonal experience of the bulimic. Five dynamic themes were selected for further investigation, as they reflected broad psychological experiences that seemed relevant both to current research and to clinical experience with bulimic women. These five themes can be briefly outlined as follows:

1. The hero feels isolated, or cut-off from her parents. This feeling of psychological isolation at the unconscious level was presumed to reflect dynamic motivators of eating disorders. In contrast, conscious self-reports of isolation were considered to reflect the results of an ongoing, pathological involvement with food.

2. Bad news is received by an older couple from their child/children. The child or children make the couple unhappy. The symbolic "bad news" here is the young woman's fear of and/or desire to displease her parents. This unconscious current may lead to her behavioral commitment to pleasing others, as well as to her conscious image of herself as successfully meeting her parents' standards and fulfilling their expectations of a daughter.

3. An older woman controls a younger woman. The older woman is described positively but felt negatively. Ambivalence towards mother, who is loved but felt as controlling, seemed to emerge through the contradiction between angry, negative feelings at the unconscious level and loving, positive descriptions of mother at the conscious level.

4. A father-figure is disapproving of his daughter. He is feared but respected by his daughter. The positive aspects of this relationship seemed to emerge through conscious self-reports of bulimics, but more fearsome aspects of such hero worship were revealed through projective testing.

5. Sex is equated with murder, and the murderer is not caught. This unconscious theme was interpreted as reflecting fears of personal harm as a result of closeness with men, either sexually or interpersonally. While the bulimic may fear the consequences of such heterosexual relationships, she expects the men involved to be unaffected emotionally and unharmed physically by their involvements with women. This unconscious fear was not openly expressed by bulimic women; rather, the consciously reported feelings about men reflected their desire for closeness with men and their hopes for greater happiness and self-esteem

as a result of heterosexual involvement.

Most of these themes were evoked by a range of TAT stimulus cards, although the psychological equation of sex with murder emerged only on card 13MF. Because of the blatantly sexual hature of this stimulus, this theme was interpreted in all sories told about card 13MF in which the woman is murdered and/or raped. The assaulter leaves his victim and escapes judiciary punishment as well as internal feelings of guilt or regret.

For scoring ease, some of these themes were partitioned into their less complex constituent themes, which together comprised the constellations of feelings noted in the pilot study. "Comparison constellations" were added to allow for complementary evaluations of relationships with both parents, and for the sake of completeness. means were developed to assess all psychological themes at both the conscious and unconscious levels, in anorexics as well as in bulimics.

Hypotheses

Unconscious Dynamics

In the present investigation, the TAT was utilized to assess unconscious psychological themes presumed to be relevant to the genesis of eating disorders. These themes can be summarized as follows:

Isolation
1. The hero feels isolated. Words used in the story indicate separation from parents and feelings of abandonment.

Bad news
2. Bad news is received by an older couple from their child or children. The child or children make the couple unhappy.

Mother Constellation
3. An older woman controls a younger woman.
4. An older woman is described positively, but felt negatively (ambivalence to mother).

Father Constellation
5. A father-figure is disapproving of his daughter.
6. A father-figure is idolized by the hero.
7. A father-figure is feared by the hero.

Father Comparison Constellation
8. An older man controls a younger woman.
9. An older man is described positively but felt negatively (ambivalence to father).

Mother Comparison Constellation
10. A mother-figure is disapproving of her daughter.
11. A mother-figure is idolized by the hero.
12. A mother-figure is feared by the hero.

Heterosexual Relations
13. Men are viewed as dangerous and hurtful to women.
14. Men are seen as 'getting away with' hurting women.
15. Sex is equated with murder (13MF).
16. Sex is equated with death by means other than murder (13MF).

TAT protocols were scored for the presence or absence of these themes in each story. Each time a theme appeared, one point was scored; hence each subject could earn a maximum of 12 points for each theme. However, where designated, hypotheses were scored only on one particular card. Scores here ranged from 0 to 1.

A sample coding form is included in Appendix A, and the TAT scoring manual can be found in Appendix B.

Significant differences between groups were predicted for all hypotheses except 8 through 12 and 16; these 'comparison' items were included to contrast the predicted behaviors of each parent. On these themes, no differences were predicted across groups. For each of the primary hypotheses (1-7, 13-15), it was predicted that subjects in the bulimic and anorexic groups would emerge as more distressed at the unconscious level than control subjects. No differences were predicted comparing anorexics and bulimics, except on themes 6 and 7. As discussed above, the psychological absence of the anorexic's father was

expected to render him less fearsome and less admirable than his bulimic counterpart.

Conscious Dynamics

The differences predicted above for the unconscious dynamic patterns of anorexics, bulimics and controls were not expected to be maintained in comparisons of consciously reported feelings. In a number of areas the eating disordered subjects were expected to deny or repress their feelings, while their conscious expression of feelings in other areas was expected to be more accurate. Responses to 15 Likert-type scales were analyzed and correlations were computed between these conscious self-report items and the unconscious themes that emerged on the TAT. (See Appendix C for conscious self-report items). The following predictions concern the conscious dynamics of the bulimic or anorexic young woman:

1. She does not report feeling isolated from her family as a child, presumably because such memories are too painful. However, she reports current feelings of isolation, which stem from her eating disorder.

2. She reports that she makes her parents happy, in direct contrast to her unconscious feeling that she makes them unhappy. The conscious report reflects her efforts to compensate for unconscious feelings of inadequacy through compliance and success. Here the self-report is derived from the defense against distressing unconscious material.

3. (Mother Constellation) Mother is described positively. Although she may unconsciously be felt as negative and controlling, only the positive side of the anorexic's or bulimic's ambivalence is expressed consciously.

4. (Father Constellation) Father is idolized by bulimics at both the conscious and unconscious levels, but the feeling that he is critical or disapproving is not consciously expressed. Again, the negative side of the bulimic's ambivalence emerges only through examination of unconscious dynamics. The anorexic was predicted to report only that father is critical of her.

5. (Father Comparison Constellation) Father is described in positive

terms; there is no discrepancy between conscious and unconscious dynamics with regard to father being felt negatively or seen as controlling.

6. (Mother Comparison Constellation) Mother, like father, is idolized by the bulimic or anorexic, but she is not felt to be disapproving. Here there is no discrepancy between conscious and unconscious feelings.

7. On items regarding heterosexual relationships, it was predicted that bulimics would deny their fears and anger towards men. While they may unconsciously feel that men are dangerous and hurtful, their conscious report was expected to reflect the desire for heterosexual relationships and a highly positive estimation of the male sex. Anorexics, in contrast, were expected to report conscious fears of men and closeness in heterosexual relationships.

Method

Subjects

Subjects were 50 undergraduate women selected from a larger subject pool on the basis of their stated eating patterns. Using DSM-III criteria, twenty subjects were classified as bulimics. Ten subjects, the "recovered anorexics", reported having experienced the DSM-III sumptoms of anorexia nervosa in the past, although none were presently anorexic. Two comparison groups were matched to the pathological groups on demographic variables; one group consisted of 10 young women who dieted occasionally, and the other was comprised of 10 subjects with no prior history of weight or eating difficulties. All project participants were unmarried Caucasian women aged 17 to 20; most were Catholic or Protestant, and most came from upper middle class families (SES strata IV and V; Hollingshead, 1975). See Tables 4 and 5 for demographic variables as they relate to group membership. These demographic characteristics closely resemble those reported in other studies of eating disorders (Garfinkle & Garner, 1982; Herzog, 1982, and others).

Descriptive information about the eating habits of the bulimic sample is presented in Table 6. These young women binge on large quantities of high caloric food and resort to a variety of methods of purgation and weight reduction, including laxative abuse, self-induced vomiting, dieting and fasting. These eating patterns, which are both

Table 4

Demographic Features of Project Participants

	Group							
	Anorexics		Bulimics		Controls		Dieters	
	n = 10		n = 20		n = 10		n = 10	
Variable	Mean	SD	Mean	SD	Mean	SD	Mean	SD
Age	18.40	.52	18.15	.59	18.50	.53	18.00	.47
SES[a]	54.80	5.57	46.45	11.30	53.10	8.44	49.00	11.54
Exercise[b]	65.00	43.01	51.00	36.87	47.00	41.11	23.50	14.15

Note. There were no significant differences across groups on these variables.

[a]Socioeconomic Status was calculated according to Hollingshead (1975). The scores given here can be translated into five social strata: I = 8-19; II = 20-29; III = 30-39; IV = 40-54; V = 55-66. [b]Total minutes per day.

Table 5

Demographic Features of Project Participants

	Group							
	Anorexics		Bulimics		Controls		Dieters	
Variable	n	%	n	%	n	%	n	%
Ethnicity								
Caucasian	10	100	20	100	10	100	10	100
Year in School								
Freshman	6	60	17	85	6	60	9	90
Sophomore	3	30	2	10	4	40	1	10
Junior	1	10	1	5	-	-	-	-
Marital Status								
Never married	10	100	20	100	10	100	10	100
Living Situation								
Dormitory	8	80	1	5	9	90	1	10
With female friends	3	30	17	85	3	30	10	100
With parents	1	10	5	25	-	-	-	-
Birth Position								
First born	2	20	6	30	3	30	3	30
Middle child	2	20	2	10	2	20	5	50
Last child	6	60	10	50	5	50	1	10
Only child	-	-	1	5	-	-	1	10
Twin	-	-	1	5	-	-	-	-
Religion								
Protestant	3	30	4	20	5	50	1	10
Catholic	5	50	8	40	3	30	4	40
Jewish	1	10	2	10	2	20	2	20
Other	1	10	4	20	-	-	2	20
None	-	-	2	10	-	-	1	10

Note. There were no significant differences across groups on these variables

Table 6

DSM-III Symptoms Reported by Bulimic Subjects (n = 20)

Symptom	Yes, Now n	%	Used To n	%	No n	%
Binge-eating	14	(70)	6	(30)	-	
Self-induced vomiting	7	(35)	8	(40)	5	(25)
Laxative abuse	8	(40)	6	(30)	6	(30)
Fasting after a binge	10	(50)	2	(10)	8	(40)
Dieting for weight control	17	(85)	2	(10)	1	(5)
Anorexia nervosa	-		2	(10)	18	(90)

Symptom	Always n	%	Often n	%	Sometimes n	%	Rarely/Never n	%
Rapid consumption	7	(35)	7	(35)	3	(15)	3	(15)
Binge on large quantities of food	4	(20)	12	(60)	4	(20)	-	
Inconspicuous eating	5	(25)	9	(45)	4	(20)	2	(10)
Binges are terminated by:								
Abdominal pain	4	(20)	5	(25)	4	(20)	7	(35)
Sleep	1	(5)	4	(20)	5	(25)	10	(50)
Social interruptions	-		3	(15)	9	(45)	8	(40)
Fear of not being able to stop eating, out of control	4	(20)	7	(35)	7	(35)	2	(10)

Table 6 - Continuation

Symptom	n	%
Frequency of Binges		
More than once a day	1	(5)
Daily	3	(15)
At least once a week	7	(35)
A few times a month	3	(15)
Once a month or less	5	(25)
Length of Binges		
Less than one hour	12	(60)
1 - 2 hours	7	(35)
More than 2 hours	-	
Weight Fluctuations		
Not at all	2	(10)
Sometimes	11	(55)
Frequently	7	(35)
Depressed Mood After Binges		
Yes	15	(75)
No	5	(25)

Symptom	Mean	SD
Calories per binge	1585	1130
Cost per binge	$5.44	$4.59
Duration of binge-eating pattern (years)	3.35	2.64

extreme and bizarre, were also considered to be problematic by subjects. They reported fears of not being able to control their eating, and they frequently experienced feelings of depression after episodes of bingeing.

Women in the anorexic group reported the following symptoms of anorexia nervosa: deliberate weight loss, loss of menstrual period, overactivity or exercise without enjoyment, terror of fat, feeling fat despite protests of others who say they are too thin, and obsession with thoughts of food. Members of the anorexic group differed significantly from those of the other groups on all of these diagnostic criteria ($p < .01$) (See Table 7). Weight loss ranged from 14 to 50% of original body weight; the group mean was a 26.3% loss (Table 8). Roughly half of these anorexics could be described as restricters; the others engaged in bingeing and purging behaviors (see Table 9). All the women in this group reported histories of anorexia nervosa, but none of them were presently anorexic. For convenience they will be referred to as the anorexic group, although a more accurate description would be "recovered anorexics".

The eating patterns of these pathological groups stand in direct contrast to those of the control groups, as shown in Table 10. 'Dieters' had minimal experience with binge-eating, but were currently involved with dieting behaviors for weight control. Members of the 'control' group were even less involved with food and eating. If ever they had binged, their binges tended to be quite small (500-750 calories) and were not felt as problematic. While these individuals can be considered normal control subjects in that they eat three square meals a day, they are statistically a rare minority. The predominant

Table 7

Frequency of Reported Symptoms of Anorexia Nervosa

	Group									
	Anorexics		Bulimics		Controls		Dieters			
Symptom	n	%	n	%	n	%	n	%	df	χ^2
Deliberate weight loss	10	(100)	11	(55)	-		2	(20)	3	23.63**
Amenorrhea	9	(90)	5	(25)	1	(10)	2	(20)	3	18.14**
Overactivity or exercise without enjoyment	8	(80)	8	(40)	-		2	(20)	3	15.28*
Terrified of fat	10	(100)	10	(50)	-		3	(30)	3	21.42**
Feel fat despite others saying you're too thin	10	(100)	7	(35)	2	(20)	3	(30)	3	16.52**
Obsessed by thoughts of food and eating	8	(80)	14	(70)	-		-		3	26.46**

*$p < .01$. **$p < .001$.

Table 8

Percent Weight Loss of Subjects by Group

Group	n	Mean	SD	df	F	p
Anorexic	10	26.32	9.91	3, 46	2.304	.089
Bulimic	20	18.10	8.05			
Control	10	16.59	29.45			
Dieters	10	8.95	4.92			

Table 9

Bulimic Symptoms Reported by Subjects in the Anorexic Group (n = 10)

Symptom	Yes, now n	%	Used to n	%	Never n	%
Binge-eating	2	(20)	3	(30)	5	(50)
Self-induced vomitting	-		3	(30)	7	(70)
Laxative abuse	2	(20)	2	(20)	6	(60)

Symptom	Always n	%	Often n	%	Sometimes n	%	Rarely/Never n	%
Binge on large quantities of food	2	(20)	3	(30)	2	(20)	2	(20)
Eat very rapidly	1	(10)	4	(40)	2	(20)	2	(20)
Fear of not being able to stop eating, out of control	2	(20)	2	(20)	3	(30)	2	(20)
Inconspicuous eating	3	(30)	4	(40)	5	(50)	1	(10)
Abdominal pain after binges	-		4	(40)	2	(20)	4	(40)

Table 9 - Continuation

Symptom	n	%
Weight Fluctuation		
Not at all	-	
Sometimes	3	(30)
Frequently	7	(70)
Frequency of Binges		
Daily	2	(20)
Weekly	1	(10)
Monthly	3	(30)
Less than monthly	2	(20)

Symptom	Mean	SD
Calories per binge	1219	1247
Cost per binge	$2.75	$3.41

Table 10

Breakdown of History of Eating Patterns by Group

	Group									
	Anorexic		Bulimic		Control		Dieters			
Variable	n	%	n	%	n	%	n	%	df	χ^2
Last binged										
Never	3	(30)	-		7	(70)	6	(60)	12	34.63**
Years ago	-		-		-		1	(10)		
Months ago	5	(50)	5	(25)	1	(10)	3	(30)		
Weeks ago	1	(10)	4	(20)	-		-			
Days ago	1	(10)	11	(55)	1	(10)	-			
Duration of bingeing problem										
Not applicable	3	(30)	2	(10)	9	(90)	10	(100)	6	34.80**
Years	6	(60)	18	(90)	1	(10)	-			
Months	1	(10)	-		-		-			
Last vomited										
Never	7	(70)	6	(30)	10	(100)	9	(90)	12	26.44*
Years ago	-		-		-		1	(10)		
Months ago	3	(30)	10	(50)	-		-			
Weeks ago	-		2	(10)	-		-			
Days ago	-		2	(10)	-		-			
Duration of vomiting problem										
Not applicable	7	(70)	8	(40)	10	(100)	10	(100)	6	17.25*
Years	2	(20)	9	(45)	-		-			
Months	1	(10)	3	(15)	-		-			
Last laxative abuse										
Never	7	(70)	7	(35)	10	(100)	10	(100)	12	26.72*
Years	2	(20)	1	(5)	-		-			
Months	-		5	(25)	-		-			
Weeks	1	(10)	4	(20)	-		-			
Days	-		3	(15)						

Table 10 - Continuation

Variable	Group: Anorexic n	%	Bulimic n	%	Control n	%	Dieters n	%	df	χ^2
Duration of laxative abuse problem										
Not applicable	8	(80)	10	(50)	10	(100)	10	(100)	9	15.60
Years	2	(20)	5	(25)	-		-			
Months	-		4	(20)	-		-			
Weeks	-		1	(10)	-		-			
Last fasted										
Never	5	(50)	8	(40)	10	(100)	10	(100)	12	26.44*
Years	1	(10)	-		-		-			
Months	2	(20)	4	(20)	-		-			
Weeks	-		6	(30)	-		-			
Days	2	(20)	2	(10)	-		-			
Duration of fasting problem										
Not applicable	7	(70)	8	(40)	10	(100)	10	(100)	6	18.27*
Years	3	(30)	9	(45)	-		-			
Months	-		3	(15)	-		-			
Last Dieted										
Never	2	(20)	1	(5)	9	(90)	-		12	42.54**
Years	1	(10)	-		-		-			
Months	4	(40)	4	(20)	1	(10)	5	(50)		
Weeks	-		7	(35)	-		3	(30)		
Days	3	(30)	8	(40)	-		2	(20)		
Duration of dieting problem										
Not applicable	1	(10)	2	(10)	9	(90)	1	(10)	6	29.43**
Years	9	(90)	16	(80)	1	(10)	7	(70)		
Months	-		2	(10)	-		2	(20)		

*$p < .01$. **$p < .001$.

eating profile of the young women surveyed in this study featured both binge-eating and dieting for weight control.

In order to check the validity of diagnosing DSM-III disorders in this non-clinical population, scores on the Eating Disorders Inventory (EDI, Garner, Olmstead & Polivy, 1983b) were compared across groups. Eight subscales were derived from EDI responses, using the procedure outlined by Garner, Olmstead & Polivy, (1983a) (see Appendix D). Multiple analysis of variance revealed significant differences between the two pathological and the two control groups ($F(8, 39) = 9.204$, $p < .0001$), but no differences comparing anorexics with bulimics on the psychological concomitants of disordered eating behaviors (See Tables 11 and 12). The pattern of responses to EDI subscales suggests that the recovered anorexics in this study are best classified as having "subclinical anorexia nervosa" (Button & Whitehouse, 1981). Their scores were significantly higher than those of the control subjects on the Drive for Thinness, Bulimia, Body Dissatisfaction and Interoceptive Awareness Subscales, but the typically anorexic feelings of ineffectiveness and fears of maturity (Bruch, 1973) were absent. The patterns of EDI subscale scores for both pathological groups closely resembled those of bulimics and bulimic anorexics studied by Garner, Olmstead and Polivy (1983a).

All subjects received extra credit in their psychology courses for their participation in this project.

Measures

Several questionnaires and a projective test were used in this study. A modified form of the Eating Problems Questionnaire (EPQ,

Table 11

Scores on EDI Subscales as a Function of Group

	Group							
	Anorexics		Bulimics		Controls		Dieters	
	n = 10		n = 20		n = 10		n = 10	
EDI Scales	Mean	SD	Mean	SD	Mean	SD	Mean	SD
Drive for Thinness	9.60	4.06	9.95	3.09	3.30	2.67	3.90	2.51
Interoceptive Awareness	10.40	3.50	9.25	3.61	6.30	2.58	7.80	1.55
Bulimia Subscale	6.10	3.28	6.70	3.67	2.20	1.69	1.80	1.87
Body Dissatisfaction	11.00	4.21	12.00	3.36	9.80	2.62	6.80	2.25
Ineffectiveness	8.20	2.44	8.85	2.62	10.40	1.71	9.70	2.00
Maturity Fears	5.00	2.91	4.85	2.74	8.80	2.15	9.40	2.41
Perfectionism	4.80	1.48	5.20	2.12	4.60	1.96	4.00	1.25
Interpersonal Distrust	8.90	1.91	8.60	2.39	9.20	2.70	8.80	2.82

Table 12

MANOVA on EDI Subscales and Group

Source	df	MS	F
EDI Subscales	24,123	.889	2.161**
A & B vs. C & D			
Overall F-test	8,39	.654	9.204****
Drive for Thinness	1,46	466.253	47.624****
Interoceptive Awareness	1,46	80.083	8.375**
Bulimia Subscale	1,46	243.000	27.377****
Body Dissatisfaction	1,46	136.013	13.002***
Ineffectiveness	1,46	24.083	4.492*[a]
Maturity Fears	1,46	211.680	31.154****[a]
Perfectionism	1,46	7.053	2.118
Interpersonal Distrust	1,46	1.080	.178
A vs. B			
Overall F-test	8,39	.067	.352
Drive for Thinness	1,46	.817	.083
Interoceptive Awareness	1,46	8.817	.922
Bulimia Subscale	1,46	2.400	.270
Body Dissatisfaction	1,46	6.667	.637
Ineffectiveness	1,46	2.817	.525
Maturity Fears	1,46	.150	.022
Perfectionism	1,46	1.067	.320
Interpersonal Distrust	1,46	.600	.099

Table 12 - Continuation

Source	df	MS	F
B vs. C and D			
Overall F-test	8,39	.615	7.786****
Drive for Thinness	1,46	403.225	41.187****
Interoceptive Awareness	1,46	48.400	5.062*
Bulimia Subscale	1,46	220.900	24.887****
Body Dissatisfaction	1,46	136.900	13.087***[a]
Ineffectiveness	1,46	14.400	2.686
Maturity Fears	1,46	180.625	26.583****[a]
Perfectionism	1,46	8.100	2.432
Interpersonal Distrust	1,46	1.600	0.264

[a]Opposite predicted direction.
*$p < .05$. **$p < .01$. ***$p < .001$. ****$p < .0001$.

Stuckey, Lewis, Jacobs, Johnson & Schwartz, 1981) provided descriptive information regarding current bingeing, purging, fasting and dieting behavior, and history of weight and eating disorders. The instrument also surveys attitudes and medical difficulties associated with these behaviors. It was used to generate DSM-III diagnoses of anorexia nervosa and bulimia. A second questionnaire examined conscious feelings about parents and family using 7-point Likert-type scales. In addition, a brief demographic questionnaire and the Eating Disorders Inventory (EDI), which addresses psychological concomitants of eating disorders, were administered to all subjects. Copies of objective test materials are included in Appendices C, D, and E. The Thematic Apperception Test (TAT) is a projective test, which is designed to tap into unconscious processes through the stories subjects tell about a standard series of pictures. TAT slides were used for group administration of this test, as research indicates that administration technique has little overall effect upon quality of stories (Stein, 1978). While this method may evoke stories that are somewhat shorter and less elaborate than those told orally (Karon, 1981), it was assumed to be adequate for present purposes.

Procedure

Students interested in participating in this study were administered questionnaires in groups of 20-30 people. Each subject was given a packet containing the EPQ and a short demographic questionnaire. All questionnaires were coded numerically, and participants submitted a separate identification page with their names, telephone numbers and subject numbers.

Fifty subjects were then selected from a pool of 283 young women according to their responses on the EPQ. Twenty met the DSM-III criteria for bulimia, and 10 reported recovery from the DSM-III Symptoms of anorexia nervosa. Two comparison groups of 10 subjects each were then formed, each matched to the pathological groups on demographic variables. Of the 50 young women selected, eight refused to participate in the second phase of the study. The refusal rate was roughly equal across groups: one anorexic, three bulimics, three dieters and one control subject. Replacement subjects were selected from the original subject pool using the same diagnostic criteria described above.

In groups of four to eight people, subjects were shown TAT slides by the investigator, who was blind to group membership. The cards used were numbers 1, 2, 3BM, 4, 5, 6GF, 7GF, 10, 12F, 13G, 13MF, and 16.

The following instructions (Karon, 1981) were given to subjects taking the TAT:

> I'm going to show you a set of 12 pictures, one at a time. I want you to write a story, telling what's going on, what the characters might be feeling and thinking, what led up to it, and what the outcome might be. In other words, write a good story. Use the pen and paper in front of you. You can change anything that you have written, but do NOT cross it out. Strike it out with a single line and correct it.

Card 16 (the blank card) was introduced as follows:

> Up to now I have asked you to tell stories. Now I would like you to make up a picture. It can be a picture you've seen or one that's entirely yours. Write a description of the picture.

After the subjects had written their descriptions, the investigator said:

> Now take the picture you have described, and use it like the other ones. Write a story about it.

Following the TAT administration, subjects were asked to complete the Eating Disorders Inventory and the questionnaire on conscious psychological themes.

All TAT protocols were independently rated by two psychologists trained in the interpretation of projective techniques. Both raters were blind to group membership of subjects. After extensive training on pilot data, interrater reliability was established on 30 TAT stories from the data pool. Using a binary code for each of 16 unconscious themes, the concordance rate between raters was 94.2%.

Conscious self-report data was analyzed in raw form, with the exceptions of items addressing feelings of isolation and ambivalence towards parents, and the items which comprise the EDI. Conscious feelings of isolation were calculated by averaging the numerical responses to the following two items:

> When I was young, I often felt like I didn't have a family, because I felt so disconnected from my parents (and siblings)
>
> I feel separate, or cut-off from other people.

Feelings of ambivalence towards mother and towards father were calculated using the following self-report items:

> My mother/father often seemed kind and sweet.
>
> I believe that inside, my mother/father was mean or dangerous.

Responses to the items on ambivalence towards parents were each summed and recoded, since two mutually contradictory questionnaire items comprised this topic. All sums less than or equal to eight were coded "1"; sums from 9 to 14 were reassigned consecutive values from 2 to 7. Hence all computed scores still ranged from 1 to 7, where "1" denoted "Never or almost never true" and "7" denoted "Always or almost always

true."

Responses to the EDI were combined into eight subscales, using the system set forth by Garner, Olmstead and Polivy (1983a). See Appendix D for a listing of subscales and constituent items.

Each cluster of hypotheses regarding conscious and unconscious dynamics was tested using multiple analysis of variance, followed by three planned comparisons of groups. In each case these comparisons were 1) anorexics and bulimics versus controls and dieters, 2) anorexics versus bulimics, and 3) bulimics versus controls and dieters.

Consent Procedures

Prior to participation in this study, all subjects were instructed to read the consent agreement found in Appendix F. Their choice to participate in this study implied an understanding and an acceptance of the terms set forth in the consent form. Subjects were invited to leave the testing room and to return their unanswered questionnaires if they did not accept these terms. All subjects did, however, agree to continue participation.

Separate from the consent letter and the numerically coded questionnaire and answer sheet was a subject identification form. This was used to compile a coded list of participants for the second phase of the study (projective testing). Coded identification sheets were separated immediately from completed questionnaires. They were stored in a locked file, and destroyed within three months. Only the principal investigator had access to this information.

Results

Unconscious Processes

Multivariate analysis of variance revealed few significant differences comparing groups on unconscious dynamic conflicts. As shown in Tables 13 and 14, groups were not distinctive from each other on any of the following themes: feelings of isolation, feeling that one makes one's parents unhappy, relationship with father, and perceptions of heterosexual relationships. Groups also resembled each other on all comparison themes.

Statistically significant differences were noted, however, on themes subsumed under the Mother Constellation (mother is seen as controlling; she is described positively but felt negatively) ($F(6, 92) = 2.752$, $p < .05$). This difference was not maintained in planned comparisons, as it reflected the dieters' perceptions of mother as less controlling combined with their more strongly conflicted and ambivalent feelings about her.

Two post hoc correlational analyses were performed on the TAT data, comparing scores on unconscious themes with demographic/behavioral data (Table 15) and with EDI subscales (Table 16). While these analyses yielded some significant relationships between variables, no consistent patterns emerged. Given the large number of correlations computed (736 correlations between unconscious themes and eating behaviors, 128

Table 13

Frequencies of Unconscious Themes by Group

	Group							
	Anorexics		Bulimics		Controls		Dieters	
	n = 10		n = 20		n = 10		n = 10	
Unconscious Themes	Mean	SD	Mean	SD	Mean	SD	Mean	SD
Isolation	3.00	1.76	2.80	1.47	3.10	0.88	3.10	.99
Bad News	.90	.99	1.30	1.16	1.50	0.71	1.10	.99
Mother Constellation								
Controlling	1.70	1.34	1.60	1.05	1.70	1.25	1.40	0.96
Ambivalence	.20	.42	.20	.52	.10	.32	.90	.57
Father Constellation								
Critical	.60	.70	.45	.60	.80	1.03	.30	.48
Respect, Admire	.20	.42	.05	.22	.10	.32	.10	.32
Fearsome	.20	.63	.15	.37	.20	.42	.20	.42
Relationships with Men								
Hurtful	2.00	1.15	1.95	1.53	1.80	1.13	1.50	.85
Men get away with hurting women	.70	.82	.85	1.04	.60	.70	.50	.71
Sex=Murder	.30	.48	.30	.47	.20	.42	.40	.52
Mother Comparison Constellation								
Critical	.50	.53	.60	.60	.70	.67	.60	.52
Respect, Admire	.10	.32	.05	.22	0	0	0	0
Fearsome	.20	.63	.10	.44	.10	.32	.10	.32
Father Comparison Constellation								
Controlling	.50	.71	.80	.91	1.20	1.14	.60	.52
Ambivalence	0	0	.05	.22	0	0	.10	.32
Sex=Death, other causes	.60	.84	.30	.47	.50	.53	.20	.42

Table 14

MANOVA on Unconscious Themes by Group

Source	df	MS	F
Isolation			
Overall F-test	3,46	.307	.166
A & B vs C & D	1,46	.653	.354
A vs B	1,46	.267	.144
B vs C & D	1,46	.900	.487
Bad News			
Overall F-test	3,46	.650	.622
A & B vs C & D	1,46	.333	.319
A vs B	1,46	.817	.782
B vs C & D	1,46	.025	.024
Mother Constellation			
Overall F-test	6,92	.304	2.752*
A & B vs C & D	2,45	.096	2.380
A vs B	2,45	.003	.076
B vs C & D	2,45	.079	1.940
Father Constellation			
Overall F-test	9,138	.102	.541
A & B vs C & D	3,44	.002	.028
A vs B	3,44	.039	.592
B vs C & D	3,44	.010	.154
Relationships with Men			
Overall F-test	9,138	.064	.337
A & B vs C & D	3,44	.023	.348
A vs B	3,44	.010	.145
B vs C & D	3,44	.025	.380
Mother Comparison Constellation			
Overall F-test	9,138	.053	.275
A & B vs C & D	3,44	.032	.479
A vs B	3,44	.019	.282
B vs C & D	3,44	.014	.203
Father Comparison Constellation			
Overall F-test	6,92	.125	1.019
A & B vs C & D	2,45	.019	.434
A vs B	2,45	.017	.396
B vs C & D	2,45	.007	.154
Sex = Death, Other Causes			
Overall F-test	3,46	.360	1.127
A & B vs C & D	1,46	.030	.094
A vs B	1,46	.600	1.878
B vs C & D	1,46	.025	.078

*$p < .05$

Table 15

Behavioral Correlates of Unconscious Themes

Behaviors	Unconscious Themes							
	2 Bad news	3 Mom controls	4 Ambiv. Mom	8 Dad controls	13 Hurt-ful	14 Men get away	15 Sex= Murder	16 Other causes
Binge-eating	.063	.046	-.253*	.048	.047	.166	.084	-.063
Eat large amounts	.153	.048	-.161	.115	.143	.189	.062	.325*
Frequency of binges	.073	-.026	.258*	-.003	-.171	.063	.031	.044
Abdominal pain after binges	-.047	.261*	-.066	-.048	.364**	.325*	.004	.072
Vomiting	.231	.073	-.061	-.074	-.130	.100	-.052	.364**
Frequency of vomiting	-.235*	-.167	-.093	-.148	-.246*	-.306*	-.140	-.020
Laxative abuse	-.239*	.131	-.135	-.210	.251*	.245*	-.239*	-.206
Frequency of laxative abuse	.242*	-.086	.052	.274*	-.201	-.266*	.231	.300*
Age at first laxative abuse	-.267*	.060	-.093	-.254*	.233	.246*	-.259	-.231
Fasting	-.113	.090	-.055	-.165	.278*	.239*	-.139	-.210
Age at first fast	-.101	.170	-.088	-.168	.371**	.278*	-.069	-.163
Length of fasts	-.065	.193	-.078	-.132	.362**	.234	-.063	-.238*
Dieting	-.146	-.092	-.004	-.275*	.041	-.038	.181	-.055
Age at first diet	-.099	.035	.212	-.251*	-.028	.036	.041	-.099
Length of diets	-.203	.026	.124	-.271*	-.083	-.225	.020	.006
Amenorrhea	-.186	.082	-.189	-.094	-.112	.005	-.194	.341*
Exercise without enjoyment	-.275*	.059	-.211	-.275*	-.139	.068	-.218	.234
Terrified of fat	-.104	.134	.121	-.209	.022	.136	-.254*	.161

Feel fat despite what others say	-.137	.229	-.003	-.314*	-.146	-.160	-.317*	.118
Lowest weight	-.237*	.178	.199	-.289*	-.094	-.126	-.356**	.082
Have a boyfriend	.083	.104	-.073	.100	-.100	-.127	.238*	-.009
Regular Menses	.160	.062	-.170	.039	-.138	-.132	.245*	.094
Intentional self-injury	-.070	-.094	-.205	-.250*	-.277*	-.170	-.120	.030
Frequency of exercise	-.068	.316*	.000	-.116	.028	-.002	-.298*	-.017
LL	-.247*	-.003	-.079	-.186	.279*	.235*	-.202	-.143
DL	-.213	.091	-.090	-.120	.359**	.308*	-.269*	-.092
LF	-.134	.036	-.027	-.227	.213	.218	-.158	-.300*
DF	-.122	.079	-.109	-.144	.379**	.253*	-.103	-.111
LD	-.043	-.029	.236*	-.226	-.101	-.106	-.039	-.101
DD	-.224	.007	.124	-.258*	-.129	-.072	-.024	-.037
TSLW	-.189	-.026	.009	-.153	-.241*	-.383**	-.146	-.100

Note. Several behavioral measures and unconscious themes have been deleted from this table beause their intercorrelatins were not statistically significant with any other variables.
Note. LL = Last use of laxatives, DL = Duration of laxative abuse problem, LF = Last fasted, DF = Duration of fasting problem, LD = Last dieted, DD = Duration of dieting pattern, TSLW = Time elapsed since lowest weight.
*$p < .05$. **$p < .01$.

Table 16

Correlations Between Unconscious Themes and EDI Scales

	EDI Subscales							
Unconscious Themes	Drithin	Intawar	Bulsub	Bodydis	Ineff	Matfears	Perfx	Intdis
1. Isolation	-.111	-.203	.010	.153	-.088	-.136	-.063	-.221
2. Bad News	.017	-.061	-.155	.338**	.102	-.017	-.084	.066
3. Mom Controls	.128	.042	.125	.178	-.099	-.280*	.232	-.329**
4. Ambiv,Mom	.065	.060	-.002	.129	.106	.019	-.003	-.095
5. Dad Dissaproves	-.126	-.240*	-.025	.107	-.246*	-.106	-.044	-.004
6. Idolize Dad	-.104	.000	-.101	-.066	-.057	.208	-.140	.110
7. Fear Dad	-.151	-.259*	-.093	-.087	-.173	-.060	-.226	-.144
8. Dad Controls	-.065	-.211	-.107	.221	-.065	.021	-.024	-.041
9. Ambiv, Dad	.198	.118	.102	.094	.070	-.162	.084	-.071
10.Mom Disapproves	.064	.075	.225	.159	.271*	-.201	.219	-.113
11.Idolize Mom	.174	.025	-.096	-.046	.026	.089	-.029	.145
12.Fear Mom	-.022	.006	-.054	-.202	-.103	-.136	.011	-.038
13.Men, Hurtful	.086	-.266*	.208	.388**	-.078	-.271	.126	-.296*
14.Men get away	.066	-.143	.172	.312*	-.120	-.298*	.187	-.155
15.Sex = Murder	-.174	-.120	-.247*	-.010	-.204	.071	-.179	-.024
16.Other Causes	.054	.299*	.056	.136	-.027	-.077	-.048	.186

Note. Drithin = Drive for Thinness; Intawar = Interoceptive Awareness; Bulsub = Bulimia Subscale; Bodydis = Body Dissatisfaction; Ineff = Ineffectiveness; Matfears = Maturity Fears; Perfx = Perfectionsim; Intdis = Interpersonal Distrust.
*$p < .05$. **$p < .01$.

correlations with EDI subscales), the number of statistically significant relationships that did emerge (59 and 7 respectively) would be expected on the basis of chance alone. Therefore these results will not be discussed in any further detail.

Conscious Dynamics

Analysis of conscious self-report data revealed differences across groups in the areas of relationships with men and feelings towards father. In contrast to predictions about conscious dynamics, those differences which did emerge across groups were on negative affects; no differences were noted on warm or positive feelings.

As shown in Tables 17 and 18, no differences were found comparing groups on reported feelings of isolation. A nonsignificant trend ($p < .20$) was noted comparing subjects in the two pathological groups; anorexics and bulimics tend to report feelings of isolation more often than control subjects or dieters. No differences were found, though, comparing current feelings of disconnection from others with childhood feelings of psychological remoteness.

Direct questionning about feelings of displeasing one's parents also failed to reveal differences across groups. Subjects in all groups reported that they rarely made their parents unhappy.

In the feelings they reported about their mothers, anorexics and bulimics closely resembled subjects in the comparison groups. They tended to agree with the statement "I respected and admired my mother," but they were unlikely to describe mother as controlling, critical or mean. Strong conscious feelings of ambivalence towards mother were not reported by any of the subjects studied.

Table 17

Frequencies of Conscious Themes by Group

	Group							
	Anorexics		Bulimics		Controls		Dieters	
	n = 10		n = 20		n = 10		n = 10	
Conscious Themes	Mean	SD	Mean	SD	Mean	SD	Mean	SD
Isolation	5.90	3.31	5.65	2.70	4.60	2.84	4.40	3.20
Bad News	2.20	1.93	2.70	1.45	2.00	1.05	2.50	1.43
Mother Constellation								
Controlling	2.80	1.87	3.75	1.94	3.60	1.90	2.80	1.48
Ambivalence	1.60	1.90	1.10	.31	1.00	0	1.10	0.32
Father Constellation								
Critical	2.30	1.42	3.25	2.00	2.10	1.52	1.70	1.16
Respect, Admire	5.10	2.02	6.25	0.85	4.90	2.28	5.90	1.20
Mean inside	2.00	1.56	1.65	1.27	2.10	1.91	1.40	0.97
Relationships with Men								
Hurtful	3.60	1.51	4.85	1.31	3.10	1.45	3.90	1.66
Get away with hurting	3.40	1.65	3.95	2.01	2.40	1.35	3.00	1.33
Mother Comparison Constellation								
Critical	2.20	1.48	3.30	1.78	3.00	1.70	2.80	1.69
Respect, Admire	5.70	1.89	5.30	1.75	5.10	1.99	5.60	1.58
Mean inside	1.70	1.89	1.70	.99	1.50	.97	1.70	1.16
Father Comparison Constellation								
Controlling	2.50	1.18	3.85	2.01	3.00	1.63	2.30	1.64
Ambivalence	1.40	.97	1.05	.22	1.10	.32	1.00	0

Table 18

MANOVA on Conscious Themes and Group

Source	df	MS	F
Isolation			
Overall F-test	3,46	6.290	.719
A & B vs. C & D	1,46	18.253	2.087
A vs. B	1,46	.417	.048
B vs. C & D	1,46	13.225	1.512
Bad News			
Overall F-test	3,46	1.293	.582
A & B vs. C & D	1,46	.963	.433
A vs. B	1,46	1.667	.749
B vs. C & D	1,46	2.025	.911
Mother Constellation			
Overall F-test	6,92	.116	.941
A & B vs. C & D	2,45	.021	.472
A vs. B	2,45	.076	1.862
B vs. C & D	2,45	.020	.462
Father Constellation			
Overall F-test	9,138	.293	1.659
A & B vs. C & D	3,44	.135	2.299*
A vs. B	3,44	.142	2.434*
B vs. C & D	3,44	.213	3.958*
Critical	1,46	18.225	6.609**
Respect, admire	1,46	7.225	3.009*
Mean inside	1,46	.100	.049

Table 18 - Continuation

Source	df	MS	F
Relationships with Men			
Overall F-test	6,92	.230	1.996*
A & B vs. C & D	2,45	.115	2.912*
Hurtful	1,46	10.453	4.970**
Get away	1,46	13.653	4.696**
A vs. B	2,45	.106	2.671*
Hurtful	1,46	10.417	4.953*
Get away	1,46	2.017	.694
B vs. C & D	2,45	.164	4.423*
Hurtful	1,46	18.225	8.665**
Get away	1,46	15.625	5.374*
Mother Comparison Constellation			
Overall F-test	9,138	.078	.409
A & B vs. C & D	3,44	.003	.045
A vs. B	3,44	.060	.940
B vs. C & D	3,44	.013	.191
Father Comparison Constellation			
Overall F-test	6,92	.297	2.262**
A & B vs. C & D	2,45	.051	1.197
A vs. B	2,45	.193	5.387***
Controlling	1,46	12.150	4.075**
Ambivalence	1,46	.817	3.665*
B vs. C & D	2,45	.103	2.592*

*p< .10. **p < .05. ***p <.01.

Analysis of reported feelings towards father revealed more complicated patterns. Subjects in all groups reported stronger feelings of respect and admiration for father than dysphoric feelings, but several important differences emerged in cross-group comparisons. While the overall F-test of predicted feelings towards father (father is critical, mean, and admired) revealed no differences across groups, planned comparisons pointed to significantly different patterns in this constellation of feelings. Nonsignificant trends were noted comparing anorexics and bulimics with the two control groups, and comparing the pathological groups with each other, but statistically significant differences emerged comparing the bulimic group with the two control groups ($F(3, 44) = 3.958$, $p < .05$). This difference reflects the bulimic's significantly stronger perception of father as critical ($F(1, 46) = 6.609$, $p < .05$) and the trend for bulimics to feel greater respect and admiration for father compared to subjects in the two control groups ($F(1, 46) = 3.009$, $p < .10$).

Contrary to hypothesized predictions, statistically significant differences also emerged on the conscious self-report items subsumed under the Father Comparison Constellation (father is seen as controlling; he is described positively but felt negatively) ($F(6, 92) = 2.262$, $p < .05$). No differences were found contrasting the two pathological groups with the control groups, but the bulimics differed significantly from the anorexics in this regard ($F(2, 45) = 5.387$, $p < .01$), and a nonsignificant trend differentiated them from the two comparison groups ($F(2, 45) = 2.592$, $p < .10$). These multivariate differences reflect the bulimic's perception of father as controlling ($F(1, 46) = 4.075$, $p < .05$), and the anorexic's more ambivalent feelings towards

father ($F(1, 46) = 3.665$, $p < .10$).

Multivariate analysis of variance on items that addressed feelings about men and heterosexual relationships did not yield significant differences across groups ($F(6, 92) = 1.996$, $p < .10$), but a number of significant trends emerged at the univariate level. Anorexics and bulimics agreed more strongly than control subjects or dieters with statements that men are hurtful to women ($F(1, 46) = 4.970$, $p < .05$) and that men get away with it when they create pain for women ($F(1, 46) = 4.696$, $p < .05$). Differences also emerged comparing anorexics and bulimics on attitudes towards men. The bulimics were considerably more adamant about the dangers of heterosexual involvements than anorexics ($F(1, 46) = 4.953$, $p < .05$). Differences were also significant comparing the bulimics with the control groups ($F(2, 45) = 4.423$, $p < .05$). The bulimics again felt more strongly about the probability of getting hurt in a close relationship with a man ($F(1, 46) = 8.665$, $p < .01$), and they were more likely to believe that men 'get away with' hurting women ($F(1, 46) = 5.374$, $p < .05$).

Turning to a more behavioral index of attitudes towards heterosexual relationships, clear differences also emerged across groups on current dating behavior. As shown in Table 19, anorexic and bulimic subjects were less likely to be involved in ongoing dating relationships than control subjects or dieters ((3, $N = 46$) = 10.05, $p < .05$).

Post hoc correlational analyses were performed on those variables which distinguished pathological and control subjects (See Table 20). A central core of bulimic behaviors seems related to the perceptions of father as critical and controlling, and men as dangerous to women (they hurt women and get away with it). Among these behavioral correlates are

Table 19

Current Dating Behavior of Pathological and Control Groups

Group	n	Currently Dating	Not Currently Dating	df	χ^2
Anorexic	10	3	7	3	10.05*
Bulimic	17	6	11		
Control	9	8	1		
Dieters	10	7	3		

*$p < .05$.

Table 20

Correlates of Significant Conscious Themes

	Themes				
Behaviors	Respect, Admire Father	Father Critical	Father Controls	Men are hurtful	Men get away with it
Binge-eating	.327	.207	.290*	.443***	.260*
Large amounts of food	.127	.252*	.322*	.462***	.348**
Eat rapidly	.046	.248*	.382**	.297*	.379**
Eating out of control	.182	.390**	.163	.292*	.407**
Frequency of binges	-.122	-.005	.068	.304*	.106
Calories per binge	.157	.024	.268	.388*	.164
Abdominal pain after binges	.134	.170	.269*	.453***	.571***
Sleep after binges	-.016	.449**	.381**	.453***	.449***
Social interruptions end binges	.171	.134	.091	.155	.278*
Self-induced vomiting	.086	.225	.255*	.433***	.308*
Laxative abuse	.218	.617***	.240*	.245*	.250*
Fasting	-.040	.507***	.186	.185	.151
Obsessed by thoughts of food	.026	.389**	-.118	-.086	.128
Currently dating	-.090	-.318*	-.144	-.254*	-.423**
Suicidal thoughts	-.030	.242*	-.008	.250*	.248*
Exercise without enjoyment	-.032	.235*	.075	.212	.045
Total exercise per day	.012	.237*	-.001	-.034	.193

*$p < .05$. **$p < .01$. ***$p < .001$.

various features of binge-eating, as well as laxative abuse and self-induced vomiting. Women who consciously agreed with these themes and engaged in those behaviors were also less likely to have steady boyfriends. No clear pattern emerged connecting specific bulimic behaviors with endorsement of particular conscious themes.

Table 21 shows the relationships between EDI subscales and consciously reported themes. The magnitude and statistical significance of these correlations points to the close relationship between these themes and the psychological experience of eating pathology.

Feelings of isolation and being cut-off from others correlated with the Drive for Thinness (r = .389, p < .01), and with the Bulimia (r = .420, p < .001) subscales of the EDI. In this sample, psychological isolation was inversely related to Maturity Fears (r= -.503, p < .001) and to Interpersonal Distrust (r = -.430, p < .001).

The perception of mother as controlling was significantly correlated with the Drive for Thinness (r = .303, p < .05), with Body Dissatisfaction (r = .257, p < .05), with Perfectionism (r =.329, p < .01), and with Interpersonal Distrust (r = -.246, p < .05). Likewise, feelings that father was controlling correlated with two EDI subscales: Bulimia (r = .250, p < .05), and Maturity Fears (r = -.284, p < .05).

Feeling disapproved of by one's parents related closely to the psychological concomitants of anorexia nervosa and bulimia. Disapproval by mother was significantly correlated with the Bulimia Subscale (r = .251, p < .05), while disapproval from father was closely linked to several EDI subscales: Drive for Thinness (r = .311, p < .01), Bulimia (r = .384, p < .01) Maturity Fears (r = -.429, p < .001) and Interpersonal Distrust (r = -.312, p < .05).

Table 21

Correlations Between Conscious Themes and EDI Subscales

Conscious Themes	EDI Subscales			
	Drithin	Intawar	Bulsub	Bodydis
Isolation	.389**	.207	.420***	.157
Bad News	.041	.081	.214	.174
Mom Controls	.303*	.133	.134	.257*
Ambivalence to Mom	.178	.258*	.196	.070
Dad Disapproves	.311*	.051	.384**	.168
Dad Idolized	.022	.155	.053	-.137
Dad Feared	.138	.101	.073	.039
Dad Controls	.231	-.003	.250*	.127
Ambivalence to Dad	.118	.133	-.037	.105
Mom Disapproves	.177	.140	.251*	.115
Mom Idolized	-.064	.042	.032	.005
Mom Feared	.253	.251*	.088	-.067
Men are Hurtful	.351**	.216	.409**	.308**
Men Get Away	.427***	.223	.452***	.470***

Table 21 - Continuation

Conscious Themes	EDI Subscales			
	Ineff	Matfears	Perfx	Intdist
Isolation	-.192	-.503***	-.023	-.430***
Bad News	-.147	-.284*	.206	-.123
Mom Controls	.017	-.203	.329**	-.246*
Ambivalence to Mom	.199	-.187	-.152	-.033
Dad Disapproves	.009	-.429***	.144	-.312*
Dad Idolized	-.154	-.003	.092	-.063
Dad Feared	.112	-.173	-.023	-.068
Dad Controls	.134	-.284*	.207	-.190
Ambivalence to Dad	-.022	-.214	-.013	.019
Mom Disapproves	.193	-.095	.232	-.165
Mom Idolized	-.157	.066	.114	-.148
Mom Feared	.131	-.140	-.047	-.142
Men are Hurtful	-.140	-.435***	.247*	-.279*
Men Get Away	-.212	-.542***	.313*	-.358**

Note. Drithin = Drive for Thinness; Intawar = Interoceptive Awareness; Bulsub = Bulimia Subscale; Bodydis = Body Dissatisfaction; Ineff = Ineffectiveness; Matfears = Maturity Fears; Perfx = Perfectionism; Intdist = Interpersonal Distrust.

*$p < .05$. **$p < .01$. ***$p < .001$.

Finally, the beliefs that men are hurtful to women, and that men leave heterosexual encounters emotionally unscathed, were both closely related to six of the eight EDI scales. Theme-subscale correlations were statistically significant for Drive for Thinness (r = .351, p < .01; r = .427, p < .001), Bulimia (r = .409, p < .01; r = .452, p < .001), Body Dissatisfaction (r = .380, p < .01; r = .470, p < .001), Maturity Fears (r = -.435, p < .001; r = -.542, p < .001), Perfectionism (r = .247, p < .05; r = .313, p < .05), and Interpersonal Distrust (r = -.279, p < .05; r = -.358, p < .01) respectively. Correlations with subscales were consistently higher for the item "Men always seem to get away with it when they create pain for women" than for the item "If you are in a close relationship with a man, you always end up getting hurt."

Table 22 shows the correlational relationships between TAT themes and feelings accessible to consciousness. On only two items were the corresponding correlations between conscious and unconscious themes statistically significant: Mother is feared (r = .274, p < .05), and Men get away with hurting women (r = .271, p < .05). Interestingly, on two other items, disapproval and control, the conscious perception of father was significantly correlated with unconscious feelings about mother (r = .339, p < .01; r = .257, p < .05). This pattern is repeated, albeit less precisely, in many of the other statistically significant correlations; rough equivalents of consciously expressed feelings towards one parent are unconsciously felt towards the other parent. In most cases, the negative affects admitted to consciousness were in relation to father, while those not consciously expressed tended to concern mother.

Table 22

Correlations Between Conscious and Unconscious Themes

	Unconscious Themes					
Conscious Themes	1	2	3	4	5	6
1. Isolation	.108	-.216	.101	-.036	.027	.041
2. Bad news	.260*	.066	-.052	.158	.080	.041
3. Mom controls	-.154	.073	.152	.072	-.092	-.209
4. Ambivalence to Mom	-.117	-.019	-.216	-.080	.044	-.069
5. Dad disapproves	.081	-.189	.063	.015	.008	-.101
6. Dad idolized	-.054	-.023	.095	-.043	-.102	.109
7. Dad feared	.192	.178	.078	-.004	.333**	-.086
8. Dad controls	.045	0	.257*	-.095	.135	-.131
9. Ambivalence to Dad	.104	.118	.174	.083	.173	-.084
10.Mom disapproves	-.138	.057	.200	.028	-.204	-.104
11.Mom idolized	.210	-.035	-.006	.076	.257*	.039
12.Mom feared	-.188	.007	-.109	.044	-.172	.039
13.Men are hurtful	.227	.031	.156	.260*	.063	-.056
14.Men get away	.138	-.074	.295*	.349**	.101	-.142

Table 22 - Continuation

Conscious Themes	Unconscious Themes 7	8	9	10	11
1. Isolation	.173	-.041	.124	.119	-.228
2. Bad news	.134	.064	.151	.083	-.129
3. Mom controls	.075	-.088	-.038	.093	-.151
4. Ambivalence to Mom	-.087	-.184	-.043	.106	-.043
5. Dad disapproves	-.099	-.200	-.062	.339**	-.062
6. Dad idolized	-.044	-.027	.169	-.031	.105
7. Dad feared	-.094	.085	-.111	.487***	-.111
8. Dad controls	-.023	.159	.218	.258*	-.126
9. Ambivalence to Dad	-.105	.070	-.052	.253*	-.052
10.Mom disapproves	.269*	-.041	.254*	.009	-.112
11.Mom idolized	.011	.105	-.047	.082	.130
12.Mom feared	-.075	-.352**	.058	.006	-.113
13.Men are hurtful	.043	.041	.123	.187	-.205
14.Men get away	-.108	.041	.254*	.159	-.275*

Table 22 - Continuation

	Unconscious Themes				
Conscious Themes	12	13	14	15	16
1. Isolation	.137	-.034	.037	-.129	.165
2. Bad news	.111	.104	.246*	-.069	.147
3. Mom controls	-.027	-.082	.040	-.122	.167
4. Ambivalence to Mom	-.058	-.029	-.171	-.086	.147
5. Dad disapproves	-.003	.190	.257*	-.199	.081
6. Dad idolized	.056	.146	.062	.214	.002
7. Dad feared	-.085	.024	-.061	-.169	.168
8. Dad controls	-.146	.152	.020	-.159	.102
9. Ambivalence to Dad	-.070	.067	.089	-.165	.354**
10.Mom disapproves	.152	-.122	.053	-.151	.011
11.Mom idolized	-.091	.300*	.203	.101	.008
12.Mom feared	.274*	-.199	-.257*	-.179	.014
13.Men are hurtful	.019	.234	.330**	.087	.111
14.Men get away	-.028	.276*	.271*	.023	.011

Note. Unconscious themes are labelled as follows: 1. Isolation; 2. Bad News; 3. Mom Controls; 4. Ambivalence to Mom; 5. Dad Disapproves; 6. Dad Idolized; 7. Dad Feared; 8. Dad Controls; 9. Ambivalence to Dad; 10. Mom Disapproves; 11. Mom Idolized; 12. Mom Feared; 13.Men are Hurtful; 14. Men Get Away with Hurting; 15. Sex = Murder; 16. Death, Other Causes.
*$p < .05$. **$p < .01$. ***$p < .001$.

Discussion

In contrast to the psychodynamic conflicts hypothesized to underlie anorexia nervosa and bulimia, the present investigation lends little support to formulations linking these eating patterns with internal psychological distress. Projective data, presumed to reflect dynamically critical themes which may not be accessible to conscious awareness, did not reveal clear anorexic or bulimic profiles. Psychological and interpersonal variables relevant to eating disorders did emerge, however, through examination of conscious conflicts and feelings. The findings of this investigation lead both to methodological considerations and clinical implications.

Turning first to the data regarding unconscious psychodynamics, the failure of the present study to detect differences across groups suggests two broad conclusions: either the hypothesized differences do not exist, or the design of this investigation precluded their uncovery. Acceptance of the first of these interpretations requires reconsideration of the basic tenets of psychodynamic theory, namely that psychological disorders reflect unresolved conflicts at the unconscious level, and it calls into question the degree to which anorexia nervosa and bulimia are psychogenic syndromes.

More parsimonious interpretations focus upon the design of the present investigation. Real differences may have been obscured by any combination of the following factors. First, the TAT may not have

succeeded in tapping unconscious processes. Even if intrapsychic conflicts were projected onto TAT stories, this study may have addressed irrelevant dimensions of psychologically relevant variables. Use of the group administration technique of the TAT, in which subjects write rather than tell stories, may have also reduced the richness of TAT data. Furthermore, differences across groups would have had to be quite dramatic to emerge in the present study, given the small number of subjects in each group. Finally, the use of a nonclinical population in the study of psychopathology leads to the question of whether project participants were, in fact, bona fide anorexics and bulimics. Diagnoses were not confirmed by personal interviews, as advocated by Nagelberg (1983), and subjects in the anorexic group were recovered anorexics suffering at most from a subclinical disorder. Many of the postulated dynamics of anorexia nervosa and bulimia may, in fact, be operative in the development of clinically critical symptomatology. Of course, such relationships cannot be addressed satisfactorily through the study of less severely disturbed individuals.

Consciously experienced feelings about father and fears of close, personal relationships with men do, however, covary with eating habits. The bulimic behavioral profile is closely associated with feelings of respect and admiration for father, as well as perceptions of him as critical and controlling. The prominence of this finding suggests that the role of the father in the development of bulimic symptomatology may be far greater than previously assumed. His impact upon his daughter is much stronger than would be expected from the passive and ineffective father described in the clinical literature, and the valence of this impact is clearly quite negative. Because he is so admired by his

daughter, his criticisms seem to carry more weight than those of a parent who commands no respect. His daughter may hence become caught in a spiraling pattern: she strives to please him and to respond to his wishes, but her efforts are viewed as inadequate by her father. In response she may redouble her efforts to meet her father's standards, and/or seek refuge in bulimic behavior.

The bulimic's relationship with her father seems an exaggeration of widely accepted sociocultural values. Modern changes in sex role behavior have not yet altered the patriarchal structure of most families; as a rule, father heads the household, implicitly or explicitly controlling through economic and physical power. Rather than confront his importance and power, and risk the loss of his love, family members often organize themselves around father, catering to him and thereby averting his displeasure. To an extreme degree, the bulimic seems to have internalized this traditional but unhealthy view of father. Perhaps all members of bulimic families adhere more closely to stereotyped roles than families of healthy young women. Alternatively, the perception of father as admirable but critical and controlling may be indelibly imprinted upon the bulimic young woman as a function of her personal attributes, those of her father, and/or the specific nature of their relationship.

This unhappy father-daughter relationship may be projected onto later relationships, real or imagined, with male members of one's peer group. In the same manner as she felt hurt by her father's demands and criticisms, the bulimic anticipates personal destruction in heterosexual relationships. As much as she hopes to gain self-esteem through her relationships with men, she fears men's power to reject women. She

views men as potentially dangerous to women, while expecting that they will in no way be hurt or affected by their closeness to women. In spite of her fears, the bulimic strives to succeed with men, overvaluing and admiring them as she does her father. She repeats the dynamically established pattern described above, or else she shies away from dating altogether. Either way, she is likely to feel that she has failed to earn the highly coveted award of men's esteem; again, she may turn to the splurge-purge cycle to comfort and to punish herself. This conclusion is based not only upon the consciously reported attitudes of bulimic young women, but also upon the finding that they are less likely to successfully maintain ongoing dating relationships than other women their same age. While the bulimics in this sample may impulsively enter into sexual liasons, their involvements in ongoing interpersonal relationships with men appear quite limited.

The relationship between eating pathology and feelings about men, which is fairly straightforward for bulimics, is considerably less clear for the anorexics who participated in this study. Their feelings towards father tended to be more conflicted and ambivalent than those of bulimics, and on the whole, reported feelings about father and heterosexual relationships more closely resembled those of nonpathological eaters and dieters than those of bulimics. Like the bulimics, the anorexics' dating experience was limited, but overall they emerged as intermediate to the bulimics and control subjects on their attitudes towards men.

This finding can be interpreted from several perspectives. First, support is lent to the original hypothesis that the anorexic's father is psychologically more distant than his counterpart in the bulimic family.

He is peripheral to the daughter's development, neither facilitating nor hindering her growth in any direct way. His remoteness, though, renders his adolescent daughter poorly prepared for heterosexual challenges. She fears and avoids dating relationships not because she felt frightened or criticized by her father, but because she never knew him.

Alternatively, it may be that anorexics are, in fact, less disturbed psychologically than women who binge and purge. Such a conclusion is supported by Strober's research (1981; in press) comparing restricter and bulimic subtypes of anorexia nervosa. Restricters and their parents consistently emerge as less disturbed than their counterparts who binge and purge, and their prognosis is considerably more favorable (Beumont et al., 1976; Garfinkle et al., 1980; Selvini Palazzoli, 1971; Strober, in press).

However, the young women who participated in this study were not hospitalized patients or clinic clients. They were recovered anorexics who matched the description of "subclinical anorexia nervosa" (Button & Whitehouse, 1981). On several critical psychological dimensions associated with anorexia nervosa they seemed quite healthy, a finding which suggests that the resolution of their issues with men may have paralleled their recovery from anorexia nervosa. Such psychological recovery is slow, though. As noted by Pillay and Crisp (1977), psychosexual maturation among anorexics may lag behind the rate of maturity of their healthy peers, even after weight restoration. This interpretation may also help to explain the strong negative relationships noted between the anorexic profile of project participants and EDI measurements of maturity fears and feelings of ineffectiveness. Although development of this disorder may be fueled by problems in each of these areas, the

triumph over an obsession with dieting and body size may lead to new feelings of self-efficacy and strong desires to accelerate the maturational process.

Another possibility is that subjects in this group never suffered from more than "subclinical anorexia nervosa". The symptoms they presented indicate that anorexia nervosa does occur on a continuum; their internal psychodynamics may likewise deviate only slightly from the norm. Such a conclusion is supported by Bruch's (1973) speculation that "true" anorexia nervosa, which entails specific ego deficits in body image, interoception and feelings of personal effectiveness, must be differentiated from "anorexic-like" behavior. Thompson and Schwartz (1982) empirically illustrated this point. They compared clinically identified anorexic patients to two groups of college women: those with high scores on the Eating Attitudes Test (EAT, Garner & Garfinkle, 1979) and those who scored low on this measure of eating pathology. While behaviorally the high-EAT students resembled the anorexics, their responses to a psychiatric symptom checklist and a social adjustment inventory indicated that psychologically they were no more distressed than their low-EAT counterparts. Given the media's glamorization of anorexia nervosa, it would not be surprising for young women to self-diagnose their dieting episodes as bouts of anorexia. Psychologically sound young women may hence be eager to admit to any number of bizarre anorexic symptoms, although their problems may actually be quite minor, reflecting more broad sociocultural fashion as opposed to psychogenic distress.

On the basis of the conscious self-report data regarding feelings towards father and relationships with men, a clear psychological profile

emerges, even in the absence of conclusive projective data. The same is not true, however, for hypotheses concerning the young woman's relationship with her mother, her feelings about pleasing her parents or making them unhappy, or her sense of psychological isolation. Conclusions based upon data in these areas are tentative at best.

The nonsignificant trend noted on feelings of isolation suggests that anorexics and bulimics may feel more cut-off or separate from other people than do comparison subjects. Given the small sample size of the present investigation and the consequently reduced power of the findings, speculation here is warranted. This argument is bolstered by the strong relationships noted between feelings of isolation, pathologically bulimic attitudes, and personal requirements for thinness. The data are inconclusive, however, regarding the question of cause and effect. Because no differences were noted comparing present and retrospective indices of isolation, it remains unclear whether eating disorders emerge in response to loneliness, whether such pathological involvement with food distances the individual from peers and family, or, as clinical experience suggests, whether eating pathologies and feelings of social isolation synergistically reinforce each other.

Responses to questionnaire items regarding the anorexic's or bulimic's relationship with her mother, and the feeling of making one's parents unhappy, closely matched the original hypotheses of this study. The data suggest that these young women do not experience conscious conflict around the issue of pleasing or displeasing their parents. Likewise, they do not consciously experience mother as controlling, nor are they aware of having mixed or contradictory feelings about her.

Support for these hypotheses regarding conscious dynamics seems a pyrrhic victory, though, in the absence of conclusive evidence concerning unconscious processes. Consistent with the original hypotheses of this investigation, these findings hint at denial of internal conflict. It remains unproven, though, whether such conflict exists in anorexics or bulimics. Again, the use of a nonclinical sample may have precluded uncovering real differences across groups.

On the whole, the anorexic and bulimic behaviors of these young women appear to relate to personally problematic but culturally normative relationships with father, and fears of heterosexual involvements. These data do not, however, support the hypothesis that such bizarre behaviors always stem from severe psychopathological conflict. Rather, they point to the possibility that such anorexic- or bulimic-like behaviors may be common among college-aged women who are psychologically quite sound.

As suggested above, it is possible that the alarmingly high prevalence of anorexia nervosa and bulimia among young American women is a pseudo-phenomenon. The trendy fascination with eating disorders, which have captured such glamorous victims as Jane Fonda and Karen Carpenter, may lead to the overreporting of behavioral symptoms associated with these disorders.

If, in fact, the young women who participated in this study were as pathologically involved with food as their self-disclosures indicated, then an alternative interpretation should be considered. Perhaps bingeing, purgation and self-starvation are behavioral symptoms which can accompany a range of psychological problems.

The prevalence of anorexic-like symptoms in non-anorexic women has been well documented; the obsessive fear of fatness, the drive for thinness, and the perpetual dissatisfaction with one's body shape, which are the hallmarks of anorexia nervosa, are omnipresent in the psychologically "healthy" population. Anorexia nervosa is more, however, than just a condition of excessive dieting. Garfinkle and Garner (1982) suggest that weight control may be used by non-anorexics "to deal with issues similar to those of anorexics - the regulation and expression of self, autonomy, and self-control" (p.33). The full anorexic syndrome develops less often. Possible protective factors against the escalation of life-threatening emaciation include healthier interpersonal and familial relationships, social supports, ability to trust in others, greater self-esteem, more autonomous ego functioning and a more abstract level of conceptual development (Garfinkle & Garner, 1982).

Bingeing and purging behaviors may likewise be symptoms reflecting varied degrees of psychic organization. Johnson (1983) suggests that bulimia is a multidetermined disorder, which emerges along a continuum of psychopathological disorganization. The most severely disturbed group consists of anorexics who episodically binge and purge. They are best described as borderline personalities; their poor premorbid history and polysymptomatic presentation include clingy but transient relationships, emotional lability, and substance abuse. A less disturbed group of bulimics struggle with a pseudo-autonomous false self. These young women experience themselves as having a dual identity. Their false self hides a frightened and needy self, the discovery of which is both hoped for and feared. The most healthy bulimics are those caught in a developmental conflict over desires, drives, and identity issues. Their

cognitive processes and interpersonal relationships reflect psychological integrity; their depression stems more from superego fears of failure, rejection, or disapproval.

Most probably the bulimics identified by surveys of college students fall into this third category of developmental conflict. For them, bingeing and purging may be transitional objects, enlisted in the struggle for separation from parents. While the aim of weight control is probably consonant with parental values, self-indulgent binges and self-destructive purges may bespeak a silent rebellion. The secrecy and shame which generally shroud bulimia may make this a less effective means of joining one's peer group against the parental generation compared with adolescent experimentation with sex, drugs or alcohol. But there is solace in the knowledge that one suffers from an epidemic, and the private nature of this syndrome may comfortably suit the young woman who fears interactions with male peers. Again, heterosexual fears and bulimic behaviors reciprocally intensify each other.

Recent research emphasizes the fact that seemingly pathological involvement with food and weight may be statistically normal. Nylander (1971), in an epidemiological study of 2370 normal 14- to 20-year-olds, found that over half the girls thought that they were fat, and one-third had dieted. Ten percent of the females in this survey reported three or more symptoms of anorexia nervosa in connection with dieting. Along the same lines, Wardle (1980) found a high frequency of binge-eating among normal young women and men, accompanied by food cravings and difficulty stopping eating once begun. As confirmed by the screening phase of the present investigation, these behaviors are not themselves abnormal. Normal and clinical groups may differ on the frequency and content of

binges, but "the possibility remains that it is the salience or meaning of the dieting and bingeing which, as much as anything else, provokes the distress" (Wardle & Beinart, 1981).

In conclusion it seems that anorexia nervosa and bulimia are intricate syndromes which at once are both more common and less consistently severe than has been presumed. Given the physiological damage caused by these behaviors it behooves us to respond prophylactically and therapeutically to their high prevalence among young American women. This is a major undertaking, considering the duration of time required for effective treatment and the documented difficulty of such psychotherapeutic work. However, the recent wave of publicity among lay and professional writers about this bizarre epidemic may prove to be an overreaction. More microscopic analysis of the psychological concomitants of eating disorders may clarify and distinguish the diverse causal agents of these disorders, leading to the development of more specialized and effective psychotherapeutic treatments.

Appendix A

TAT Scoring Sheet

APPENDIX A

CODING SHEET FORM B

0 = No
1 = Yes

Code # _____

Coder: AM KL

1. Isolation, abandoned _____
2. Child is bad news _____

Felt parental behavior

3. Mother controls _____
4. Mother disapproves _____
5. Father controls _____
6. Father disapproves _____

Child's feelings towards parents

7. Ambivalence to Mom _____
8. Idolizes Mom _____
9. Fears Mom _____
10. Ambivalence to Dad _____
11. Idolizes Dad _____
12. Fears Dad _____

Heterosexual Relations

13. Men are dangerous _____
14. Men get away (with it) _____
15. (13MF) Murder _____
16. (13MF) Death, other causes _____

Appendix B

TAT Scoring Manual

APPENDIX B

TAT SCORING MANUAL

Coding Instructions

1. Copy the story code on a coding sheet.
2. Read protocol from beginning to end.
3. Rate themes 1 - 14.

   0 = No

   1 = Yes
4. If the protocol is for card 13MF (code number ends in 11), rate themes 15 and 16.
5. Circle your initials on the scoring sheet.
6. If you cannot decide how to rate a story, clip the incomplete score card to the protocol and put it aside. Go through the easiest ones first, then take a second run through your pile of harder stories. Continue sorting through the pile until the hard decisions become easier. For these harder ones, write down the criterea you used on the score card, in case we need to discuss it later. Do NOT write on the protocol.

Conversion of Protocol Code Numbers

In case you want to refer to the TAT card described in a protocol, look at the last two digits in the code number. They correspond to the card indicated below.

Code	TAT Card	
01	1	Boy with a violin
02	2	Country scene
03	3BM	A figure huddled against a couch
04	4	A woman clutching the shoulders of a man
05	5	Woman in a doorway (Mother card)
06	6GF	Man standing behind a seated young woman
07	7GF	Woman reading to a girl who holds a doll
08	10	Two people embracing
09	12F	Young woman in front of a weird old woman
10	13G	Girl climbing a flight of stairs
11	13MF	Sex card
12	16	Blank card

Theme 1 - Isolation

The hero feels isolated. Words in the story indicate separation from parents. Look for feelings of abandonment and loss in relation to parents as well as friends and lovers. Score this even if there is evidence that someone may try to ease the pain of isolation.

In some cases this theme may be alluded to in phrases like "sitting in her room" or "they split up", but this should only be scored if the overall theme is one of isolation and abandonment.

Examples:

alone
by oneself
orphanage
boarding school
parents have left
(family members) don't match or go together
crying alone
getting lost
going to one's room alone
surrounded (separated) by a wall
doing something differently than the rest of the family
escaping from family
not paying attention to a parent

Theme 2 - Bad News

Bad news is received by an older couple from their child/children. The child or children make the couple unhappy. The child may cause concern, or may displease his/her parents. 'Bad News' is implied in parental disapproval or criticism, although it is not limited to behaviors evoking such reactions. Score this regardless of whether mother, father, or both are made unhappy.

Theme 2 should not be scored if: 1) it is not explicit that the bad news was from a child 2) a parent is unhappy about a son- or daughter-in-law, but still satisfied with their own child.

Examples:

Parents force the child to do something against his will (implying that they are not happy with the previous failure to do it).
His parents are going to get angry.
The mother isn't going to be too happy.
They got bad news from their children.
The mother is sad because her daughter died.

Themes 3 and 5 - Control

3. A mother figure (older woman) controls her daughter (younger woman).

5. A father figure (older man) controls his daughter (younger woman).

This can be scored regardless of whether or not the attempt to control succeds, as long as the hero experiences pressure from someone in a position of authority. Often the implied feeling of the child/hero is 'Why don't you leave me alone?'.

N.B. If both parents jointly are described as controlling, score both themes 3 and 5.

Examples:

Her mother doesn't want them to see each other, so one night they ran off and got married in the city.
Her mother is trying to keep her attention.
The mother says 'I don't want to hear it' (records).
His mother is making him study the violin.
Threats from father.
He's scolding her, telling her what to do.

Themes 4 and 6 - Disapproval

4. A mother figure is disapproving of her daughter.

6. A father figure is disapproving of his daughter.

This can be scored even if the disapproving mother is dead. Do not score if the parent disapproves of the daughter's husband, but still approves of the daughter.

N.B.: If both parents jointly are described as disapproving, score both themes 4 and 6.

N.B.: Any time that a parent disapproves of the child, the child can be considered "Bad News", so Theme 2 should also be scored.

Examples:

The mother isn't going to be too happy . . . child will be denied privileges.
Mother criticizes what the girl does.
Mother confronts her daughter.
He is accusing her of something.
Her father's telling her "don't do that".
Her mother gave her a look of disgust . . . She had wanted more out of the farm.

Themes 7 and 10 - Ambivalence

Mother (7) or father (10) is described positively but felt negatively. The teller of the story has mixed feelings, but does not express anger, hate, rage, etc. overtly. Often a parent may be doing something "good" but unappreciated by the child. The parent is described positively but felt negatively. In stories where the mother is reading to the daughter, the intention is definitely positive on the mother's behalf, but the critical issue in scoring is whether the child views it as such.

Examples:

The mother is helping her . . . She's daydreaming, mother will be unhappy, and the girl will be punished.
He's scolding her, but being real gentle about it.
The old woman has something up her sleeve . . . She makes the younger one pose for a picture, which she resents.
She knew that mom was trying to help her with her homework, but she couldn't bear to listen.

Do NOT score: Mom was reading to her and she didn't want to listen,

(Does not include child's perception of positive intent).

Themes 8 and 11 - Idolizing

Mother (8) and father (11) are admired, worshipped or idolized by the hero/storyteller. Words used in the story indicate deep admiration or respect.

Examples:

She always liked to go to Grandma's and Grandpa's house, becase they were always so nice to her. She knew she would always want to spend time with them, even though they feared that she wouldn't want to visit when she got older.
His father is a very famous violinist, and he hopes that one day he'll become famous too, just like his father.

N.B.: If both parents are jointly described as admirable and respected, score both themes 8 and 11.

Themes 9 and 12 - Fear

Mother (9) and father (12) are described as fearsome or dangerous. They may threaten, intimidate, physically or emotionally hurt the child/hero. Although the threat may be explicit, the fearful reaction to it may derive more from the tone of the story.

Examples:

Father never kissed her . . . dealing with men is too scary, she thought. Her parents were in another fight. She always became so afraid when they yelled at each other like that. She didn't know what to do.

N.B.: If both parents are described as fearsome, score both themes 9 and 12.

Theme 13 - Men are Dangerous

In heterosexual relationships, men are seen as dangerous or destructive to women. The man can be described as controlling, manipulative, bullheaded, macho, etc. He is hurtful either physically or emotionally (He broke her heart).

Examples:

He's not listening to her, he's going to go do what he planned anyway.
He used her.
He convinces her to go sky diving, even though she's really afraid and doesn't want to. He lands safely, but her rip cord doesn't work, so she dies as a result.
He talks his secretary into dinner at his house. His wife leaves so they can "work", but to the surprise of the secretary, he just wants her for sex.
The story teller voices criticism about a man who has a sexual affair while still married.

Theme 14 - Men get away with it

(Predicated upon theme 13) Men are described as hurtful to women, and they get away with it. They are not reprimanded or caught, they leave and do not feel appropriate guilt or regret. Score this unless the story explicitly states that the man was caught or reprimanded, or that he felt sad or guilty afterwards.

Examples:

He's going to leave before anyone catches him.
He left the scene before anyone suspected that he had killed her.
He used her for sex and now he's going to leave before she wakes up.

Theme 15 - Sex Equals Murder

(Predicated upon theme 13) (Card 13MF) Sex is equated with murder.

Score any story on 13MF in which the woman is killed or raped by a man.

Examples:

He killed her.
He became violent, raped her, and now she's dead.
He came in and found his wife had been murdered.

Theme 16 - Other Causes

(Card 13MF) Death from causes other than murder or rape.

Examples:

She wasn't feeling well in the morning. When he came home that night she was dead.
She had been sick for a long time, but he still couldn't believe that she had passed away.
She had an accident and died.

Appendix C

Conscious Themes Questionnaire

Appendix C

Conscious Themes Questionnaire

Directions: Consider each of the following items seperately. Use the scale provided to describe the degree to which each statement measures feelings you have had. Mark your response in the space provided. Thank you.

1	2	3	4	5	6	7
Never or Almost Never True	Usually Not True	Sometimes but Infrequently True	Occasionally True	Often True	Usually True	Always or Almost Always True

1. ___ My mother often seemed kind and sweet.
2. ___ If you are in a close relationship with a man, you always end up getting hurt.
3. ___ I respected and admired my father.
4. ___ The things I did made my parents very unhappy.
5. ___ My father controlled most aspects of my life.
6. ___ I respected and admired my mother.
7. ___ When I was young, I often felt like I didn't have a family, because I felt so disconnected from my parents (and siblings).
8. ___ My mother was very critical of me.
9. ___ I feel seperate, or cut-off from other people.
10. ___ My mother controlled most aspects of my life.
11. ___ I believe that inside, my father was mean or dangerous.
12. ___ Men always seem to get away with it when they create pain for women.
13. ___ My father was very critical of me.
14. ___ My father often seemed kind and sweet.
15. ___ I believe that inside, my mother was mean or dangerous.

Appendix D

Eating Disorders Inventory

APPENDIX D

EATING DISORDERS INVENTORY

EDI

Name: _____ Date: _____

Age: _____

Present Weight: _____ (lbs) Height: _____ Sex: _____

Highest Past Weight (excluding pregnancy): _____ (lbs)

How Long Ago? _____ (months)

How Long Did You Weigh This? _____ (months)

Lowest Past Adult Weight: _____ (lbs)

How Long Ago? _____ (months)

How Long Did You Weigh This? _____ (months)

What Do You Consider Your Ideal Weight To Be? _____ (lbs)

Age at Which Weight Problem Began (if any): _____

Father's Occupation: _____

INSTRUCTIONS

This is a scale which measures a variety of attitudes, feelings and behaviours. Some of the items relate to food and eating. Others ask you about your feelings about yourself. THERE ARE NO RIGHT OR WRONG ANSWERS SO TRY VERY HARD TO BE COMPLETELY HONEST IN YOUR ANSWERS. RESULTS ARE COMPLETELY CONFIDENTIAL. Read each question and place an (X) under the column which applies best for you. Please answer each question very carefully. Thank you.

ALWAYS	USUALLY	OFTEN	SOMETIMES	RARELY	NEVER		
☐	☐	☐	☐	☐	☐	1.	I eat sweets and carbohydrates without feeling nervous.
☐	☐	☐	☐	☐	☐	2.	I think that my stomach is too big.
☐	☐	☐	☐	☐	☐	3.	I wish that I could return to the security of childhood.
☐	☐	☐	☐	☐	☐	4.	I eat when I am upset.
☐	☐	☐	☐	☐	☐	5.	I stuff myself with food.

EDI - D.M. Garner, M.P. Olmsted and J. Polivy (1983) Toronto General Hospital, Toronto, Canada

ALWAYS	USUALLY	OFTEN	SOMETIMES	RARELY	NEVER		
☐	☐	☐	☐	☐	☐	6.	I wish that I could be younger.
☐	☐	☐	☐	☐	☐	7.	I think about dieting.
☐	☐	☐	☐	☐	☐	8.	I get frightened when my feelings are too strong.
☐	☐	☐	☐	☐	☐	9.	I think that my thighs are too large.
☐	☐	☐	☐	☐	☐	10.	I feel ineffective as a person.
☐	☐	☐	☐	☐	☐	11.	I feel extremely guilty after overeating.
☐	☐	☐	☐	☐	☐	12.	I think that my stomach is just the right size.
☐	☐	☐	☐	☐	☐	13.	Only outstanding performance is good enough in my family.
☐	☐	☐	☐	☐	☐	14.	The happiest time in life is when you are a child.
☐	☐	☐	☐	☐	☐	15.	I am open about my feelings.
☐	☐	☐	☐	☐	☐	16.	I am terrified of gaining weight.
☐	☐	☐	☐	☐	☐	17.	I trust others.
☐	☐	☐	☐	☐	☐	18.	I feel alone in the world.
☐	☐	☐	☐	☐	☐	19.	I feel satisfied with the shape of my body.
☐	☐	☐	☐	☐	☐	20.	I feel generally in control of things in my life.
☐	☐	☐	☐	☐	☐	21.	I get confused about what emotion I am feeling.
☐	☐	☐	☐	☐	☐	22.	I would rather be an adult than a child.
☐	☐	☐	☐	☐	☐	23.	I can communicate with others easily.
☐	☐	☐	☐	☐	☐	24.	I wish I were someone else.
☐	☐	☐	☐	☐	☐	25.	I exaggerate or magnify the importance of weight.
☐	☐	☐	☐	☐	☐	26.	I can clearly identify what emotion I am feeling.
☐	☐	☐	☐	☐	☐	27.	I feel inadequate.
☐	☐	☐	☐	☐	☐	28.	I have gone on eating binges where I have felt that I could not stop.
☐	☐	☐	☐	☐	☐	29.	As a child, I tried very hard to avoid disappointing my parents and teachers.
☐	☐	☐	☐	☐	☐	30.	I have close relationships.

ALWAYS	USUALLY	OFTEN	SOMETIMES	RARELY	NEVER		
☐	☐	☐	☐	☐	☐	31.	I like the shape of my buttocks.
☐	☐	☐	☐	☐	☐	32.	I am preoccupied with the desire to be thinner.
☐	☐	☐	☐	☐	☐	33.	I don't know what's going on inside me.
☐	☐	☐	☐	☐	☐	34.	I have trouble expressing my emotions to others.
☐	☐	☐	☐	☐	☐	35.	The demands of adulthood are too great.
☐	☐	☐	☐	☐	☐	36.	I hate being less than best at things.
☐	☐	☐	☐	☐	☐	37.	I feel secure about myself.
☐	☐	☐	☐	☐	☐	38.	I think about bingeing (over-eating).
☐	☐	☐	☐	☐	☐	39.	I feel happy that I am not a child anymore.
☐	☐	☐	☐	☐	☐	40.	I get confused as to whether or not I am hungry.
☐	☐	☐	☐	☐	☐	41.	I have a low opinion of myself.
☐	☐	☐	☐	☐	☐	42.	I feel that I can achieve my standards.
☐	☐	☐	☐	☐	☐	43.	My parents have expected excellence of me.
☐	☐	☐	☐	☐	☐	44.	I worry that my feelings will get out of control.
☐	☐	☐	☐	☐	☐	45.	I think that my hips are too big.
☐	☐	☐	☐	☐	☐	46.	I eat moderately in front of others and stuff myself when they're gone.
☐	☐	☐	☐	☐	☐	47.	I feel bloated after eating a normal meal.
☐	☐	☐	☐	☐	☐	48.	I feel that people are happiest when they are children.
☐	☐	☐	☐	☐	☐	49.	If I gain a pound, I worry that I will keep gaining.
☐	☐	☐	☐	☐	☐	50.	I feel that I am a worthwhile person.
☐	☐	☐	☐	☐	☐	51.	When I am upset, I don't know if I am sad, frightened or angry.
☐	☐	☐	☐	☐	☐	52.	I feel that I must do things perfectly, or not do them at all.
☐	☐	☐	☐	☐	☐	53.	I have the thought of trying to vomit in order to lose weight.
☐	☐	☐	☐	☐	☐	54.	I need to keep people at a certain distance (feel uncomfortable if someone tries to get too close).

ALWAYS	USUALLY	OFTEN	SOMETIMES	RARELY	NEVER		
☐	☐	☐	☐	☐	☐	55.	I think that my thighs are just the right size.
☐	☐	☐	☐	☐	☐	56.	I feel empty inside (emotionally).
☐	☐	☐	☐	☐	☐	57.	I can talk about personal thoughts or feelings.
☐	☐	☐	☐	☐	☐	58.	The best years of your life are when you become an adult.
☐	☐	☐	☐	☐	☐	59.	I think that my buttocks are too large.
☐	☐	☐	☐	☐	☐	60.	I have feelings I can't quite identify.
☐	☐	☐	☐	☐	☐	61.	I eat or drink in secrecy.
☐	☐	☐	☐	☐	☐	62.	I think that my hips are just the right size.
☐	☐	☐	☐	☐	☐	63.	I have extremely high goals.
☐	☐	☐	☐	☐	☐	64.	When I am upset, I worry that I will start eating.

EDI Subscales

Drive for Thinness

Item Number	Item on Subscale
1.*	I eat sweets and carbohydrates without feeling nervous.
7.	I think about dieting.
11.	I feel extremely guilty after overeating.
16.	I am terrified of gaining weight.
25.	I exaggerate or magnify the importance of weight.
32.	I am preoccupied with the desire to be thinner.
49.	If I gain a pound, I worry that I will keep gaining.

Interoceptive Awareness

Item Number	Item on Subscale
8.	I get frightened when my feelings are too strong.
21.	I get confused about what emotion I am feeling.
26.*	I can clearly identify what emotion I am feeling.
33.	I don't know what's going on inside me.
40.	I get confused as to whether or not I am hungry.
44.	I worry that my feelings will get out of control.
47.	I feel bloated after eating a small meal.
51.	When I am upset, I don't know if I am sad, frightened or angry.
60.	I have feeelings I can't quite identify.
64.	When I am upset, I worry that I will start eating.

Bulimia

Item Number	Item on Subscale
4.	I eat when I am upset.
5.	I stuff myself with food.
28.	I have gone on eating binges where I have felt that I could not stop.
38.	I think about bingeing (overeating).
46.	I eat moderately in front of others and stuff myself when they're gone.
53.	I have the thought of trying to vomit in order to lose weight.
61.	I eat or drink in secrecy.

Body Dissatisfaction

Item Number	Item on Subscale
2.	I think that my stomach is too big.
9.	I think that my thighs are too large.
12.*	I think that my stomach is just the right size.
19.*	I feel satisfied with the shape of my body.
31.*	I like the shape of my buttocks.
45.	I think my hips are too big.
55.*	I think my thighs are just the right size.
59.	I think my buttocks are too large.
62.*	I think that my hips are just the right size.

Ineffectiveness

Item Number	Item on Subscale
10.	I feel ineffective as a person.
18.	I feel alone in the world.
20.*	I feel generally in ccontrol of things in my live.
24.	I wish I were someone else.
27.	I feel inadequate.
37.*	I feel secure about myself.
41.	I have a low opinion of myself.
42.*	I feel that I can achieve my standards.
50.*	I feel that I am a worthwhile person.
56.	I feel empty inside (emotionally).

Maturity Fears

Item Number	Item on Subscale
3.	I wish that I could return to the security of childhood.
6.	I wish that I could be younger.
14.	The happiest time in life is when you are a child.
22.*	I would rather be an adult than a child.
35.	The demands of adulthood are too great.
39.*	I feel happy that I am not a child anymore.
48.	I feel that people are happiest when they are children.
58.*	The best years of your life are when you become an adult.

Perfectionism

Item Number	Item on Subscale
13.	Only outstanding performance is good enough in my family.
29.	As a child, I tried very hard to avoid disappointing my parents and teachers.
36.	I hate being less than best at things.
43.	My parens have expected excellence of me.
52.	I feel that I must do things perfectly or not do them at all.
63.	I have extremely high goals.

Interpersonal Distrust

Item Number	Item on Subscale
15.*	I am open about my feelings.
17.*	I trust others.
23.*	I can communicate with others easily.
30.*	I have close relationships.
34.	I have trouble expressing my emotions to others.
54.	I need to keep people at a certain distance (feel uncomfortable if someone tries to get too close).
57.*	I can talk about personal thoughts or feelings.

* Indicates negaatively keyed item.

Appendix E

Objective Test Materials

APPENDIX E

OBJECTIVE TEST MATERIALS

Instructions

This questionnaire contains a number of questions dealing mostly with how you see yourself. Please answer them to the best of your ability.

For the purposes of this questionnaire, "bingeing" is used to refer to the rapid consumption of large amounts of food, which are usually high in caloric content. Some people call this "pigging out". It can be done in a variety of situations, as with friends, alone, when depressed, when "high" etc. "Anorexia Nervosa" is defined as deliberate weight loss and feeling terrified of fat, even though others say you are too thin.

If you have questions about the meanings of any other terms on this questionnaire, please feel free to ask for a definition.

QUESTIONNAIRE

Please mark your answers directly on this page. You will NOT need a separate answer sheet for any of the following questions.

1. Age_____

2. Ethnicity:
   ___Caucasian
   ___Asian
   ___Hispanic
   ___Black
   ___American Indian
   ___Other_____

3. Current level in school:
   ___Freshman
   ___Sophomore
   ___Junior
   ___Senior
   ___Other_____

4. Marital Status:
   ___Never married
   ___Married
   ___Separated
   ___Divorced
   ___Widowed

5. Parents' Marital Status:
   ___Never married
   ___Married
   ___Separated
   ___Divorced
   ___Widowed

6. How would you describe your present living situation? (Check all that apply)
   ___Live with parents
   ___Live with husband/male
   ___Live alone
   ___Live in a dormitory
   ___Live with a female friend

7. Which of the following describes your birth position in your family? (Check all that apply)
   ___First born
   ___Middle child
   ___Last child
   ___Only child
   ___Twin

8. What is your religion?
   ___Protestant
   ___Catholic
   ___Jewish
   ___Other_____
   ___None

9. What is your father's occupation?_____

10. What is the highest educational degree held by your father?
    _____

11. What is your mother's occupation?_____

12. What is the highest educational degree held by your mother?
    _____

13. What is your present weight?_____lbs

14. What is your height?_____ft_____in

15. What is the LOWEST YOU'VE WEIGHED since reaching your present height?_____

16. What is the MOST YOU'VE WEIGHED since reaching your present height?_____

17. In your opinion, you are now (check one)
    very underweight _____
    underweight _____
    average _____
    overweight _____
    very overweight _____

18. How often does your weight fluctuate?
    a. not at all
    b. sometimes
    c. frequently

EATING PROBLEMS QUESTIONNAIRE

INSTRUCTIONS: This questionnaire covers several eating problems that may or may not apply to you. You may find it difficult to answer some questions if your eating pattern is irregular or has changed recently. Please read each question carefully and choose the answer that BEST describes your situation MOST OF THE TIME. Also, please feel free to write remarks in the margins if this will clarify your answer. Thank you.

1. Do you have a problem with binge eating?
   ___ Yes,now ___ Used to ___ No

2. When was the last time you had a binge?
   Specify number: ___years, ____months, ____weeks, ____days ago

3. Please describe your binges:

	Always	Often	Some-times	Rarely/ Never
Eat a large amount of food.....	_____	_____	_____	_____
Eat very rapidly.....	_____	_____	_____	_____
Feel I can't stop/out of control..	_____	_____	_____	_____
Eat in private.....	_____	_____	_____	_____

If you answered "Rarely/Never" to two or more parts of Question 3, please skip to Question 17.

4. How often do you binge?
   ___ More than once a day
   ___ Daily
   ___ At least once a week
   ___ A few times a month
   ___ Once a month or less

5. How long does the binge usually last?
   ___ Less than one hour
   ___ 1-2 hours
   ___ More than 2 hours

6. What foods do you eat when you're bingeing? When you're not bingeing? Check all that apply:

	Binge Foods	Non-binge Foods
Bread/cereal/pasta.....	_____	_____
Cheese/milk/yogurt.....	_____	_____
Fruit.....	_____	_____
Meat/fish/poultry/eggs.....	_____	_____
Salty snack foods.....	_____	_____
Sweets.....	_____	_____
Vegetables.....	_____	_____

7. About how many calories do you consume in a typical binge?
_____calories

8. About how much would you estimate you spend on binge eating?
$_____per binge

9. How old were you when you first started bingeing? ____years old

10. How long have you had a problem with binge eating?
Specify number: ___years, ___months, ___weeks

11. What event or feeling triggers a binge? (explain)_____
_____
_____
_____

12. What best describes how you feel DURING a binge? Check all that apply:

__Calm	__Excited	__Disgusted	__Panicked
__Helpless	__Angry	__Energized	__Relieved
__Stimulated	__Spaced-out	__Secure	__Guilty
__Depressed			

13. How do you usually feel AFTER a binge (BEFORE purging)? Check all that apply:

__Calm	__Excited	__Disgusted	__Panicked
__Helpless	__Angry	__Energized	__Relieved
__Stimulated	__Spaced-out	__Secure	__Guilty
__Depressed			

14. Please describe how your binges end:

	Always	Often	Sometimes	Rarely/ Never
Abdominal pain.....	_____	_____	_____	_____
Sleep.....	_____	_____	_____	_____
Social interruption...	_____	_____	_____	_____
Self induced vomiting.	_____	_____	_____	_____
Other				

_____
_____

15. What time of the day are you most likely to binge?
___ Mornings (7 am - 12 Noon)
___ Afternoons (12 Noon - 4 pm)
___ Evenings (4 pm - 10 pm)
___ Night (after 10 pm)
___ Varies

16. Why do you think you started binge eating in the first place?
_____
_____
_____

17. Have you ever induced yourself to vomit, or have you ever thrown up after a binge?
___Yes, now ___Used to ___No

If you answered "No" to Question 17, skip to Question 26.

18. If yes, when was the last time you induced vomiting?
Specify number: ___months, ___weeks, ___days ago

19. How often do you induce vomiting?
___More than once a day
___Daily
___At least once a week
___A few times a month
___Once a month or less

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

21. How long have you been vomiting in this way?
Specify number: _____years, _____months, _____weeks

22. How do you usually get yourself to throw up?_____
_____
_____
_____

23. Has it become harder or easier to vomit since you first began?
_____Harder _____Easier _____About the same

24. Do you remember why you did this originally? (explain)_____
_____
_____
_____

25. What best describes how you feel AFTER you have purged by vomiting? Check all that apply:

__Calm	__Excited	__Disgusted	__Panicked
__Helpless	__Angry	__Energized	__Relieved
__Stimulated	__Spaced-out	__Secure	__Guilty
__Depressed			

26. Have you ever used laxatives to control your weight or "get rid of food"?
___Yes, now ___Used to ___No

If you answered "No" to Question 26, please skip to Question 34.

27. If yes, when was the last time you took laxatives for weight control?
Specify number: _____months, _____weeks, _____days ago

28. How often do you take laxatives for this purpose?
___ More than once a day
___ Daily
___ At least once a week
___ A few times a month
___ Once a month or less

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

30. How long have you been doing this?
Specify number: _____years _____months _____weeks

31. What dosage do you take? Brand_____ Amount_____

32. Do you remember why you started using laxatives for weight control?

_____

_____

_____

33. What best describes how you feel AFTER you have purged by using laxatives? Check all that apply:

__Calm	__Excited	__Disgusted	_ Panicked
__Helpless	__Angry	__Energized	__Relieved
__Stimulated	__Spaced-out	__Secure	__Guilty
__Depressed			

34. Have you ever fasted, or starved yourself AFTER A BINGE?
___Yes, now ___Used to ___No

If you answered "no" to Question 34, please skip to Question 43.

35. If yes, when was the last time you fasted?
Specify number: ___months, ___weeks, ___days ago.

36. How often do you start fasting?
___More than once a day
___Daily
___At least once a week
___A few times a month
___Once a month or less

37. How old were you when you fasted for the first time?
_____years old

38. How long have you been fasting in this way?
Specify number: ___years, ___months, ___weeks

39. How long is your average fast?
___Less than a day
___24 hours or less
___A week or less
___More than a week

40. Has it become harder or easier to fast since you first began?
___ Harder ___ Easier ___ About the same

41. Do you remember why you did this originally? (Explain)_____
_____
_____
_____

42. What best describes how you feel AFTER you have fasted? Check all that apply:

__Calm	__Excited	__Disgusted	__Panicked
__Helpless	__Angry	__Energized	__Relieved
__Stimulated	__Spaced-out	__Secure	__Guilty
__Depressed			

43. Have you ever dieted, or tried to diet to control your weight?
___ Yes, now ___ Used to ___ No

If you answered "no" to Question 43, please skip to Question 51.

44. If yes, when was the last time you dieted for weight control?
Specify number: _____ months, _____weeks, _____days ago

45. How often do you begin diets for this purpose?
___More than once a day
___Daily
___At least once a week
___A few times a month
___Once a month or less frequently

46. How old were you when you first dieted for weight control?
_____ years old

47. How long have you been doing this?
Specify number: _____ years, _____ months, _____ weeks

48. How long is your average diet?
___Less than a day
___24 hours or less
___A week or less
___More than a week
___More than a month

49. Do you remember why you started dieting for weight control?_____
_____
_____
_____

50. What best describes how you feel AFTER you have dieted? Check all that apply:

__Calm	__Excited	__Disgusted	__Panicked
__Helpless	__Angry	__Energized	__Relieved
__Stimulated	__Spaced-out	__Secure	__Guilty
__Depressed			

51. Do you consider yourself to have (or to have had) anorexia nervosa?
___ Yes,now ___ Used to ___ No

52. Please indicate any of the following symptoms you have had:
___ Deliberate weight loss (not due to medical illness)
___ Loss of menstrual period
___ Overactivity/exercise without enjoyment
___ Feeling terrified of fat
___ Feeling fat despite others saying you are too thin
___ Being obsessed or totally preoccupied with thoughts of food

53. Lowest weight reached? _____pounds

54. How long ago was this (lowest weight)?
Specify number: _____ months, _____ weeks,or _____ days ago

55. Exercise:

Type	Daily	Weekly	Monthly	Less than Monthly	Never
_____	___	___	___	___	___
_____	___	___	___	___	___
_____	___	___	___	___	___
_____	___	___	___	___	___

How much time do you spend exercising each day?
Specify time: ___hours or ___minutes

56. Are you presently involved with a man? ___ Yes ___ No

57. Have you noticed any changes in your physical health since your eating problem began?
___ Yes ___ No If yes, please describe:_____-_____
_____

58. How often do you worry about possible ill effects of bingeing and/or purging?
___ Always ___ Often ___ Sometimes ___ Rarely/Never

59. How often do you worry about possible ill effects of fasting and/or dieting?
___ Always ___ Often ___ Sometimes ___ Rarely/Never

60. Have you ever taken any psychiatric medication? ___Yes ___No
Type:_____
_____
Reason:_____
_____

61. Are your menstrual periods regular? ___ Yes ___ No

62. If you do not menstruate regularly, please describe your pattern over the past year:_____

_____

_____

63. When was your last menstrual period?
Specify number: _____ months, _____weeks,or _____days ago

64. How often do you feel depressed?
___Always/Very Often ___Often ___Sometimes ___Rarely/Never

65. Have you ever injured yourself intentionally? ___ Yes ___ No
Please describe what happened:_____

_____

_____

_____

66. Have you ever felt so bad or hopeless that you thought of suicide?
___ No.
___ Yes, considered it, but didn't act on the idea.
___ Yes, made a suicidal gesture or plea for help.
___ Yes, made a serious suicide attempt.
What brought this on?_____

_____

_____

_____

Please feel free to use this space for comments about this study, your reactions to it and/or your eating behaviors.
Thank you for your cooperation.

Appendix F

Research Consent Form

APPENDIX F

RESEARCH CONSENT FORM

Michigan State University
Department of Psychology
Research Consent Form

Eating Behavior Study

Investigator: Abby L. Golomb, M.A.
Supervisor: Bertram P. Karon, Ph.D.

The aim of this study is to learn about the eating patterns of young women, and to investigate some of the personality features associated with these eating behaviors.

In the first part of this study, you will be asked to complete a questionnaire. It pertains to your eating habits, how you describe your family and how you describe your personality. This should take approximately one hour. You will be awarded two extra credit points for your participation in this part of the study. Some questions are extremely personal. You may skip any item which you do not wish to answer, and you are free to discontinue your participation at any time without penalty.

Some of the people participating in this part of the study will be asked to return for a second one-hour testing session. During this hour, subjects will be asked to tell a number of stories in an individual interview. Participants in the second part of this study will receive an additional two points of extra credit. They will be selected according to their eating behaviors, as described on the original questionnaire. We are looking for subjects with a variety of eating habits. There is no right or wrong way to answer this questionnaire; we are interested in a wide range of behavior. In giving your consent to participate in this study, you are agreeing to fill out the following questionnaire, and to be recontacted for the second part of this study. If you change your mind later, you are free to discontinue participation without any penalty. Bear in mind, though, that you may not be recontacted for the second part of this study.

The results of this study will be treated in strict confidence, and the anonymity of subjects will be carefully protected. Within these restrictions, results of the study will be made available to any subject at her request.

Participation in this study does not guarantee any beneficial results to individual participants.

If you have any questions about your rights as a participant in this study, please feel free to ask. By responding to this questionnaire, you will be explicitly agreeing to the terms set forth above. No separate consent form will be used. If these conditions are unacceptable to you, please return your unanswered questionnaire.

Please detach this page and keep it for your personal reference.

Thank you.

Please detach this page and hand it in with your questionnaire.

Name_____

Local Address_____

Telephone_____

Subject Code Number_____

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