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A STUDY OF SELF CONCEPT, ANXIETY AND BODY IMAGE AMONG NORMAL WOMEN AND WOMEN SUFFERING FROM EATING DISORDER

A Thesis Submitted to

Saurashtra University, Rajkot

For

The Degree of

DOCTOR OF PHILOSOPHY
IN
PSYCHOLOGY

By

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C E R T I F I C A T E

This is to certify that the content of this thesis entitled " A STUDY OF SELF CONCEPT, ANXIETY AND BODY IMAGE AMONG NORMAL WOMEN AND WOMEN SUFFERING FROM EATING DISORDER" is the original research work for the award of the degree of Doctor of Philosophy in Psychology of Vaishali H. Panchal carried out under my supervision.

I further certify that the work has not been submitted either partly or fully for any other university or institute for the award of any degree.

Signature of the Guide

CANDIDATE'S STATEMENT

I hereby declare that the work incorporated in the present thesis is original and has not been submitted to any university or institute for the award of a diploma or degree. I further declare that the results presented in the thesis considerations made their contribution in general to the advancement of knowledge in psychology and in particular to "A STUDY OF SELF CONCEPT, ANXIETY AND BODY IMAGE AMONG NORMAL WOMEN AND WOMEN SUFFERING FROM EATING DISORDER".

Signature of the Candidate

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Place:

Date: Vaishali H Panchal

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CHAPTER : 1
INTRODUCTION

1. Introduction:

Rapid changes are being carried out in every walk of life due to the development of science and technology and industrialization, urbanization in modern age. On account of this, life style of human beings is being changed. Changed life style has increased human needs. Due to the blind running after the means of material happiness, the proportion of complication, conflict, anxiety, pressure, frustration have increased. Such situation produces stress. There are individual differences in coping with such stressful situation. Some people face stressful situations quietly, while some others become the victim of behavioral disorders.

Rapid changes in the life style of modern age have made the role of women complex. The women have to against simultaneously with individual family, social, vocational and cultural situation. In during so the women experiences severe stress. Such severe stress brings mental disorder in women. Amongst different disorders prevailing in current age, the proportion of eating disorder is more. Such disorder is found more in women than men. Specifically, it is found more in women between age of 18 to 35 years. There are also types of eating disorders (1) *Anorexia Nervosa* (2) *Bulimia Nervosa.*

Such belief prevails amongst women that thinness of body brings success, attraction, health, happiness are popularly. It is helpful in adjusting with family members while on the other side instead of eating for survival, people live for eating. Food has become pleasurable activity today. It has

become a sign of social complication to eat Gujarati, Punjabi, Marathi, Chinese, and Continental Mugalai and invite friends and relatives to eat such items. On account of such items. On account of such opposing tendencies, some women d more dieting than necessary while some women eat more than necessary (They become foodaholics) and some others become the victim of bulimia nervosa. Some other women are keeping themselves thin and in the anxiety of becoming overweight become the victim of anorexia nervosa. Some women believe that dieting disturbs their lifestyle. As a result they being to take more food and become the victim of Obesity.

The study of personality indicates that the women who have become the victim of Anorexia Nervosa, whose weight is balanced, are found more neurotic or obsessional. The women who had decreased their weight is balanced are found more neurotic or obsessional. The women who had decreased their weight by dieting are more introvert, more anxious are more parasite than women of normal weight. While the women who had become the victim of bulimia Nervosa or Obesity are anxious, depressed and with low self esteem. They wish to be perfect, yet have a poor self-image, negative self worth are shy are lack assertive. They are often pre-occupied with fewer rejections in sexual relationship and with not being attractive enough to please a man.

In the present research, the attempt has been made to make comparative study of self-concept, anxiety and body image of women suffering from eating disorder and Normal Women between age 15 to 25 age and 30 to 40 years.

2. Case Study of Jessica & Elise :

2.1. Jessica , a 20 years old college junior majoring in psychology, was a model student. She worked hard, earned excellent grades, and high ambitions for a future career. Like many young college women, Jessica wanted to lose a few pounds-8or10. However, unlike most other women, she was already dangerously thin – five feet four inches tall and weighting 81 pounds. Jessica had anorexia nervosa, an eating disorder that intentional starvation and a distorted body image.

At age 15, Jessica weighed 130 pounds, ate well, and was a normal teenager. In 4 years all this had changed. When she was 16, Jessica took a job as a dance instructor. Her employer suggested that she lose a few pounds, so Jessica began a conscientious program to lose weight. When her weight dropped to110 pounds, her parents, boyfriend, and girlfriends all complemented her on how good she looked. However, Jessica continued to diet, and her eating habits became stranger as her concern with weight intensified. She would skip breakfast but drink five or six cups of coffee every morning. Her only food of the day was lunch, which consisted of a slice of low-calorie cheese on a half of it. After eating, she would pick at her lunch for 20 to30 minutes and eventually consume about half of it. After eating, she goes to the dance studio, where she exercised strenuously for 6 or 7 hours. After work, if daylight permitted, she would ride her bike for several miles or play a couple of sets of tennis. In addition to her morning coffee, she would drink one or two cups of hot tea and three or four diet drinks a day.

As her weight continued to drop, Jessica began to hide her weight loss beneath large, loose-fitting clothing. She weighed herself several times a day and spent a good deal of time looking at herself in a mirror. Where others saw an emaciated body, Jessica always saw a figure that seemed too fat. She also worried that her parents or doctor would put her in a hospital and forces her to gain weight.

When her weight dropped below 90 pounds, Jessica began noticing soft black hair growing on parts of her body. At the same time she began to feel cold all the time. Even on hot summer days. Despite constantly feeling sick, Jessica was neither concerned nor displeased about her loss of weight. Except for believing that she was a little too fat, she liked her body as it was and had no desire to reverse the downward spiral of weight loss. On the contrary, she became even more determined to loss additional weight and began to fast completely for 4 or 5 days at a time.

2.2. Elise was a senior in high school who had always been an excellent student. She made good grades and was involved in much school – related activities, but like Jessica and many other young women, she was unhappy with her weight. Elise wanted to weight less than 100 pounds, a weight she felt was reasonable for her 5’2"frame, but she weighed over 120 pounds. She began eating less – not eating at all during the day, missing dinner due to school –related activities, and fooling her family in to thinking that she was eating. Like Jessica, she tended to wear baggy clothing, so at first her family and friends did not notice her weight loss. Unlike Jessica, Elise found fasting difficult and did not feel like exercising to lose weight, so she

began to vomit as a way to compensate for eating. Soon she added laxatives as an additional technique. She kept both practices secret from her family, who she believed would have tried to stop her.

It was not her disordered eating that resulted in her receiving treatment, but rather it was signs of depression – she cried easily, was always tried, and didn't seem to enjoy anything. Elise's family insisted that she go to a psychiatrist, who recognized her eating problems and tried to get Elise to recognize them, too. Elise listened to her psychiatrist and trusted her, forming a positive relationship, but she resisted the notion that she had an eating problem.

Not only did Elise deny her eating problem, but she also continued to vomit to abuse laxative as ways to lose weight. By the time she graduated from the high-school, she has lost more than 15 pounds (but still weighted 104 pounds, 5 pounds away from her goal). Her weight begun to be an issue with her family and friends, who told her that she was too thin and that she looked terrible. Despite the amount of weight she had lost, she dint meet the criteria to be diagnosed as anorexic according to the diagnostic and statistical manual of eating disorder (American Psychiatrics association, 1987. 1994). Those criteria includes weight lost to the point that the person in 15 % below ideal weight which Elise was not. However, she executed that distorted body image, fear of gaining weight and *amenorrhea* (cessation of menstrual periods) that are symptoms of Anorexia.

Elise's diagnosis was *"Bulimia"*, an eating disorder consisting of Binge Eating followed by some methods to compensate for the Binge such as fasting, excessive exercising or purging through either vomiting or using

laxatives. Elise executed these symptoms forcing herself to vomit and abusing laxatives, even when amount of food she had eaten was not excessive.

Elise's eating problems got worse when she begun college. She purged by both vomiting and using laxatives but more laxatives she consumed, the less effective they became. So she increased the dosage to the point of once taking 45 tablets in less than 2 days this precipitated a medical crisis, resulting in her being hospitalized and receiving psychotherapy, her therapist tries to convincing Elise to except a reasonable body image to eat reasonably, and to stop purging.

Elise tried hard to get better over the next five years but her distorted body image continued. She still unhappy with her weight but she continuous to work on her recovery. She purged for years but say that urged to do so has decreased.

Like millions of Americans Jessica and Elise suffer from some from *eating disorder.* And eating disorder is any serious and habitual disturbance in eating behavior that produced unhealthy consequences. This definition excludes both starvation resulting from inability to find enough food and unhealthy eating resulting from inadequate information about nutrition. Also excluded are disturbance in eating disorder such as pica or eating of non-nutritive substance such as plastic and wood, and the rumination disorder of infancy-that is, regurgitation of food without nausea or gastrointestinal illness. Neither of these later disorder present serious health problems to adults and they are from relatively minor importance in health psychology.

3. Eating Disorder:

Besides overeating, to the other eating disorder has received considerable attention both in popular media and in scientific literature. These unhealthy eating habits are anorexia nervosa and Bulimia.

The term Anorexia nervosa means lack of appetite due to a nervous or physiological conditions, bulimia means the continuous, morbid hunger. Neither meaning however, is quite accurate.The patterns of eating behavior to which these label apply are only marginally related to the literal meaning of the two terms. People with anorexia nervosa have not lost their appetite, ordinary they are perpetually hungry, but they insist that they do not wish to eat. Like Jessica, these people become preoccupied with losing weight, and their self induced starvation often results in a life threatening conditions. Similarly, bulimia comes to mean more than continuous morbid hunger. Achieve identifying mark of these eating disorder is repeated Binging and Purging, the purge usually coming after eating hung quantities of food, usually high in calories and loaded in carbohydrates, fat, or both. Like Elise, people with bulimia ordinarily purged by Vomiting, but fasting and using laxatives and diuretics are also frequently part of the purging process.

These two eating disorders obviously common and Elise experience symptoms of both. Infect many authorities regard them as two dimension of the same illness. Others see that as two separate but related illnesses. We regard neither of them as an illness; they are both unhealthy eating patterns that, along with overeating, may eventually produced physical illness.

3.1 Symptoms of Eating Disorders:

Here is a list of thing that might be noticed in individuals who have an eating problem.

3.1.1. Behavioral Symptoms:

- € Dramatic weight loss in relatively shot period of time
- € Wearing weak and baggy clothes of dressing in layers to hide body shape/ or weight loss.
- € Frequent trips to the bath room immediately following meals (Some times a complained means water running in the bath room in long period of time to hide the sound of Vomiting.)
- € Visible food restriction and self starvation.
- € Visible binge eating and / or purging.
- € Use of hiding, use of dieted pills, laxatives ipecac syrup, or enemas.
- € Hiding food in strange place (Closet, cabinets, suit case, under the bed). to avoid eating or to eat at a later time.
- € Flushing uneaten food down the toilet (can cause sewage problems).

3.1.2. Cognitive Symptoms:

- € Obsession with weight or with weight problems (even if "average "weight or thin).
- € Obsession with calories with fat contains of food.
- € Obsession with continuous exercise.
- € Isolation, that is, fear of eating around and with others.
- € Pre-occupied thoughts of food, weight, and cooking.
- € Self defeating, statements after food consumption.
- € Perfectionist personality.

3.1.3. Emotional Symptoms:

- € Low self esteem, feeling worthless, individuals often putting themselves down and complaining of being "to stupid" or "To fat" and saying they don't matter.
- € Need for acceptance and approval from others.
- € Mood swings; depression.

3.2. Types of eating disorder:

3.2.1. Anorexia nervosa:

Anorexia nervosa is a major eating disorder associated with refusal to maintain a minimally normal weight. The word "anorexia" is derived from the Greek for lack of appetite or avoidance of food (Blinder & Chao, 1994). Although lack of appetite is a misnomer, people who have anorexia nervosa do avoid food. They are quite thin- too thin-and they want to be thinner. In fact they think they are fat and have an intense fear of gaining weight or becoming fat. It is common for individuals with anorexia to deny the seriousness of low body weight.

What, exactly, is anorexia nervosa? Most people have heard of anorexia, but it is important to know the criteria used to determine if a person has this eating disorder. *The Diagnostic and Statistical Manual of Mental Disorders*-IV-TR (APA, 2000a) provides the criteria for defining anorexia nervosa. The specific criteria used to define each kind of psychiatric or psychological disorder are contained

3.2.1.1. Diagnostic Criteria for Anorexia Nervosa:

A. Refusal to maintain body weight at or above a minimally normal weight for age and height, (e.g. weight loss leading to maintenance of body weight less than 85 % of weight less and 85 % of that expected, or failure to make accept weight gain during period of growth, leading to body weight less than 85 % of that expected.)
B. Intense fear of gaining weight and becoming fat, even though under weight.
C. Disturbance in weight in which once body weight or shape is experienced, undue influence of body weight or shape on self evaluation, or denial of the seriousness of the current low body weight.
D. In postmanarcheal female, amenorrhea, i.e. the absence of the at least three consecutive menstrual cycle.(A woman is considered to have amenorrhea if her periods occur only following hormones, e.g. Estrogen administration.).

When psychologist and Psychiatrist is assessing an individual for an eating disorder, it is appropriate begin with the criteria for the Anorexia, if the individuals does not meet these criteria, the next one who consider are those for Bulimia. Finally, the criteria fro the eating disorder not otherwise specified are used if the person does not meet the criteria for either Anorexia or Bulimia. It is clear that eating and body weight are issues of concern of all three of these eating disorder

3.2.1.2. Description of anorexia:

Like Jessica, most anorexics are young, white women who are outwardly compliant and high achievers in school. They are preoccupied with food; usually like to cook for others (Jessica didn't), insist that others eat their food, but eat almost nothing themselves. They lose from 15% to50% of their body weight, yet continue to see themselves as overweight. Like Jessica they are ambitious, perfectionist, and come from high achieving families. Preoccupation with body fat usually leads to a strenuous program of exercise- dancing, logging, calisthenics, or playing tennis. Excessively active and energetic behavior continues until their weight loss reaches a level that produce fatigue and weakness, making further activity impossible.

Whether the characteristics connected with anorexia precede the weight loss or are a consequence of starvation. For example, anorexic women often display some hostility toward their mothers. But whereas many anorexics exhibit an increase in hostility before their excessive dieting, for others the mother daughter friction seems to revolve around the daughter's lack of concern over weight loss that the mother considers alarming.

A second characteristic that may either precede or follow dieting is *amenorrhea*, cessation of the menses. Because the attainment of a given percentage of body Ft is necessary for menstruation, post pubescent women develop amenorrhea if they lose enough weight. However, cessation of the menstrual cycle often precedes dieting (Neuman& Halvorson, 1983). This somewhat puzzling event reinforces the view that simple explanations of anorexia nervosa are inadequate and that complex factors are related to both the causes and the course of the disorder.

After substantial weight loss occurred, individual differences tend to disappear; accounts of the disorder itself are remarkably similar. Interestingly, most of the descriptions are also consistent with the sketch of starving conscientious objectors drawn by Keys et al. (1950). Thus, these conditions are probably an effect of starvation and not its cause. As weight loss becomes more that 25% of one's previous normal weight, the person constantly feels chilled, grows a soft, downy covering of body hair, loses scalp hair, loses interest in sex, and develops an unusual preoccupation with food. As starvation nears a perilous level, the anorexic becomes more hostile toward family and friends who try to reverse the weight loss.

Many authorities, including Hilde Bruch (1873, 1978, 1982), have regarded anorexia nervosa as a means of gaining control. Bruch, who spent more than 40 years studying eating disorders and the effects of starvation, reported that prior to dieting, anorexics typically are troubled girls who feel in capable in changing their leaves. These young women often see their parents as over demanding and absolute control of their life, yet they remind to complain to rebel openly. They try to seize control of their life in the most personal manner possible: by changing the shape of their bodies. Short of force-feeding, no one can stop these young women their own body size and shape. They take great pleasure and pride in doing something that is difficult and often compare their superior willpower with that of others who are overweight or who shun exercise. Bruch (1978) stated that anorexics enjoy being hungry and eventually regard any food in the stomach as dirty or damaging.

Becky Thompson (1994) has taken a somewhat different view, holding that women often use eating as a way to cope with problems in their lives. Thompson proposed that explaining anorexia as an extension of fashion -consciousness is demanding to women, trivializing the problems that prompt eating disorders. In interviewing and treating a verity of women from many ethnic backgrounds, Thompson concluded that physical, psychological and sexual assaults on women are among the factors contributing to eating problems.

3.2.1.3. Who Is Anorexic?

Anorexia nervosa cuts across cultural boundaries (Steinhausen, Winkler, & Meier 1997), but it remains somewhat more prevalent among upper-middle-class white women in North America and Europe. In terms of incidence most clinicians and researchers believe that anorexia has become more common in United States then it was 40 years ago, but Anorexia Nervosa is still a very rare disorder one estimate (Hoek, 1993), placed the incidence of Anorexia at about 8 for every 1,00, 000 people per year. However among some populations incidents rates are much higher. Young women between the age of 15 to 19 are at elevated risk (Lucas, beard, O'Fallon, & Kurland, 1991, Steinhausen, et al. 1997), and young women who attended ballet classes or modeling academics are at especially high risk, the competitive, weight conscious atmosphere of professional school for dance and modeling promote their development of Anorexia, and 6.5 % of dull students and 7 % of modeling students made the diagnostic criteria for Anorexia Nervosa (Garner & Garfinkel, 1980). Athletics

competition is also a risk of Anorexia and Athletes weight with eating disorder can be found in programmes for all sports, even though they do not emphasized appearance and overly thin body (Thompson & Shareman, 1993). In addition, women who participate in study about eating disorder may be more likely to have such disorder and there absence lowers the frequency estimates below the actual number (Beglin & Fairburn, 1992). Analyzing a number of studies that used different methodologies led to the conclusion (Hsu, 1990), that the prevalence of Anorexia Nervosa in all women in the United States and Western Europe is between 0.7 % and 2.1 %. Over the years Anorexics have tended whelmingly to be women and research and treatment have focused on women. Men make up about 5 %t to 10 % of all Anorexics (Garfinkel & Garner, 1982). These estimates that 90 % to 95 % of all Anorexics are Women – has remind constant over a period of years but it is based on mostly on clinical impression and incomplete empirical data.

Male Anorexics are quite similar to female Anorexics in social class and family configuration, symptoms, treatment and prognosis as well as in the behaviors and personality characteristics before the onset of Anorexia (Crisp & Burns, 1990), but men are less likely then women to receive a diagnosis. In addition gay men are slightly Overrepresented among the Anorexics but sexual orientation probably nor important factor in Anorexia among men, indeed, one recent study (Carlat, Camarlgo, Herzog, 1997), found that more than half of male Anorexics identified themselves as sexual, a finding consistent with lose of sexual interest among female Anorexics.

3.2.2. Bulimia Nervosa:

Bulimia is often regarded as companion disorder to Anorexia Nervosa. Like Anorexia, Bulimia affects mostly women and often centers on maladaptive attempts at weight control. Unlike Anorexics, who rely mostly on strict fast to lose more and more weight, Bulimics engaged in Binged Eating, that is they consume hung quantities of food in an uncontrolled manner as defined by the fourth edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM- IV) of the American Psychiatric Association (1994) bulimia nervosa involves recurrent episodes of binge eating, a sense of lack of control overeating and inappropriate, drastic measures to compensate for binging. Some bulimic fast or exercise excessively but most used self induced vomiting to maintain to relatively normal weight. Binge eating may occur without any attempts to purge, but this pattern does not meet the DSM-IV criteria for bulimia.

The seemingly bizarre practice of binge eating followed by purging is not new. The ancient Romans sometimes indulged in very similar eating rituals. After they had feasted on great quantities of rich food, these Romans would retire to the vomitorium, empty their stomachs, and then return to eat some more (Friedlander, 1968). The ancient Romans were neither the first nor the last to binge and purge, but theirs was perhaps the only society to have elevated this practice to such a refined state. Today, millions of women (and a smaller number of men) continue this custom of bingeing and purging as a means of controlling weight.

3.2.2.1. Diagnostic Criteria for Bulimia Nervosa:

A. Recurrent episodes of binge eating. An episode of eating is characterized by both of the following:
    1) Eating, in discrete period of time (e.g., within any 2-hour period), an amount of food that is definitely larger than most people would eat during a similar period of time and under similar circumstances.
    2) A sense of lack of control over eating during the episode (e.g. a feeling that one cannot stop eating or control what or how much is eating).
B. Recurrent inappropriate compensatory behavior in order to prevent weight gain, such a self-induced vomiting ,misuse of laxatives, diuretic, enemas, or other medications, fasting or excessive exercise.
C. The binge eating and inappropriate compensatory behaviors both occur, on average, at least twice a week for 3 months.
D. Self-evaluation is unduly influenced by body shape and weight.
E. The disturbance does not occur exclusive during episodes of Anorexia Nervosa.

3.2.2.2. Description of Bulimia:

In many ways, Elise, our second case study, was not typical of people with bulimia, but in other ways she was. Like most other bulimics, she began purging as part of a diet. The common pattern of bulimia involves binge eating compensated by fasting, with this pattern developing into one of vomiting or laxatives abuse or both as methods of purging. Unlike most

bulimics, Elise's binges were never a central part of her eating problem, but her purging behavior was. Like most bulimics, Elise felt guilty about her bingeing and purging and after several years, managed to end this cycle.

Depression is a frequent correlate of bulimia, but some authorities question whether it is a cause or an effect. One study (Pope & Hudson, 1984) reported that half the bulimic women had been depressed for a year or more before the onset of bulimia. Whether depression causes the bulimia or bulimia causes the depression is still unknown, but the majority of bulimics experience depression.

A second correlate of bulimia is a history of alcohol or drug abuse. Research suggests that other people to have serious problems with alcohol (Cauwells, 1983; Garfinkel & Garner, 1982; Pope & Hudson, 1984). In addition, binge eaters have higher rates of substance abuse, drunkenness, marijuana use, and cigarette use than the population at large (Holderness, Brooks-Gunn, & Warren, 1994). Like many college students, Elise's alcohol use was not always wise, but her into serious trouble, and except for laxatives, she dint misuse drugs.

Another behavior more common among bulimics than among the general population is *Kleptomania* , the compulsive stealing of unneeded items. Although most kleptomania bulimics steal food and laxatives-items related to their bingeing and purging-they may also pilfer such items as alcohol, clothing, cosmetics, and jewelry. in other words, although bulimia is an expensive habit and some bulimics steal to obtain food, a disproportionate number seem to take items that have no relationship to food or to their bingeing (Pyle, Mitchell, & Eckert, 1981).

Childhood experience with sexual abuse, physical abuse, and posttraumatic stress are additional correlates of bulimia (Dansky, Brewerton, Kilpatrik, & O'Neil, 1997; Welch, Doll, & Fairburn, 1977). A disproportionate number of female bulimics have been victims of sexual abuse during childhood. Stephen Wonderlich's team of researchers (Wonderlich, Wilsnack, Wilsnack & Harris, 1996) surveyed a nationally representative sample of bulimic women and reported that nearly of bulimic women and reported that nearly one-fourth of all female victims of childhood sexual abuse displayed bulimic behaviors later on. Wonderlich et al. called childhood sexual abuse a significant risk factor for bulimia and estimated that a substantial fraction (one-sixth to one-third) of bulimic behavior in women is attributable to childhood sexual abuse. A later review of more than 50 studies (Wonderlich et .al, 1997) showed that childhood sexual abuse is more closely associated with bulimia then it is with anorexia. Although not all Victims of childhood sexual abuse become bulimic and not all the bulimics are victims of childhood abuse, there is a relationship between the two.

Perhaps as a result of depression, a substantial number of bulimics attempt suicide. Two studies (Garfinkel & Garner, 1984; Pope &Hudson, 1984) found that between 20% and 33% of bulimics in treatment had made at least one serious suicide attempt. Because many suicide attempts are not successful, one might guess that bulimic women are not deadly serious. However, bulimia remains a largely hidden disorder, and the possibility exist that many young women who kill themselves were secretly suffering from bulimia.

Another characteristic of bulimia is a close relationship with food. One study (Lehman & Rodin, 1989) revealed that bulimics derive a greater percentage of their self-nurturance from food than from any other source. However, while treating themselves with food, bulimics frequently criticize themselves harshly. In addition, they tend to react more strongly to negative events and to experience sustained negative reactions that interface with effective coping. These findings painted a picture of bulimic's as people who use food for comfort. Because bulimics experience many negative feelings and have difficulty coping with the negative experiences in their lives, they have a great need for comfort.

Elise felt a lot of stress in her life when she started purging, and her life centered on controlling her eating. When she ate more than she thought she should (and her criteria were very strict) she would vomit or take laxatives. Indeed, she often took laxatives in anticipation of eating and feared her stomach being full for long. Unlike most bulimics, Elise dint plan eating sprees in advance or collect special types of food for her binges. Also unlike most bulimics, she was not completely secretive about vomiting or laxative abuse. On other hand, Elise was like many other bulimics in her continued belief that she was too heavy. She thought that if she could weigh less than 100 pounds, she would be happier. This continued dissatisfaction of one's body reflects the distorted thinking that is even more typical of bulimics than of anorexics (Cash & Deagle, 1977).

3.2.2.3. Who is Bulimic?

In at least one way the population of bulimics is quite similar to that of anorexics. Both eating disorders occur far more often in women than in

men, with about 90% to 95% of both groups being women (DSM IV, American Psychiatric Association, 1994). In other ways, however, the two populations differ. Although anorexia nervosa is spreading to all social classes and ethnic groups, upper middle- and upper class whites are still overrepresented. Bulimia however is a more democratic disorder. Its prevalence seems to be about equally spread throughout the various social classes, although firm evidence for this assumption is still lacking.

How prevalent is bulimia? is its incidence increasing or decreasing? Early surveys generally found high prevalence rates, much higher than the rates for anorexia. Tow investigations of college students in the 1980's (Halmi, Falk & Schwartz, 1981; Pyle et .al., 1983) found that between 8% and 13% of women met the DSM III criteria for bulimia and that 1.4% of the men was bulimic. Similarly, a survey conducted in a shopping mall (Pope, Hudson, & Yurgelun-Todd, 1984) yielded an estimate of 10.3% of women with binge eating and a fear of loss of control over eating.

However, the definition of bulimia has changed in later editions of the American Psychiatric Association's diagnostic and statistical manual of Mental Disorder (DSM). The 1980 edition of the DSM (DSM-III)-Which yielded prevalence rates around 10% for women-failed to include purging as an essential features of bulimia, defining it only in terms of bingeing. Although bingeing may be fairly common, bulimia is not widespread according to the definitions in DSM III-R (1987) and DSM IV (1994). These stricter definitions, which include fasting, excessive exercising, or purging as method of compensating for bingeing, have generally led to decreased estimates if the prevalence of the disorder. More recent studies (Hoek 1993;

pemberton, Vernon, & Lee, 1996) reflect these stringent criteria, yielding low estimates of bulimia. Around 1% of women and about 0.2% of men meets the current definition of bulimia.

Is prevalence of bulimia on the decreased? One review (Fairburn, Hay, & Welch, 1993) noted not only higher rates of bulimia in younger women but also higher lifetime occurrence. That is, women born after 1960 were at higher risk to have ever been bulimic than women born before 1950, indicating that the prevalence of bulimia is increasing. This estimate held that between 0.5% and 1% of young adult women are bulimic, but this may be an underestimate. Perhaps as many as 10% to 15% of college-age women have engaged in binge eating on a regular basis, but with the revised criteria of the DSM IV, the rate for young women has dropped to about 1% to 3%.

3.3. Obesity:

There are considerable controversy among nutritionists as to obesity can be classified as an eating disorder. The problem is that people whose weight is 'normal' often eat erratically, sometimes putting on weight, sometimes losing weight. Recently a study was made of over 5000 food choice at various restaurants, snack bars, and cafes. The conclusion of the study was that the major influence on how much people ate was *where they ate,* and that obese people had as wide a range of eating behavior as 'normal' people. On the other hand many researchers have shown that obese people choose to eat more food and eat it more quickly than non-obese people. Other researchers have argued that obesity, and particularly

severe (or morbid) obesity, occurs in people with a psychiatric problem. However, a study of severely obese people in United State showed that anxiety, depression, low self esteem, and poor body image reported by severely obese people were a result, rather than a cause, of their obesity. The study added support to the theory that severe obesity is a habitual disturbance of eating. The experience of nutritionists who try to induce severely obese people to lose weight also suggests that obesity is an eating disorder.

3.4. Effects of eating disorder:

3.4.1. Physical effects:

The physical effects can be serious, but are generally reversible if the illnesses are tackled early. If left untreated, severe anorexia and bulimia can be life-threatening. Responding to early warning signs and obtaining early treatment is essential.

Both illnesses, when severe, can cause: harm to the kidneys; urinary tract infection and damage to the colon; dehydration, constipation and diarrhea; seizures, muscle spasms or cramps (resulting form chemical imbalances); chronic indigestion; loss of menstruation or irregular period; and strain on most body organs.

Many of the effects of anorexia are related to malnutrition, including: absence of menstrual period, severe sensitivity to the cold, inability to think, reason and concentrate. Severe bulimia is likely to cause: erosion of dental enamel from vomiting, swollen sallively glance, the possibility of the ruptured stomach and chronic sore throat and gullet.

3.4.2. Emotional and psychological effects:

In emotional and psychological effects include: difficulties with activities which involves food; loneliness due to self impose isolation and a reluctance to develop personal relationship; deceptive behaviors relating to food; fear of the disapproval of others if the illness become known, tinged with the hope that family and friends might intervene and provide assistance; and mood swings, changes in personality, emotional outbursts or depression.

3.5. Causes of eating disorder:

In spite of a considerable amount of research in the past three decades on consensus has been obtained to answer the question: Why do some adolescents have an eating disorder? Three explanations have been advanced, but none of them has been proved conclusively. They are (1) the developmental and learning theory explanation; (2) the social explanation; (3) the psychological explanation. These theories are not mutually exclusive and referring to more than one may give a closer explanation.

3.5.1. The developmental and learned theory explanation:

From the earliest days of its life the quality of care a mother gives to her baby, and the love she lavishes on the baby, are related at least indirectly to the amount of fat covering its body. A chubby baby is seen by the mother and her neighbours as a well-cared-for baby. In childhood, too, the provision of substantial amounts of food, often rich in refined carbohydrates and fat, is seen as a way of showing love for children, as well as an ensuring that

they are adequately nourished. In our culture, which has an abundance of food, children learn to increase progressively the amount of food they eat, and often increase the quantity of energy they ingest beyond that needed for growth, body functions, and the demands of exercise. In the three years before puberty, a biological spurt of growth occurs, and the food intake is increased still further.

Studies, have shown that in boys the energy requirements for growth, and the spurt in growth, occur at about the age of 15, and because boys increase their muscle mass after this age, additional energy continues to be needed the growth spurt in girls occurs between the ages of 12 and 14, earlier than that of boys, and the girl's energy requirements peak over the same period. By the age of 16, the girl's energy requirements have fallen considerably, as girls do not increase their muscle mass like boys. If the girl continues to eat the quantity of food she ate in early adolescence obesity is inevitable. As she becomes increasingly aware of her body weight, she learns that she becomes increasingly aware of her body weight, she learns that she can control weight gain either by dieting or by using other measures which will help her to stop her absorbing the food she eats. On the other hand, some adolescents may reject the need to control their weight and may enjoy eating, while limiting the amount of energy expended in exercise. Inevitably this will lead to obesity. Some of the adolescents who diet and control their weight successfully may become so concerned about food and about weight control that their eating behaviour escapes from what is considered 'normal' and they decide to pursue thinness- becoming anorexia

nervosa victims. Some of those who diet unsuccessfully either develop bulimia nervosa or become obese.

3.5.2. The social explanation:

In Western culture two contrasting messages about food and eating are offered by society, and particularly by the media. The first message is that a slim woman is successful, attractive, healthy, happy, fit, and popular. Canadian teenagers for example, believe that being slim will help them to be chosen for a good job, find a boy-friend, be popular with their peers, be and look fit and healthy, and get on well with their family (provided that most of the family is overweight or obese). To become slim, with all that this implies, is deemed to be a major pursuit of many women. The second massage is that eating is a pleasurable activity which meets many needs, in addition to relieving hunger, and women have a right to have these needs met. In women's magazines these two contrasting messages tend to appear inextricably mixed. In nearly every issue the magazines publish 'exciting' new diets which 'guarantee weight loss with minimum discomfort or motivation', and these diets are often followed by recipes for, and superb photographs of, luscious cakes and foods with rich sauces. It is difficult to watch television without being confronted by an advertisement, or its equivalent. The social (and usually family) pressures are also contradictory: you must eat everything other people give you but you must not get fat.

The provision of food is seen in our culture as a major sign of caring and sharing food at a meal is seen as one of the prime social contacts. These cultural imperatives place a burden on a mother to provide abundant

quantities of food, and on her loving daughter or son to eat that food. It is not surprising that in the face of the psychological bombardment of two contradictory messages, most young women diet. Some become 'foodaholics' and develop *bulimia nervosa*. Others become preoccupied with food and the avoidance of weight gain, developing *bulimia or anorexia nervosa.* Some decide that dieting is too disturbing to their way of life and return to eating more food that they require, becoming *obese.* These women may also find obesity protective against acceding to current social attitudes to sexuality, which they fear. Hidden in a fat body, they give the message that they are not attractive and do not want to form a sexual relationship.

3.5.3. The psychological explanation:

Because eating is such a basic instinct it has been postulated that those people who suffer from an eating disorder have an identifiable personality, being more obsession or neurotic than normal eaters. The *Oxford textbook of psychiatry* defines personality as 'enduring qualities of an individual shown in his or her ways of behaving in a wide variety of circumstances'. Some studies, using personality questionnaires, suggest that some women suffering from anorexia nervosa are indeed more 'neurotic' or 'obsessional' that women whose weight is in the 'desirable range'. The studies also suggest that those women who have lost weight by dieting and excessive exercise are more introverted, more anxious, and more dependent that women whose weight is normal or women with anorexia nervosa who use self-induced vomiting and purgation as methods of losing weight. No distinctive personality profiles are available for women who have bulimia nervosa or obese women.

The American Psychiatric Association has suggested a further sub-group of personality disorder which they term a 'borderline personality disorder'. For this diagnosis to be made, the person must have at least five of the following eight features: unstable relationship; impulsive behaviour that is harmful to the person (including spending, sex, substance use, shop-lifting, reckless driving, and binge-eating); variable moods; undue anger or lack of control of anger; recurrent suicidal threats or behaviour; uncertainty about personal identity; persistent feelings of boredom; and frantic efforts to avoid real or imagined abandonment. This definition may cause diagnostic problems. For example, does a young male, living in a slum neighborhood, who shop-lifts, steals cars for joy-riding, has undue anger and is often in fights, has an unstable relationship and persistent feelings of boredom, have a personality disorder when, in his culture, these behaviors are so common that they are considered normal. This suggests that a major problem in expecting the concept of border line personality disorder is that it is impressive and can depend on environmental and socio-cultural influences.

Women who are in the usual age group for diagnosis of an eating disorder may have several of the features required for the diagnosis of a border line personality disorder. However, in women with an eating disorder some of the feature are due to the bio-chemical and psychological changes resulting from the eating disorder- for example , variable moods and feelings of chronic boredom..

Other psychological explanation has been suggested, one of which is the concept that the some obeys women use eating as a substitute for

love. A person who feels lonely, empty, and unloved unless she has a constant company may eat to compensate. The emptiness of the life is the soothed if she takes food to fill her empty stomach. The most she eats the more complete and full (or fulfilled) she feels. Food and particularly beverage such as milk or bear, become mainstays of a life, suppressing lack of self esteem and providing satisfaction. As she becomes increasingly obeys, she develops a need to remain obeys and show avoid the resurgence of her feelings or inadequacy.

Furthermore, according to the personality defect theory, some women suffering from anorexia nervosa have a fear of growing up "and of becoming physically and sexually mature. By avoiding eating, the women's body contours becomes those of the prepeburtal child, her menstrual periods either do not start or ceases, she is able to withdraw from the social occasions which make her ill at ease and anxious and is able to deny her sexuality. This explanation may apply to few anorexia nervosa patients but in most cases of eating disorders the concept does not apply.

From this is follows that although psychological factors may be involved in explaining why individual patients who have an eating disorder persists with their eating behaviour, no single psychological explanation is available.

3.6. Treatment:

3.6.1. Treatment of Anorexia Nervosa:

Anorexia has a much higher mortality than bulimia making successful treatment a matter of life or death for some anorexics. Nearly 6% of all anorexics died from their disorder (Neumarker, 1997) most die of cardiac

arrhythmia, but suicide is also a frequent cause of death, despite the very real possibility of death, anorexia nervosa reminds one of the most difficult behavior disorder to treat because most anorexics see nothing wrong with their eating behavior, recent suggestion that there are two thing and resist any attempt to change their eating. Therefore, parents and friends have great difficulty motivating anorexics to seek treatment. Sort of force, family and friends have few options. The one aspect of the environment the anorexics can control is their own body. As long as they refused to eat, their control women sovereign.

As starvation continues, anorexics eventually reach the point of fatigue, exhaustion and possible physical collapse. At the point some sort of treatment is usually force on them. After two years of self imposed starvation and weighting only 52 pounds, Jessica was focused by her parents to seek her treatment. She was then hospitalized and fed intravenously.

The immediate aim of almost any treatment program for anorexia is medical stabilization of any danger due to physical symptoms of starvation (Goldner & Birmigham, 1994). After that anorexics need to work towards restoration of normal weight, healthy eating and good body image. Recommendations concerning the methods of achieving these goals are not universally accepted. Some believe that hospitalization is required, especially for medical stabilization and restoration of weight, but others have found little evidence to support the need for impatient treatment (Hsu, 1990). Weight restoration is an important step in the treatment in anorexia, but anorexics resists attempts to that them to eat. Tube feeding and

intravenous feeding can provide methods of forcing nutrient intake, the force-feeding may be undesirable because it deprives the patient of control and impede the growth of a trusting relationship between therapist and patient.

Weight restoration is a step in therapy but is not a cure for anorexia nervosa and anorexics need to change their body image as well as their eating habits.

Most therapists recommend that both family therapy and individual therapy accompany weight- gain programs (Bloom, Kogel, & Zaphiropoulos, 1994, Goldner & Birmingham, 1994). This recommendation for family therapy seems sound, because both psychotherapy (Kog & Vandereycken, 1985) and sexual abuse (Thompson, 1994, Wonderlich, Brewerton, Jocic, Dansky, & Abbott, 1997) are common in the family experiences of anorexics. For these reasons, most treatment programs are designed to change the anorexic's social environment, her attitude toward herself, and her distorted view of her body.

Behaviour modification has sometimes been used to promote weight gain (Hsu, 1990), but this procedure is not often oriented towards changing the maladaptive cognitions that accompany anorexia. Since the mid-1970s, cognitive behaviour therapy has become increasingly popular as a treatment for anorexia nervosa, and it has shown some success in both changing eating behaviour and eating conditions. Practitioners of cognitive behavior therapy recognize that the pleasure and gratification derived from the effects of self starvation act as potent reinforces for anorexics eating habits (Garner, Garfinkel, & Bemis, 1982). They attempt to change anorexic's faulty thinking

patterns and their erroneous beliefs, which extend beyond matters of weight and body image. Cognitive behavior therapists attack these irrational beliefs while maintaining a warm and accepting attitude towards patients. Anorexics are taught to discard the absolutist, all-or-one thinking pattern expressed in such self-statements as "If I gain one pound, I'll go on to gain a hundred." Patients are also encouraged to stop centering all attention on them and to realize that others do not have the same high standards for their behavior that they do. Finally, therapists need to point out the errors in superstitious food beliefs such as "Any sweet is instantly converted into fat" or "Laxatives prevent the absorption of calories" (Thompson & Sherman, 1993). When patients understand the superstitious nature of these beliefs, they can become more realistic about the effects of food on body composition.

In general, cognitive behavior therapy has been more successful with anorexia nervosa than psychoanalytic approaches. Indeed, therapists who use psychoanalytic framework need to be careful to avoid the sexist bias that often accompanies this approach (Bloom, Kogel, & Zaphiropoulos, 1994). However, no treatment offers a high rate of successes. A number of studies (Eckert, 1983; Garfinkel, Moldofsky, & Garner, 1977) have found some long-term benefits of cognitive behavior therapy, especially when a benefit is defined in terms of weight gain.

Relapse always remains a possibility. Some patients gain weight while hospitalized but have no intention of retaining it subsequent to release. Anorexics who have attained normal weight may not attained normal attitudes toward food and eating (Hsu, 1990). Many hospitalized patients gain weight because they know that doing so is a prerequisite for hospital

discharge, few anorexics learn to eat normally. Some slip back to self-starvation, other attempts suicide, some become depressed, and some develop bulimia (Goldner & Birmingham, 1994; Hsu, 1990). Similarly, review of the outcomes for male and female anorexics (Burns, Crisp, 1990) showed that anorexics often gain enough weight during to the normal weight range but about 50 % relapse or develop adult psychological or eating related problems about 20% remains underweight despite extensive treatment also, this review found that about 5% of anorexics die and that death becomes even more likely where eating disorder persists for 4 years or longer.

After being hospitalized, Jessica became convincer that continuous self starvation threatened her life with almost no physical or psychiatric intervention, she gradually

3.6.2. Treatment of bulimia:

In one important respect, the treatment of bulimia has a critical advantage over therapy programs for anorexia nervosa. Anorexics cling to their dangerous eating behaviors, but bulimics usually do not approve of their own eating habits, and many of them would like to change. Unfortunately, this motivation does not guarantee that bulimics will seek therapy. A perception that their eating is far from normal can keep bulimics judged the eating patterns of normal people to be at great variance from their own eating, but they were mistaken,. The eating patterns of normal people deviate greatly from the standards, and this unrealistic perception of eating patterns they must achieve to be normal may be one factor that prevents people with eating disorders from seeking treatment.

The immediate aim of treatment for bulimics is a change in eating patterns, but other long-term goals must also be included. For example, one therapy (Boskind-White & White, 1983) aims to change client's attitudes towards themselves relies heavily on intensive group therapy, with the emphasis on helping clients gain control over their whole life, not just eating habits. In addition, clients are encouraged to set reasonable rather than idealistic goals. Most bulimics set goal of "never again," but this goal is a near guarantee of failure because slips are likely to occur. Total bingeing often follows one lapse, especially for perfectionist who set an unrealistic goal of unrealistic goal of complete abstinence.

In addition to group therapy, cognitive behavior therapy is common in treatment of bulimia (Agras, 1993). Cognitive behavior therapists can suggest a variety of techniques to their clients, such as keeping a diary on their feeling after purging; monitoring their caloric intake and purging; eating slowly; eating regular meals; clarifying their distorted views of eating and weight control; and undergoing a procedure called *exposure plus response prevention.* In exposure plus response prevention, therapists require bulimics to eat a great deal but then prevent them from vomiting. Some researches (Hsu, 1990; Wilson, 1989) advocate the use of exposure plus response prevention, but others believe this technique may not significantly increase the effectiveness of cognitive behavioral programs (Compas, Hagga, Keefe, Litenberg, & Williams. 1998). A review on the effectiveness of cognitive behavioral treatment for bulimia (Compas et ala., 1998) found that the average reduction in the frequency of binge eating was 80%, an unusually high percentage of success for any type of therapy.

Interpersonal psychotherapy has also been used successfully in treating bulimics (Agras, 1993). Interpersonal psychotherapy is a no introspective, short term therapy that was originally applied to depression. It focused on present interpersonal problems and not on eating, taking the approach that eating problems tend to appear in late adolescence when interpersonal issues present major development challenges. In this view, eating problems represent maladaptive attempts to cope. The success rate of interpersonal therapy is comparable to cognitive behavioral therapy (Agars, 1993), but it may not provide additional help for people with binge eating disorder who failed to respond to cognitive behavioral therapy (Agras et.al.,1995).

Drugs, especially antidepressants, have been used for some time in the treatment of bulimia. Controlled studies using these drugs tend to show decrease in the frequency of binges, but drugs are not a substitute for psychotherapy for most patients (Mitchell & de Zwaan, 1993). Indeed, cognitive behavioral therapy is more effective than antidepressant drugs in managing bulimia, and drugs alone are not as good as choice as this type of psychotherapy (Compass et. al., 1998).

A combination of educational and cognitive psychology approaches can be effective in treating at risk women who have not yet developed bulimia (Kaminski & McNamara, 1996). The risks indeed for perfectionism, a history of repeated dieting, and other dysfunctional eating behavioral or attitudes, College women with such attitudes and behaviors were randomly assigned to receive no treatment or a 7 week treatment consisting of educational information about realistic weights and healthy eating habits as well as cognitive strategies for enhancing self-esteem, challenging

negative thinking styles, improving body image and combating social pressure for thinness. The treatment group showed significantly greater improvement in self esteem and body satisfaction than those in the control group and manifested fewer destructive dieting practices and less need for perfectionism. Results of this study are encouraging, suggesting that intervention can change the attitudes and risky behaviors that are symptomatic of bulimia before the appearance of the disorder.

4. Self-concept:

Thinking about oneself is an unavoidable human activity-most people are literally self centered. That is, the self is the center of each person's social universe. While as we indicate genetic factors play a role, once self-identity, or self concept, is largely based on what is learned in interactions with other people- beginning with immediate family members and then bodying to interactions with those beyond the family (Lau & Pal, 1999).

4.1. Self-concept- Basic Schema:

The self concept is an organized collection of believes and self perception about oneself in other words, it operates as a basic schema. The self provides a frame work that determines how we process information about ourselves including our motives, emotional states, self evaluation, abilities and much as decides (Klein, Loft, & Burton, 1989, van Hook and Higgins, 1988).and we work very hard protect our self-image from threatening information (sedikides & Green 2000), to maintain self-consistency (Tschanz &Rhodewalt, 2001), and to find excuses for any inconsistencies (Shlenker, Pontari, &Christopher, 2001).

Thus, people tend to resist change and to misconstrue or explain away information that is inconsistence with their self- concepts. Such defensive reactions are reduced when individual has unrelated, self-affirming experience. For example assume that a person places a high value on his or her sense of humor and is asked to write about or think about a situation in which being humorous had a positive effect. Afterward, that individual is more open to new information and less defensive about potentially threatening information about the self (Cohen, Aronson & Steele, 2000). In general, when attention is focused on some unrelated aspect of one's identity, the result is some more openness to information and less defensiveness. In a similar way, discovering that other people like you reduces defensiveness (Schimel et al., 2001).

4.2. WHAT MAKES UP THE SELF-CONCEPT AND HOW DOES IT FUNCTION?

Who are you? Before you read further, try to give twenty different answers to the question.

Questions such as "Who are you? "and "Who am I?" have been asked for more than a hundred years as psychologists beginning with William James (1890), have endeavored to determine the specific content of the individual self concept (Ziller, 1990).This technique was used by Rentsch and Heffner (1994) when they asked over tow hundred college students to give repeated answers to the questions "Who are you?" The basic content of the self, as perceived by these students, consisted of eight categories. Some of these refer to aspect of social identity (nationality, race etc.) and others refer to personal attributes (relationships, hobbies etc.).

Self-schemes are probably much more complex and detailed than can be determined by questions about who you are. Consider some of the possibilities. Beyond an overall framework, a self schema would include your past experiences, your detailed knowledge about what you are like now as opposed to in the past, and your expectancies about the changes you will undergo in the future. In other words, a self schema is the sum of everything a person remembers, knows, and can imagine about self or himself. A self schema also plays important role in guiding behaviour (Kendzierski &Whitaker, 1997). For example, the intention to lose weight is quite common, but the ability to link that intention to lose weight is quite common, but the ability to link that intention to mildly unpleasant behaviors (directing, exercising on a very hot day) requires a consistent guidance force. It helps to have a clear conceptualization of who you are now and who you want to be in the future. Otherwise, it is much easier simply to eat and drink whatever you want and avoid working up a sweat.

4.3. HOW IS THE SELF CONCEPT STRRUCTURED?

Though we each possess a self concept the content of this schema can be recognized in various ways. For example, self concept cab be relatively central or relatively peripheral (Sedikides, 1995). Central self conceptions are more extreme (positive or negative) than peripheral self conceptions. You might think of yourself as extremely bright and extremely attractive (Central) but only moderately good at math and moderately strong (peripheral). Would these self assessments can be affected by your mood? When research participants are induced to feel sad, neutral or happy,

peripheral self conceptions are influenced by the mood manipulation, but central self conceptions are not. In the example just given, even when you are very sad and you should continue to perceive yourself as bright and attractive, but you may devalue your math ability and your strength. It is more difficult to bring about change in central self conceptions than in peripheral ones because central self concepts are elaborated in greater detail, more strongly consolidated, and held with greater certainty.

4.4. SEXUAL SELF CONCEPT:

Self concept can also be divided on to specific content areas. For example, Andersen and Cyranowski (1994) have conducted research on sexual self schema - the cognitive representation of the sexual aspects of self. These investigators first studied women an d were able to identify three distinct types of sexual schemas.The research participants described themselves in terms of being passionate and romantic (warm, loving, sympathetic), open and direct (frank, outspoken, uninhibited) or embarrassed and conservative (cautions, self-conscious, timid). Further, the women's sexual attributes, emotional relations, and behaviour were based in the one specific schema that was most characteristic of them.

In many respects, men and women have similar sexual schemas. Both males and females reveal a primary dimensions involving passion and romance, and both describe themselves on a dimension that involves such concepts as open-minded and broad-minded. Two major gender differences were obvious. First many women have the quite negative schema of embarrassed/ conservative that suggests anxiety and guilt in

response to sex-men don not ordinarily respond in this way. Men have a schema based on behavioral traits involving aggression and power. This is not characteristic of women.

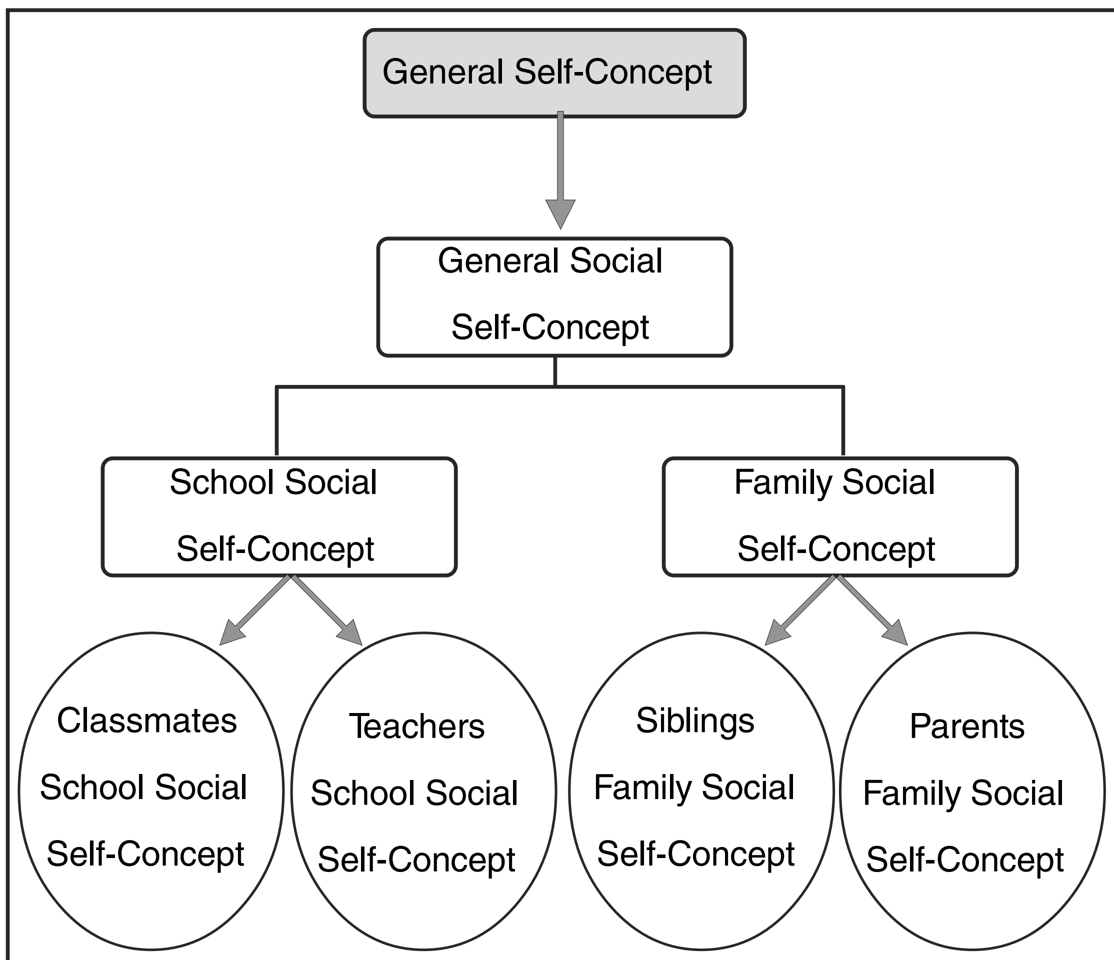
These findings can be summarized as suggestions that a major source of conflict in female sexualities centers on positive and negative reactions to sexuality for males, the conflict is between being passionate and loving on the same other hand and aggressive and domineering on the other.

4.5. SOCIAL SELF-CONCEPT:

In addition to the unique identity that is sometimes labeled the personal self concept, there are also social aspects of the self that we share with others (Brewer & Garner, 1996). It is not simplify that we form association for example, with a given ethnic group. Rather, the self concept is actually defined differently depending on our ethnic affiliation. Part of who we are and how we think of our selves is determined by collective identity that is the social self (as oppose the personal self). The social self, in turn, consist of two components: (1) that derived from interpersonal relationships and (2) that derived from belonging to larger less personal grouping such as racing, ethnicity or culture. Such relation and categories become part of self (Smith & Henry, 1996). Baumeinster and Learly, 1995) argued that the social self is based on fundamental "need to belong is genetically based characteristic of humans.

When we examine the role of interpersonal relationships in the self concept we necessarily consider a situational context in that a relationship includes someone else. For example, Byrne and Shavelson (1996)

categorized the social interaction of young people into those involving school and those involving family and these can be further categorized in terms of teachers and classmates, siblings and parents and so on. These investigation studied three age groups (preadolescents, early adolescents and late adolescents) and found that the social self concept becomes increasingly differentiated and better defined with age)



Social self-concept : Each persons overall self-concept is composed of many distinct components that provide schemas for specific aspects of one's life. One such component, social interaction, is shown here. For young people, this social self-concept can be further divided onto more specific categories such as social interactions at school and social interactions within the family. Within each, a further specification is interactions with

classmates versus teachers and with patents versus siblings. (SOURCE: BASED ON INFORMATION IN BRYNE & SHAVELSON, 1996.)

Because self concept develops in a cultural context, one would expect differences across cultures. Much of the research interest in cultural differences has centered on the effects of individualism versus collectivism on the self concept. Apparently unique to the western world is the norm prescribing that self interest is and ought to be a cultural determinant of one's behavior (Miller, 1999). In much of the rest if the world the emphasis is more on the welfare of the group than of the individual as one example, Kitayama and colleagues (1997) proposed that people rose in Western, individualistic cultures learn that everyday life involves opportunities for self-enhancement. In effect, the individual self-concept is more important than the social or collective self concept (Gaertner, Sedikides, & Graetz, 1999). In Eastern, collective cultures, however, everyday life provides opportunities for self-criticism and self improvement. Such improvement makes one a better member of the family and of other groups. For example Japanese college students are more self-critical than either European or Asian Canadians, but they are not as unhappy about discovering their deficiencies (Heine & Lehman, 1999).

The most general conclusion of these various cross-cultural findings is that a statement such as "Just be yourself" has different meanings in different cultures (Kanagawa. Cross, & Markus, 2001). A person raised in an individualistic culture assumes the request to mean that you should behave on the basis of a central set of characteristics, regardless of the situation, in a way that reflects one's unique, positive attributes. For someone

raised in a collectivist within the situation and self-critical orientation that helps one adapt to the situation. The difference is between a fixed and stable self-concept versus a changeable and evolving self-concept.

4.6. SELF-ESTEEM: ATTITUDES ABOUT ONESELF:

Probably the most important attitudes a person develops is the attributes about self. This evaluation of oneself is known as Self-esteem (jams, 1890). Thought there are a variety of measuring devices to assess self-esteem (e.g. Greenw & Farnham, 2000), the simplest involves just one item (Robins, Hendin, & Trzesniewski, 2001) "I have high self-esteem." You can respond to that statement on a five point scale ranging from 1 (not very true of me) to 5 (very true of me). Keep in mind the number that you think best describes your own evaluation as you read the following section. Think about the extent to which the research results apply to you.

Sedikides (1993) suggests three possible motives for self-evaluation. People may seek self assessment (to obtain accurate knowledge about themselves), self enhancement (to provide positive information about themselves) or self verification (to confirm what they already know about themselves).

Though we often speak of self-esteem as a single, global entity, it is common for individuals to evaluate themselves along multiple dimensions such as sports, academics, interpersonal relations, and so on. Overall self-esteem represents a summary of these specific evaluations (Marsh, 1995, Pelham, 1995a, 1995b).

Self-esteem is often measured as a rating along the dimension that ranges from negative to positive or low to high. A different approach is to ask respondents to individual what their ideal self would be, what their actual self is, and then examine the discrepancy between the two. The greater the discrepancy between self and ideal the lower the self-esteem. Even though the specific content may vary over the time, self –ideal discrepancy tends to remain stable (Strauman, 1996). It is pleasant to receive feedback that indicates awe are functioning at the ideal level in one some aspect of our live, and unpleasant to confront evidence that we are falling short of the ideal (Eisemstadr & Leippe, 1994).

A major source of information relevant to self-evaluation is other people – we judge ourselves on the basis of social comparisons (Browne, 1992, Wayment & Taylor, 1995). Depending on your particular comparison group, specific behaviour on your part may seem inadequate, average or extremely good. Two individuals whose sections are identical may have very different self-evaluations because they are comparing themselves to quite different groups. We'll use academic performance as an example.

5. Anxiety:

Anxiety occupies a focal position in the dynamics of human behaviour. It is a common reaction to frustration. Since anxiety is highly distressing, indeed one of the most intolerable psychic states with which the human organism has to deal, it demands some sort of adjustment which will afford relief. A large part of human adjustment is concerned with avoiding or relieving anxiety. Growing out of many frustrating situations, anxiety serves as the driving force for a large number of subsequent adjustments.

The mental distress of anxiety is the well known state of dread or apprehension, which may rang all the way from very acute terror or anguish, approximating pain in intensity, to mind states of vague apprehension or being ill at ease. When anxiety relates to a challenge to the personality of the individual, we speak of such states as embarrassment, confusion, feelings of inferiority and in a more special sense, guilt or shame. Probably all of these various anxious states may be though of as outgrowths of a more primitive startle reaction or fear.

5.1. Meaning and definition:

Anxiety may be defined as *mental distress with respect to some anticipated frustration.* It this sense, it is to be distinguished from the immediate response to frustration itself, which is reacted to with aggression, or the danger whish is reacted to with fear. Whatever the frustration is, it is recognized as dangerous because it will result in either pain or loss. The essence of human learning is that the individual shall acquire the capacity for recognizing by certain signs or cues, situations which promise to satisfy his needs or cause him harm so that he can anticipate them on some future occasion and thereby make ready to accept and use those that satisfy and avoid those which promise to frustrate. For example, a child may have his finger caught in the closing door. This produces a sharp pain which is reacted to by crying and feelings of range. The child associates his pain with the door, and particularly with its closing. On another occasion, he observes the door as it is closing, becomes afraid and is careful to see that his hand is not on the door's edge. If he has put his hand on the door's edge in order to close it, there is momentary anxiety which is the reaction

to the sign or signal of danger, that is, the possibility or probability of a future pain (or loss).

In the face of anticipated danger, there is not only recognition of the dangerous potentialities in the situation, but also an estimation of the person's strength or ability to adjust in comparison with the threat confronting him. When a person feels confident of his ability to cope with danger, anxiety is reduced to a minimum. A boy who has learned how to handle a sailboat and who feels confident of his ability to swim, would feel little or on anxiety in his first experience in handling a sailing canoe. On the other hand, if an individual feels incompetent or helpless in a situation, anxiety mounts to great heights. Another boy who has had little experience in managing a sailboat or who cannot swim might experience extreme anxiety in being called upon to take charge of a sailing canoe.

Anxiety is also a function of the extent to which the person himself is involved in the danger. If the anticipated danger is the bite of an insect, a scratch on the skin by a cat, or the loss of one's hat on a windy day, the anxiety, while real, will not be so intense as when the existence or safety of the person is threatened. Here, too, the threat that causes the most severe, anxiety may not necessarily be one that involves physical danger. The most acute anxiety arises when the individual feels that his personal adequacy or his existence in the group is threatened. He may fear the loss of his status as the only child in the family, or loss of his job and means of livehood or he may be threatened with failure in school. It should be recognized that behind the anxiety over a trivial frustration due to some minor loss, such as breaking a dish, or failing in an examination, lies the far greater threat to one's security in his relationship with other persons.

Probably the greatest threat to any individual Is that of extinction or separation from the world. We shall see later that the feat of separation causes the most pronounced anxiety in the infant, and fear of social ostracism, losing one's standing with others, losing one's power and capacity to enjoy, give rise to the most profound anxieties to most individuals throughout life.

5.2. Fundamental Considerations:

Anxiety is usually recognized as an under durable form of suffering. Almost as poignant as pain itself, it is a distressing state of affairs which demands relief. It would surprise most persons to realize how much behaviour is motivated by a desire to escape anxiety by either reducing it or distinguishing it in one way or another. Anxiety spoils pleasure and takes the edge off enjoyment of the common affairs of life. Most persons will go to any length, not excluding self-construction, to gain relief from anxiety.

Zinn tells the story (not verified as true) of mountains climber who felt uneasy in treacherous places because of his inexperience. All members of his party had traversed a narrow ledge, along the side of high cliff. This man held back because of his anxiety, and finally, when it became his turn to edge along the narrow footing, his anxiety became so acute, that to escape from the dilemma, he leaped to his death.

The search of relief from anxiety, then drives a person to take extreme measures, if need be.

5.3. Reduction of Anxiety—Reward:

As in case of all drives reduction of the drive through experience serves as reward. Just as hunger, as drive, is reduced by the ingestion of food, so the reduction of anxiety serves as a reward and hence as reinforcing factor in learning, as defined but the law of effects. If the anticipation of any punishment is thought of as arousing a small but of anxiety, then escape from punishment serves to reduce anxiety and hence serves an reward. On this basis can be explained the acquisition of various forms of inhabitation, withdrawal, and repression. When an individual withdraws or inhibits some behaviour for which punishment is anticipated, the anxiety over the anticipated punishment is reduced, and this serves as a reward, which results in learning, so that the next time this same situation arises, the inhibition is more surely and readily made. In this same connection, anxiety is the force behind repression.

5.4. Anxiety is learned:

Anxiety is not an instinctive or natural response, although the psychological reactions underlying anxiety is part of man's hereditary legacy. Since anxiety is a response to the anticipation of danger, it must have been learned from the actual experience of danger situations, the recognition of cues to signal their approach on subsequent occasions, and the transfer of the emergency reaction to these signals rather than tot eh events themselves. Anxiety is acquired to a large extent through identification or simple imitation. A child may find that it pays him to be afraid of the same things that other people are afraid of, and this applies

not only to fear of immediate danger but also to anxiety at its anticipation. Anxiety can be passed on from parents to child. Anxiety in a parents breeds anxiety in children, an anxious mother is almost certain to have tense, worried, nervous children. The anxious child will usually be found to have come from as insecure home.

5.5. Anxiety a Psychosomatic Event:

The precise relation between the motor response, the psychological response, and the felt emotion has simulated much speculation among psychologists and psychologists. The naïve point of view is that we run because we are afraid. According to the James Lange theory, we are afraid because we run. Actually, the process is a single psychosomatic event resulting from the danger situation and can be only separated into parts by our analysis of it. When danger parents itself or threatens, the organism prepares itself danger for an emergency reaction. Our felt emotion is probably, in large measure, our awareness of this internal readjustment. These inner adjustments are followed by the motor response or the continued postural tension. Anxiety therefore is not an epiphenomenon attached to a response to danger as something supererogatory but is the awareness of the inner preparations for the responses that one makes to the anticipated danger. However, anxiety cannot be defined solely in terms of the psychological. Anxiety is a psychological phenomenon and must be discussed in terms of the dangerous situation and the availability of adequate methods for coping with it.

5.6. How anxiety is expressed:

5.6.1. Physical Symptoms:

Anxiety shows itself by a number of well-defined physical symptoms. When these are tabulated, it seems clear that they represent the psychological reactions characterizing the activity of the sympathetic nervous system. Most frequent these symptoms indicate that the sympathetic reaction has been stimulated, but sometimes the reverse behaviour indicates a collapse of sympathetic response. In the first place, there are the cardiac disturbances, such as palpitation of the heart, a rapid heartbeat, or, on the other hand, a feeble pulse. Sometimes pain around the heart has a functional origin related to anxiety states. Some have seen a close connection between this relationship and the fact that at birth one of the major adjustments has to be the intention of breathing. In anxiety one may observe rapid breathing or the heaving of deep sighs. Sometimes anxiety is characterized by a feeling of suffocation or by choking sensations, or in extreme fright by the cessation of breathing itself. In the third place, there are alimentary disturbance in anxiety. Hunger frequently alternates with loss of appetite. Indications that the digestive process is reversed may be found in nausea or vomiting on the one hand, or diarrhea on the other. Fermentation, which frequently results when digestive processes are retarded, may show itself by belching or by colitis.

5.6.2. Sleep Disturbances:

Anxiety shows itself with particular force during the night and expresses itself in various forms of sleep disturbances. Insomnia is a frequent sign of anxiety. The anxious child may toss for hours unable to go

to sleep, or the sleep may be restless and fitful. Anxiety may also show itself in sleep-walking, talking, or in nightmares. Children may scream out in their sleep or partially wake with heavy sobs. On a simple level these sleep disturbances may represent fear of being deserted by the mother or of losing the parents love.

5.6.3. Confusion and Doubt:

Another direct expression of anxiety is to be found in confusion in thought or speech. It is a telltale sign that a sensitive area has been struck when a person becomes confused and illogical in his trend or thought or argument. Errors, blunders, and mistakes all testify to an underlying nervousness and confusion, which are certain signs of the presence of competing trends within the individual that prevents him from taking a certain position on either side, and the state of doubt indicates the anxiety which this conflict has aroused. In more extreme cases a feeling of unreality may develop.

5.6.4. Feeling:

Manifestations of anxiety have been described so far are in terms of physical symptoms and behaviour. Anxiety also expresses itself by a wide variety of feeling states. Indeed, anxiety growing as it does out of primitive startle and fear states, is perhaps first and foremost a feeling which subsequently is transformed into action of some sort. The behavioral manifestations of anxiety have been described worst because these can be observed by onlooker, whereas feeling states can only be known to the person who experiences them. By definition, anxiety is a state of dread or apprehension. In a mild state, it is known uneasiness. The pint has already

been made that anxiety is usually accompanied by a feeling of helplessness. In a more general sense, it is related to pessimism, a tendency to look on the dark side of things, always to be anticipating the worst. There are number of recurring fears which are typical anxieties. for instance, there is a fear of dying, either from sudden causes of from long-continued illness. There is a fear of going insane, which haunts numbers of people. Occasionally a mother will have some anxiety lest a son or daughter become delinquent. These fears may be either by oneself or others who are close and towards whom one has strong affectional ties. Sometimes anxiety shows itself by feelings of strain, exhaustion or fatigue. Unreasonable and violent hates and rages are probably in many instances tinctured with anxiety and become intensified because of the underlying fear behind them. Lonesomeness, a feeling of isolation, and a feeling of being rejected by others, are other forms that anxiety is much more diffused and does not have a specific anxiety is much more diffused and doesn't have a specific direction or pertain to a specific object. Depressive states and gloomy moods probably, in most cases, represent a diffused form of anxiety. Feelings of inadequacy and inferiority which beset so many persons are akin to these feelings. Many disturbances of sex many persons are akin to these feelings. Many disturbances of sex life, either by the exaggeration of feeling or by the drying up of feeling, would by represent the direction that anxiety has taken.

5.7. Methods of overcoming Anxiety:

There are two main schools of thoughts with regard to the overcoming to the fears one looks on the fear as an isolated phenomenon, a king to any other habit or skill, which has arisen from a rather immediate situation

and which results in an isolated response. Those who see fear in this light proposed to overcome it by direct methods of manipulation and reconditioning. The other groups sees anxiety as having a deeper dynamic significant and as penetrating to the heart of ones adjustment problems those who see anxiety in this later light believe that it can be overcome only by methods which penetrate beneath the surface, make inquiry in to the deeper origins of anxiety, an proposed more througoutgoing personality transformations as a way of overcoming it.

6. Body image:

Health is more than avoiding disease. Good mental health, including how we feel about ourselves, is a very important component of overall health. How we feel about ourselves has an impact on our behaviour, such as what we eat, the physical activity we do, drug and alcohol use, and a wide variety of other health behaviour. More and more people are becoming dissatisfied with their appearance. Psychology today published results of a large survey on body image that showed that over the last few decades, people's dissatisfaction with their body has grown. In 1972, 25% of women were dissatisfied. In 1996, that number rose to 56%. Similarly, for men, the number increased from 15% to 43% for the same time period. Studies reveal that people who have a poor body image are at higher risk for depression and low self-esteem. They are also more likely to have poor physical health due to severe dieting, crash diets, use of anabolic steroids and so on. Because they don't like the way they look, many people with a poor body image shy away from social situations, are reluctant to form personal relationships or they spend a great amount of time trying to achieve

a better body. This can lead to social isolation. Research indicates that people with less social interactions are at greater risk for poorer health. Moving towards a better body image can move a person's health in a positive direction.

6.1. What is body image?

Your body image is made up of 2 components:
(1) How you perceive your body, and (2) What you feel about that perception.

Although your perception of your body can vary from day to day, or even from morning to afternoon, people tend to have a relatively stable view of their body. The way you see your body is not necessarily similar to the way others view you. We have all heard someone who we think looks great mention how unattractive he or she is, or complain about body parts that he or she dislikes. We tend to be more critical of our own body than others are of us.

The emotions that we have about the way we perceive our body are a very important part of body image. A person may be overweight, yet feel great about what they see. On the other hand, a person may be perceived as attractive by others, yet he or she is very dissatisfied with what they see and has negative emotions about his or her body.

The combination of what you see and how you feel about it can range from positive to negative. If you have a positive body image, you are satisfied with what you see. Conversely, if you are dissatisfied with what you see, your body image is negative. Of course, the degree of satisfaction and dissatisfaction can vary, which creates a continuum of body image from body acceptance to body hate.

6.2. Factors that contribute to body image:

We do not have a concept of our body image at birth. Therefore, it develops over our lifetime. This image is influenced by the information we receive daily about what is considered attractive and what is considered unattractive. This information is deeply embedded in our culture. Each culture has its own ideals of beauty, which change over time and are transmitted to individuals through family, stories and legends, and through the various forms of media.

6.2.1Family:

The earliest influence on our body image is our family. For the first few years of life we are constantly in the presence of our family, and what we hear and see in this context influences our beliefs, values and attitudes. The language that our parents use shapes our perceptions and it can affect us much more than we realize. When parents, relatives or even friends of the family praise a young boy for being “big”, “strong”, or “active” they are indirectly telling that child what characteristics are desirable for males. Similarly, when they praise a young girl for being ‘pretty’, “sweet” or “well behaved” they are telling her how girls are supposed to look and behave. We praise people to reinforce desirable qualities. Parents are often not aware of the tremendous impact their words have on their child’s development of sense of self.

6.2.2. Children’s toys and fairy tales:

The toys that children play with also help shape a sense of what is physically desirable and undesirable. Perhaps the most talked about

example of this is the Barbie doll, which is one of the biggest selling toys in history. A typical young girl who owns a Barbie has an average of 7 Barbie dolls. When the doll was first released in the 1950Õs, it was considered odd to have a doll with breasts, since dolls at the time typically represented babies or young girls. Barbie was different. She was marketed as the girl who had it all. Part of children's play is to project themselves into the toys with which they are playing. Little girls playing with the doll become Barbie during play, and this can translate into wanting to be like Barbie when they grow up. This includes looking like Barbie. It may not be apparent by looking at the doll, but Barbie's measurements do not represent the measurements of the typical woman. Those working in the field of body image often point out that if Barbie were life-sized her measurements would be virtually unachievable. To get an idea of what your measurements would be if you had Barbie's proportions, do the calculations in the box to the right.

Certainly, Barbie is not the only children's toy that influences body image. Action figures such as GI Joe, Superman, Batman and other army figures have a big chest, muscular arms and legs, and a flat stomach with the desirable '6-pack'.

Animated characters often have bodies that set the standard for what children believe is desirable. The heroines in Disney classic films such as Beauty and the Beast, Cinderella, Snow White and The Little Mermaid are all thin and attractive with long legs and ample breasts. In many children's stories, the hero or heroine is described as attractive while the evil character often has a deformity or is unattractive or overweight.

These toys and children's stories, combined with family influences, firmly set in place a young person's attitudes about physical appearance and what he or she believes to be desirable physical qualities.

6.2.3. Friends:

As children get older, the influence of family still remains but friends become very influential, especially in adolescence. Friends, who have also been influenced by their families and by toys, can reinforce prevailing attitudes and values. In adolescence it becomes very important to belong to a group. It is during this time that a person's image becomes much more important, to the point that some children and teens are excluded from social groups because of how they look or what they wear. After years of receiving the same messages, the prevailing beauty ideals are further reinforced.

6.2.4. The media:

Before the advent of television and mass media, most people did not see what other people looked like around the world or even in the next village or town. Today we are bombarded with thousands of images from movies, television, magazines, newspapers, the internet and music videos.

The media has been criticized for using images of people that don't represent reality. It seems that everywhere we look we see young, big breasted, long-legged, broad shouldered women who are unbelievably thin. If we see a man in the media with his shirt off, chances are that he is lean, muscular, hairless, and young. Do the images of the people we see in the media reflect what we see every day? not at all. In fact, only about 5% of women are capable of achieving the proportions of the typical woman's

body we see in advertisements. Our genetics determine how our body is shaped, how tall we can be, etc. Exercising regularly and eating a balanced healthy diet can help condition your body, but genetics will limit a person's ability to achieve certain proportions. If you are a guy with narrow shoulders, all the exercise in the world will not give you broad shoulders.

The average person is not well represented in the media, especially in advertising, movies and television. The goal of the different forms of media is to make money by selling you products or services. Clever strategies have been devised to separate us from our money. These strategies often take advantage of our need as humans to feel like we belong. For example, products are linked to "beautiful" people who seem to have it all including many friends and admirers. This makes us want to be beautiful as well so that we can have it all. Unfortunately, it is difficult or even impossible to be one of the "beautiful" people, since they are unattainable ideals. The media regularly enhances the images that we see by using good lighting, make-up, hair stylists and good photography. Some images are even computer enhanced to remove any imperfections or to enhance features such as eyes, legs and breasts. Of course, the ideal keeps changing as more and more people attempt to get 'the look'. It is interesting to note that for women, 'normal' keeps getting thinner and thinner, whereas for men, "normal" means more muscular and cut.

6.3. Tips for becoming a critical viewer of the media:

Media messages about body shape and size will affect the way we feel about ourselves and our bodies *only if we let them* . One way to protect our self-esteem and body image from the media's often narrow definitions

of beauty and acceptability is to become a critical viewer of the thousands of media messages that confront us each day. When we effectively recognize and analyze the media messages that influence us, we can realise that the media's definitions of beauty do not define our self-image or potential.

6.3.1. To be a critical viewer remembers:

€ All media images and messages are constructions. They are NOT reflections of reality.

€ Advertisements and other media messages have been carefully crafted with intent to send a very specific message.

€ Advertisements are created to do one thing: convince you to buy or support a specific product or service.

€ To convince you to buy a specific product or service, advertisers will often construct an emotional experience that looks like reality. Remember, you are only seeing what the advertisers want you to see.

€ Advertisers create their message based on what they think you will want to see and what they think will affect you and compel you to buy their product. Just because they think their approach will work with people like you don't mean it has to work with you as an individual.

€ As individuals, we decide how to experience the media messages we encounter. We can choose to use a filter that helps us understand what the advertiser wants us to think or believe and then choose whether we want to think or believe that message. We can choose a filter that protects our self-esteem and body image.

6.3.2. To help promote healthier body image messages in the media, you can:

€ Talk back to the TV when you see an ad or hear a message that promotes only a narrow range of body ideals and makes you feel bad about yourself or your body.

€ Write a letter to an advertiser you think is sending positive, inspiring messages that recognize and celebrate the natural diversity of human body shapes and sizes. Compliment their courage to send positive, affirming messages

€ Tear out the pages of your magazines that contain advertisements or articles that glorify thinness or degrade people of larger sizes. Enjoy your magazine without negative media messages about your body.

€ Talk to your friends about media messages and the way they make you feel.

€ Make a list of companies who consistently send negative body image messages and make a conscious effort to avoid buying their products. Write them a letter explaining why you are using your "buying power" to protest their messages.

6.4. Moving towards a positive body image:

Our body image develops over a lifetime and becomes an integral part of us. Changing something that is so integral can be very difficult. If your body image is interfering with your life and you would like to work on changing it, here are a few strategies you can try:

€ Be aware of the factors that contribute to your own body image. How does your family contribute? What about the toys you played with as a child or the fairy tales and other stories you listened to and liked? What cultural forces shape what is considered to be attractive?

- € Concentrate on being healthy and having a healthy weight. To determine your healthy weight, see the section on Body Mass Index below.
- € Do things that make you feel good about yourself? Buy clothes that feel good on you.
- € Exercise for health and a sense of well-being and not just for physical appearance. Increased flexibility, endurance and energy levels are just a few of the benefits of exercising.
- € Find balance. A healthy lifestyle is one that is balanced. This means getting adequate exercise, eating a healthy diet and getting adequate sleep. It means having fun and allowing yourself to have treats (a piece of chocolate cake every once in a while, etc.) Life is meant to be lived, and we should try to enjoy our time while we are here.

6.5. What is our healthy weight?

Many people are confused about how much they should weigh. In the past, the Metropolitan Life Insurance tables established standard weights, but the weight ranges that were specified tended to be quite narrow. Today, health care professionals prefer to use the Body Mass Index (BMI) as a measure of healthy weight. This index is calculated using a person's height and weight.

The BMI scale can be used for both males and females over the age of 18. It is based on epidemiological information obtained from thousands of North Americans and Northern Europeans. Because of this, people with cultural roots outside of Europe or North America who tend to be smaller in size (such as the Japanese) may find their BMI to be below the "healthy range". Well muscled, lean men may find that their BMI is above the healthy

range and into the “obese” range. However, this should not be a worry for these people. The BMI is just a general tool to help people identify if they are at risk for obesity related diseases. Furthermore, the BMI scale needs to be used in conjunction with other information, such as physical activity, dietary practices, level of life stress, drug and alcohol use, and body fat percentage to give a clearer picture of overall health.

So what does your BMI mean? A BMI between 20 and 25 is associated with the lowest risk of diseases that are linked to being overweight, such as heart disease, stroke and diabetes. A person in this range would not be advised to lose weight for health reasons. This does not mean that someone with a BMI within this “healthy range” is immune from getting heart disease or diabetes, but statistically, his or her risk is lower. A person with a BMI between 25 and 27 is considered slightly overweight and those with a family history of cardiovascular disease or diabetes, or those with an unhealthy lifestyle, would be advised to lose weight. A BMI of over 27 is associated with the highest risk of disease and a person in this range is advised to lose weight for health reasons. A BMI of over 30 is considered clinically obese. A BMI of under 20 is associated with increased risk for diseases linked to inadequate nutrition. A person with a BMI in this range should consider consulting a dietician, nutritionist or a physician. Again, the BMI is just one factor to consider when- examining healthy weight.

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CHAPTER : 2

REVIEW OF RELATED LITERATURE

1. Introduction
2. Review of Related Literature

CHAPTER : 2

REVIEW OF RELATED LITERATURE

1. Introduction:

Review of studies of literature is an important prerequisite for actual planning and then execution of any research work. The research workers need to acquire up-to-date information of what has been thought and said in a particular area so that they can derive benefit from the work of their predecessors. According to Scot and Wertheimer (1992), “review of related literature may serve to avoid unnecessary duplication any may help to make progress towards the solution of new problems emphasizing the importance of survey of related literature”. Good, Barr and Scates (1941) have pointed out, “Survey of related literature helps us to know whether evidence already available solves problems adequately without further investigation and thus may save duplication”. Best (1978) wrote”practically all-human knowledge can be found in books and library. Unlike other animsld that must star anew with each generation, man builds upon the accumulated and recorded knowledge makes possible progress in all areas of human Endeavour. A brief of research literature in the area of my study is presented below.

2. Review of Related Literature:

Heilbun and Putter, (1986) suggested a theory on the correlation between body image and eating disorders. They suggest that some women may feel pressure to fit into a female sex role, which often includes an ideal of a low body weight and actual body weight, it often times causes

stress. This stress could serve as motivation for dieting and may lead to disordered eating.

Striegel – Moore et, al. (1986) believed that women who were at greatest risk for bulimia nervosa were those who internalized the thin ideal of attractiveness. Other researchers have agreed that this is a risk factor for bogy dissatisfaction and ultimately, an eating disorder.

According to Attie, Brooks- Gunn, (1989) Disturbances in body image have suggested to be associated with a high risk for developing EDS, depression and low self-esteem.

According to Rosen, et al., (1990) dieting is significantly associated with depression and anxiety and it is suggested that weight loss might have a negative psychological impact on female adolescents.

Hadigan and Walsh, (1991) found that patients with bulimia nervosa had higher BSQ scores than their other eating-disorder counterparts, who in turn had a higher score than those not suffering from eating disorder. This finding gave credence to the added criterion of over concern with body shape and weight in the diagnosis for bulimia nervosa in the DSM- III. Thus, women who are overly dissatisfied with their body shape are at a higher risk for an eating disorder.

A study by Bunnell, Cooper, Hertz, and Shenker, (1992) also supports the conclusion of Cooper and his colleagues (1987). They found that adolescents who suffer from bulimia nervosa seem to have higher BSQ score than other eating disordered peers. However, it was noted by the authors that adolescent females in general have higher BSQ scores than adults.

De Raich et al., (1992) have found that incidence of eating disorders and body dissatisfaction has shown in young people.

Rucker and Cash, (1992) conducted a study that compared the body images, body size perceptions and eating behaviors of African – American and Caucasian college women. In this study, they found that African – American women had a more moderate ideal of body size than that of the Caucasian women, whose ideal size was thinner. They attributed this difference to the close adherence of Caucasian women to the conception in western culture of a thin body size being ideal. African-American women, on the other hand, were somehow not as receptive as the Caucasian women and thus were more weight – tolerant.

Stice, Schupak-Neuberg, Shaw, and Stein, (1994) investigated the exact correlation between the media and eating disorders. A conclusion from this study was the media exposure has a definite correlation with eating disorder symptomatology. To describe the correlation in further detail, "greater ideal body stereotype internalization, which was related to heightened eating disorder symptoms".

Smolak & Levine, (1994). In order to increase the like hood of attending success in school and their social aspects of life, many young girls believe that they must fit the thin ideal.

Cash and Szymanki, (1995) have found that the magnitude of the discrepancy between self-perception of one's body and internalized ideas about it are associated with body dissatisfaction and eating disorders.

Cash and Szymanki, (1995) have found that the magnitude of the discrepancy between self-perception of one's body and internalized ideas about it are associated with body dissatisfaction and eating disorders.

Stomer, Thompson, (1996), body dissatisfaction is thought to arise primarily from sociocultural pressures to be thin, and physical deviation, from the current thin ideal espoused for women in western culture. Sociocultural pressure to be thin emanates from a wide number of sources, including mass media, parents, siblings, and peers and dating partners. Persistent messages that one is not thin enough putatively result in dissatisfaction with one's physical appearance and women in general are more prone to suffer those pressures.

Connors, (1996) found that the normative levels of body dissatisfaction and dieting so prevalent in the current sociocultural context may be differentiated from clinically significant eating disorders on basis of emotional disturbance. Body dissatisfaction and dieting behaviors could be viewed as spanning a continuum from slight to very intense. Individuals may mild to moderate levels without other life impairment. Women with more symptoms with eating disorders seem to have high levels of body dissatisfaction and disturbed eating attitudes and behaviors in conjunction with other psychological problems including greater levels of depression feelings of ineffectiveness, self-critism, impulsivity, emotional reactivity and life impairment.

Cash and Deagle, (1997) conducted a meta-analysis on the relationship between body-image disturbances and eating disorders. In their research, they concluded that body dissatisfaction in eating disorder patients exceeds that of controls by 87%. In addition, eating disordered patients also experience a perceptual body- size distortion that is greater than 73% of that of the controls. This provides evidence that body image disturbance is a risk factor for an eating disorder.

Schwitzer, berghol, Dore, & Salimi, (1998) found that the many pressures associated with the transition to college can place students on a precarious foundation and searching for ways to again acceptance in their lives. One way student believe will help them attain the acceptance they long for is to fit the thin ideal. College students have reported a high incidence of sub threshold problems with body dissatisfaction and weight preoccupation. All of these issues, when compounded, can place college students at a high risk for developing an eating disorder.

Showers and Larson, (1999) gave a reason for this connection between eating disorders and body shape perception. They concluded a study in which they looked at the relationship between self-knowledge about physical appearance and disordered eating had the tendency to compartmentalize their negative beliefs of their physical appearance and link them with other negative attributes.

Nelson, Hughes, Katz, and Searight (1999) conducted a study about the anorexic eating attitudes and behaviors of female college students. Using data, they constructed a picture of a typical female problem eater: she had low physical and personal self-esteem. Low physical self-esteem involves a negative perception of one's appearance, physical competence, while low personal self-esteem involves a diminished view of one's self-worth and personal competence.

According to APA, (2000) Eating disturbances and disorders occur in children, adolescents, adults and the elderly, but the majority of the research has focused on people between the age of twelve and twenty-two.

Andersen, Cohn, & Holherook. (2000) studied that unhealthy eating, weight related behaviors, and body image dissatisfaction exists in vast numbers of young females, as well as college students and adults.

Cattarin, Thompson, Thomas, and Williams, (2000), they found that media presented images of women have the ability to affect (either positively or negatively) both mood and satisfaction with appearance within a normative female sample. A moderating factor to this finding was the tendency of the participant to internalize sociocultural norms for attractiveness. Thus, if females are especially susceptible to the sociocultural norm of attractiveness being associated with thinness and are bombarded with image of such, they tend to be more at risk to have a higher level of body dissatisfaction, and thus an eating disorder.

APA, (2000), Smolak & Striegel- Moore, (2001) have found that until recently, eating disorders were typically described as a western cultural phenomenon facing primarily middle-to-upper class white females. There is evidence, however, that symptoms of eating disorders exist among various ethnic and cultural minority groups in the United States and in the whole world.

Cusumano & Thompson, (2001) have found that young girls are more weight dissatisfied than are boys.

Luiza Amélia Cabus Moreira, (2001) have studied that, Body image dissatisfaction and over concerns in reaching the ideal of an extremely thin body proved to be a frequent finding in our sample of female undergraduate medical students. Health professionals should be qualified to deal with these important risk factors in the development of EDs.

Shislak &Crago, (2001) found that low self-esteem, weight concerns, dietary restraint, body dissatisfaction, depression, negative emotionality early maturation and being overweight are risk factors for the development of eating disorders and disturbance.

Maria Isabel R Motos, Luciana S Aranha, (2002) studied that a high prevalence of binge eating disorder and isolated binge eating disorders as well as symptoms of anxiety, depression and a high degree of preoccupation with body image in severely obese patients.

Strice, (2002) completed a meta-analysis of the literature on risk and maintenance factors in eating pathology to find out what the most influential factors on eating disorders were. Through his work, it was found that body dissatisfaction is a risk factor for dieting, negative affect, and eating pathology, as well as a maintenance factor for bulimic pathology. And also concluded that body dissatisfaction is "one of the most consistent and robust risk and maintenance factors for eating pathology.

Schwitzer & Rodriquez, (2002) an individual may develop an eating disorder at any point in his or her life. The onset of an eating disorder, however, tends to occur sometime during adolescence through the early to mid-twenties. At this point in life, most individuals start preparing for and attending college. During the transition from high school to college, students face a variety of new challenges and difficulties in their academic, social and personal arenas of life. Some difficulties may include academic adjustments, determining career choice and social adjustments and relationships. Freshmen in college, when adjusting to college-level academics, tend to 'set unrealistically high expectations' of themselves which causes distress when they are not successfully attained.

Bissell& Zhou, (2004) have found that pressure to be thin can also be found in the media and magazines, which can have a profound effect upon an individual. According to social comparison theory, women often compare themselves to thin models and characters in the media and in magazines. When they find a discrepancy between the ideal and what they perceive their bodies to be, they may engage in dieting or disordered eating.

Bissell and Zhou , (2004) found in their study that high exposure to entertainment television that had 'thin ideal' characters predicted "decreased satisfaction with the body and more negative attitudes regarding the 'ideal' body shape" as well as higher scores on disordered – eating scales.

Diana Queiroz, Lediane Moura, (2005), have studied that and confirmed the general impression that body dissatisfaction is frequently found in contemporary societies. As body, dissatisfaction is considered associated with the development of EDs the identification of this group of individuals may permit the development of early preventive strategies. These strategies may be introduced in elementary school to improve youngsters' self-esteem, thus avoiding the development of serious pathologies with a high rate of morbidity-mortality

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CHAPTER: 3

METHODOLOGY

1. Introduction
2. Problem of the study
3. Objectives of the study
4. Hypotheses
5. Variables
6. Sample
7. Tools
8. Procedure
9. Statistical Analysis

CHAPTER : 3

METHODOLOGY

1. Introduction:

Any research starts with curiosities and questions about a give phenomenon or a set of phenomena. Systematic attempt are made to explore, analyzed and understand the issues under question through suitable conceptual and methodological tools. The process of inquiry and analytical tools a great extent relative to the specific domain of the concern, and the conceptual, methodological, heuristic and programmatic goals of the research.

In present investigation, main focus is on self-concept, anxiety and body image of women suffering from eating disorder and normal women with regard to age and socio economic status.

2. Problem of the study:

The problem of the present research study is as under.

"A STUDY OF SELF CONCEPT, ANXIETY AND BODY-IMAGE AMONG NORMAL WOMEN AND WOMEN SUFFERING FROM EATING DISORDER."

3. Objectives of the study:

The main objectives of the present study were as under:

1. To study and compare women suffering from eating disorder and normal women with regard to their self-concept, anxiety and body image.
2. To study and compare 15 to 25 years old and 30 to 40 years old age groups of women suffering from eating disorder and normal women with regard to their self-concept, anxiety and body image.

3. To study and compare HSES, MSES, LSES women suffering from eating disorder and normal women with regard to their self-concept, anxiety and body image.

4. Hypotheses:

   Major Hypotheses of the present research work is as under:

   1. There is no significant difference between women suffering from eating disorder and normal women in relation to self-concept.
   2. There is no significant difference between 15 to 25 years and 30 to 40 years women In relation to self-concept.
   3. There is no significant difference among HSES, MSES and LSES women in relation to self- concept.
   4. There is no significant difference between women suffering from eating disorder and normal women in relation to anxiety.
   5. There is no significant difference between 15 to 25 years and 30 to 40 years women In relation to anxiety.
   6. There is no significant difference among HSES, MSES and LSES women in relation to anxiety.
   7. There is no significant difference between women suffering from eating disorder and normal women in relation to body image.
   8. There is no significant difference between 15 to 25 years and 30 to 40 years women In relation to body image.
   9. There is no significant difference among HSES, MSES and LSES women in relation to body image.

5. Variables:

In the present study, 2x2x3 factorial design was used. The problem has three independent variables, (1) Women (2) Age (3) Socio-economic Status. Score of self-concept, anxiety and body image were taken as dependent variables. In present research work, the nature of the variables is given in the following table.

Table : 3.1

Nature of Variables

No.	Names of Variables	Nature of Variables	Number of Levels	Name of Levels
1	Women	Independent Variable	2	Women suffering from eating disorder- Normal Women
2	Age	independent Variable	2	15 yrs to 25 yrs age group 30 yrs to 40 yrs age group
3	SES	Independent Variable	3	HSES, MSES LSES
4	Self-Concept	Dependent Variable	1	Scores of self-concept
5	Anxiety	Dependent Variable	1	Scores of Anxiety
6	Body Image	Dependent Variable	1	Scores of Body Image

6. Sample :

The present research work conducted on 360 women. The purposive sampling technique used for the selection of samples. The women were selected from various areas of Gujarat such as Ahmedabad, Surat, Gandhinagar and Vallabh-Vidyanagar. The total sample is categorized as under

Table : 3.2

Nature of Sample

	A1		A2		Total
	B1	B2	B1	B2	
C1	30	30	30	30	120
C2	30	30	30	30	120
C3	30	30	30	30	120
Total	90	90	90	90	360

A = Women

A1 = Women Suffering from eating Disorder, A2 = Normal Women

B = Age

B1 = 15 to 25 yrs., B2 = 30 to 40 yrs.

C = SES

C1 = HSES, C2 = MSES, C3 = LSES

7. Tools:

Following tools used in present study.

7.1. Eating Aptitude Test (EAT-26) by Dr. D Garner.

7.2. Socio-economic Status Scale (SESS) by Dr. D. J. Bhatt

7.3. Self-Concept Questionnaire (SCQ) by V K Mittal and S Abrol.

7.4. Anxiety Measurement Scale (AMS) by S D Kapoor.

7.5. Body Shape Questionnaire (BSQ) by Cooper et.al.

7.1 Eating Attitude Test (EAT-26):

Eating Attitude test structured in 1979 by Garner and Garfinkel. EAT-26 is probably the most widely used standardized measure of symptoms and concerns characteristics of eating disorders. It is consists of 26 questions that are answered using a 6-point Likert Scale ranging from never to always.

Reliability & Validity:

EAT-26 item version (Garner et. al., 1979) is highly reliable and valid. The validity coefficient of this test is .87. (Garner, Olmsted, Bohr, & Garfinkel, 1982).

Scoring:

Scoring of 1 to 26 items such as scores of items 1 to 25, always-3,usually-2, often-1,sometimes-0, rarely-0 never-0,scores of item 26 only,alwaya-0, usually-0, often-0,sometimes-0, rarely-0 never-0, Resulting in total scores that can rang from 0 to 78. Any subject who has a total score of 20 or above on the EAT is considered to be "at risk" for eating disorder behaviour and symptom otology.

7.2. Self-Concept Questionnaire:

Self-concept questionnaire (SCQ) by V.K. Mittal and S.Abrol is a structured tool to measure an individual's sense of self-competence. It contains 100 items

There are three response categories. On each item, the respondent is required to check the category, which is most applicable to him. The questionnaire is non-timed. In general, college students take 30 to 40

minutes in recording responses. The questionnaire provides a global measure of an individual's sense of self-competence. Scoring is simple. Scoring instruction and scoring keys given in the respective manual of the test.

Reliability:

The reliability of the questionnaire has been assessed through split half and test retest methods.

1. Split half reliability:

For split half reliability, the responses were given a split on odd and even basis. Pearson's 'r' is computed between the two sets of scores and spearman brown correction is applied. The obtained corrected reliability coefficient on a sample of 100 students is r = .94.

2. Test retests reliability:

The questionnaire was read ministered second time after a gap of 7 days. On a sample of 100 students. Correlation coefficient (r) is calculated between the two set of source. The obtained test retest reliability is r = .86.

Validity:

The validity of the questionnaire has been assessed in the following manner.

a. Content validity:

Only those items have been included which are judged as relevant by the judges with respect to eleven dimensions of self-competence as reported above. These dimensions were concretely described and only those items were included on which the judges perfectly agreed.

(b) The discriminative value of each items of assessed through the contrasted group technique. Only highly discriminative items are retained.

b. Validity through pooled teacher's ratings:

Teacher's ratings were obtaining on the sense of self-competence for 50 B.Ed. students. For this purpose, a Performa was prepared, on which the concept of self-competence was explained in a gestalt like manner. A 5-point rating scale is used; value of 5 is given to the point indicative of least competence and the value of 25 for maximum competence. The ratings were obtained towards the close of the session only from those teachers who were highly interested in the study and felt confident in rating. Subsequently these rating were averaged and coefficient of correlation was computed among the numerical values of ratings and students scores of SCQ. The obtained validity coefficient is r - .68 with a t value = 9.45. The obtained validity coefficient is highly significant at .01 level of significance.

Validity:

In the preparation of preliminary draft, the careful study of relevant literature and the consideration of unanimous decision of 12 judges regarding the relevance and clarity of the statements, with various constructs of the security scale, confirm its content validity. The selection of items on the basis of highly significant discriminative index values (C-R Values) again ensured the item validity of the test. For the external validation of the test, the Security-Insecurity Inventory of Tiwari and Singh were administered among 75 randomly selected secondary level students and to the same 75 students this SIS was administered. The total scores obtained by the sample subjects in these two tests were correlated and the obtained value (r=79) was found statistically highly significant. Thus, the external validity of the test is also satisfactorily high.

7.3. Anxiety Measurement Scale:

Anxiety Measurement Scale (AMS) is a Hindi version of Cattell's self-analysis form or I.P.A.T. (1963) by S. D. Kapoor. It consisted of 40 statements measuring expression of anxiety. Scoring is done as per scoring key.

Higher score means more anxiety. The test – retest reliability was found between .87 to .93 and validity is estimated at .85 to .90 for the scale.

7.4. Body Shape Questionnaire:

The body shape questionnaire (BSQ) was developed in 1987 in England by Cooper et.al. to measure as individuals concerns about body shape. A self-report questionnaire consisted of 34 questions that refer to the subjects feelings about their appearance (body weight and shape). Questions are answered using a 6 point Likert scale ranging from 'never to always'.

Scoring:

Each scaled answer is assigned a point value from 1to6 resulting in total scores that can range from 34 to 204.

Any subjects who has a total scores of 80 or less on BSQ is considered to be no preoccupation, 80-110 to be slight preoccupation, 111-140 to be moderate preoccupation, 140 or more to be sever preoccupation.

Reliability & Validity:

Rosen, Jones, Ramirez and Waxman (1996) reported a test-retest reliability of .88 and a concurrent validity of.77 with the body dimorphic disorder examination among university undergraduates.

8. Procedure:

In the present study, with the help of EAT-26, identified the women suffering from eating disorder and normal women, with regard to their SES (HSES, MSES, and LSES) and age (15 to 25, 30 to 40). After identification of ED and normal women, three tests, self-concept questionnaire by V. K. Mittal and S. Abrol, anxiety measurement scale by S. D. Kapoor and body shape questionnaire by Copper et. Al. was administered individually. Scoring was done as par scoring key of each test.

9. Statistical Analysis:

After tabulation of scores following statistical techniques were used for testing the hypothesis such as analysis of variance (ANOVA), least significant difference (LSD).

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CHAPTER : 4

RESULTS DESCUSSION

1. Introduction
2. Results and discussion of ANOVA
    - 2.1. Results and discussion of Self – Concept
    - 2.2. Results and discussion of Anxiety
    - 2.3. Results and discussion of Body Image
3. Results and discussion of LSD

CHAPTER : 4

RESULTS DESCUSSION

1. Introduction:

In the previous chapter the sample, design, hypothesis, tool used, method of administration of the tool and the statistical analysis were described. The result of the present investigation will be presented, interpreted and discussed in this chapter. In order to test various hypotheses put forward the following analysis was carried out.

Analysis of Variance in order to examine the overall significant of the contribution of variables of women, age group, SES of subjects under the study to the self concept, anxiety and Body-image scores, I.e. to access the main as well as interaction effect of these three variables.

2. Results and discussion of ANOVA :

2.1. Results and discussion of Self – Concept:

Table 4.1

Showing Results of ANOVA on Score of Self Concept

Source of Variation	SS	DF	MS	F	Level of Significant
Ass	5640.62	1	5640.62	6.32	.05
Bss	983.40	1	983.40	1.10	NS
Css	41395.71	2	20697.86	23.18	.01
A x B	22.00	1	22.00	0.02	NS
A x C	3578.75	2	1789.37	2.00	NS
B x C	717.70	2	358.85	0.40	NS
A x B x C	838.18	2	419.09	0.47	NS
Wss	310767.97	348	893.01		
Tss	363944.33	359			

Table : 4.2

Showing Mean Scores of Self Concept -A (Women)

	A1	A2
M	184.16	192.07
N	180	180

Table : 4.3

Showing Mean Scores of Self Concept -B (Age Group)

	B1	B2
M	189.77	186.46
N	180	180

Table : 4.4

Showing Mean Scores of Self Concept -C (SES)

	C1	C2	C3
M	199.78	190.67	173.89
N	120	120	120

Table : 4.5

Showing Mean Scores of Self Concept - A x B

(Women x Age Group)

		A1	A2
B1	**M**	186.06	193.48
	N	90	90
B2	**M**	182.26	190.67
	N	90	90

Table : 4.6

Showing Mean Scores of Self Concept - A x C (Women x SES)

		A1	A2
C1	M	198.12	201.45
	N	60	60
C2	M	182.25	199.09
	N	60	60
C3	M	172.10	175.69
	N	60	60

Table : 4.7

Showing Mean Scores of Self Concept - B x C (Age Group x SES)

		B1	B2
C1	M	199.62	199.95
	N	60	60
C2	M	192.52	188.82
	N	60	60
C3	M	177.17	170.62
	N	60	60

Table : 4.8

Showing Mean Scores of Self Concept - A x B x C

(Age Group x SES)

		A1		A2	
		B1	B2	B1	B2
C1	M	198.47	197.77	200.77	202.13
	N	30	30	30	30
C2	M	186.07	178.43	198.97	199.20
	N	30	30	30	30
C3	M	173.63	170.57	180.70	170.67
	N	30	30	30	30

Table : 4.33

LSD Results of Self Concept (Simple effect)

Pair			Mean			Diff.	.01	.05	Level of Sig.
A1B1C1	-	A1B1C2	198.47	-	186.07	12.40	15.76	21.22	NS
A1B1C1	-	A1B1C3	198.47	-	173.63	24.84	15.76	21.22	**
A1B1C1	-	A1B2C1	198.47	-	197.77	0.70	15.76	21.22	NS
A1B1C1	-	A1B2C2	198.47	-	178.43	20.04	15.76	21.22	*
A1B1C1	-	A1B2C3	198.47	-	170.57	27.90	15.76	21.22	**
A1B1C1	-	A2B1C1	198.47	-	200.77	2.30	15.76	21.22	NS
A1B1C1	-	A2B1C2	198.47	-	198.97	0.50	15.76	21.22	NS
A1B1C1	-	A2B1C3	198.47	-	180.70	17.77	15.76	21.22	*
A1B1C1	-	A2B2C1	198.47	-	202.13	3.66	15.76	21.22	NS
A1B1C1	-	A2B2C2	198.47	-	199.20	0.73	15.76	21.22	NS
A1B1C1	-	A2B2C3	198.47	-	170.67	27.80	15.76	21.22	**
A1B1C2	-	A1B1C3	186.07	-	173.63	12.44	15.76	21.22	NS
A1B1C2	-	A1B2C1	186.07	-	197.77	11.70	15.76	21.22	NS
A1B1C2	-	A1B2C2	186.07	-	178.43	7.64	15.76	21.22	NS
A1B1C2	-	A1B2C3	186.07	-	170.57	15.50	15.76	21.22	NS
A1B1C2	-	A2B1C1	186.07	-	200.77	14.70	15.76	21.22	NS
A1B1C2	-	A2B1C2	186.07	-	198.97	12.90	15.76	21.22	NS
A1B1C2	-	A2B1C3	186.07	-	180.70	5.37	15.76	21.22	NS
A1B1C2	-	A2B2C1	186.07	-	202.13	16.06	15.76	21.22	*
A1B1C2	-	A2B2C2	186.07	-	199.20	13.13	15.76	21.22	NS
A1B1C2	-	A2B2C3	186.07	-	170.67	15.40	15.76	21.22	NS
A1B1C3	-	A1B2C1	173.63	-	197.77	24.14	15.76	21.22	**
A1B1C3	-	A1B2C2	173.63	-	178.43	4.80	15.76	21.22	NS
A1B1C3	-	A1B2C3	173.63	-	170.57	3.06	15.76	21.22	NS
A1B1C3		A2B1C1	173.63		200.77	27.14	15.76	21.22	**
A1B1C3	-	A2B1C2	173.63	-	198.97	25.34	15.76	21.22	**
A1B1C3	-	A2B1C3	173.63	-	180.70	7.07	15.76	21.22	NS
A1B1C3	-	A2B2C1	173.63	-	202.13	28.50	15.76	21.22	**
A1B1C3	-	A2B2C2	173.63	-	199.20	25.57	15.76	21.22	**
A1B1C3	-	A2B2C3	173.63	-	170.67	2.96	15.76	21.22	NS
A1B2C1	-	A1B2C2	197.77	-	178.43	19.34	15.76	21.22	*

A1B2C1	-	A1B2C3	197.77	-	170.57	27.20	15.76	21.22	**
A1B2C1	-	A2B1C1	197.77	-	200.77	3.00	15.76	21.22	NS
A1B2C1	-	A2B1C2	197.77	-	198.97	1.20	15.76	21.22	NS
A1B2C1	-	A2B1C3	197.77	-	180.70	17.07	15.76	21.22	*
A1B2C1	-	A2B2C1	197.77	-	202.13	4.36	15.76	21.22	NS
A1B2C1	-	A2B2C2	197.77	-	199.20	1.43	15.76	21.22	NS
A1B2C1		A2B2C3	197.77		170.67	27.10	15.76	21.22	**
A1B2C2	-	A1B2C3	178.43	-	170.57	7.86	15.76	21.22	NS
A1B2C2	-	A2B1C1	178.43	-	200.77	22.34	15.76	21.22	**
A1B2C2	-	A2B1C2	178.43	-	198.97	20.54	15.76	21.22	*
A1B2C2	-	A2B1C3	178.43	-	180.70	2.27	15.76	21.22	NS
A1B2C2	-	A2B2C1	178.43	-	202.13	23.70	15.76	21.22	**
A1B2C2	-	A2B2C2	178.43	-	199.20	20.77	15.76	21.22	*
A1B2C2	-	A2B2C3	178.43	-	170.67	7.76	15.76	21.22	NS
A1B2C3	-	A2B1C1	170.57	-	200.77	30.20	15.76	21.22	**
A1B2C3	-	A2B1C2	170.57	-	198.97	28.40	15.76	21.22	**
A1B2C3	-	A2B1C3	170.57	-	180.70	10.13	15.76	21.22	NS
A1B2C3	-	A2B2C1	170.57	-	202.13	31.56	15.76	21.22	**
A1B2C3	-	A2B2C2	170.57	-	199.20	28.63	15.76	21.22	**
A1B2C3	-	A2B2C3	170.57	-	170.67	0.10	15.76	21.22	NS
A2B1C1	-	A2B1C2	200.77	-	198.97	1.80	15.76	21.22	NS
A2B1C1	-	A2B1C3	200.77	-	180.70	20.07	15.76	21.22	*
A2B1C1	-	A2B2C1	200.77	-	202.13	1.36	15.76	21.22	NS
A2B1C1	-	A2B2C2	200.77	-	199.20	1.57	15.76	21.22	NS
A2B1C1	-	A2B2C3	200.77	-	170.67	30.10	15.76	21.22	**
A2B1C2	-	A2B1C3	198.97	-	180.70	18.27	15.76	21.22	*
A2B1C2		A2B2C1	198.97		202.13	3.16	15.76	21.22	NS
A2B1C2	-	A2B2C2	198.97	-	199.20	0.23	15.76	21.22	NS
A2B1C2	-	A2B2C3	198.97	-	170.67	28.30	15.76	21.22	**
A2B1C3	-	A2B2C1	180.70	-	202.13	21.43	15.76	21.22	**
A2B1C3	-	A2B2C2	180.70	-	199.20	18.50	15.76	21.22	*
A2B1C3	-	A2B2C3	180.70	-	170.67	10.03	15.76	21.22	NS
A2B2C1	-	A2B2C2	202.13	-	199.20	2.93	15.76	21.22	NS
A2B2C1	-	A2B2C3	202.13	-	170.67	31.46	15.76	21.22	**
A2B2C2		A2B2C3	199.20		170.67	28.53	15.76	21.22	**

Figure : 4.1

Showing Mean Scores of Self Concept -A (Women)

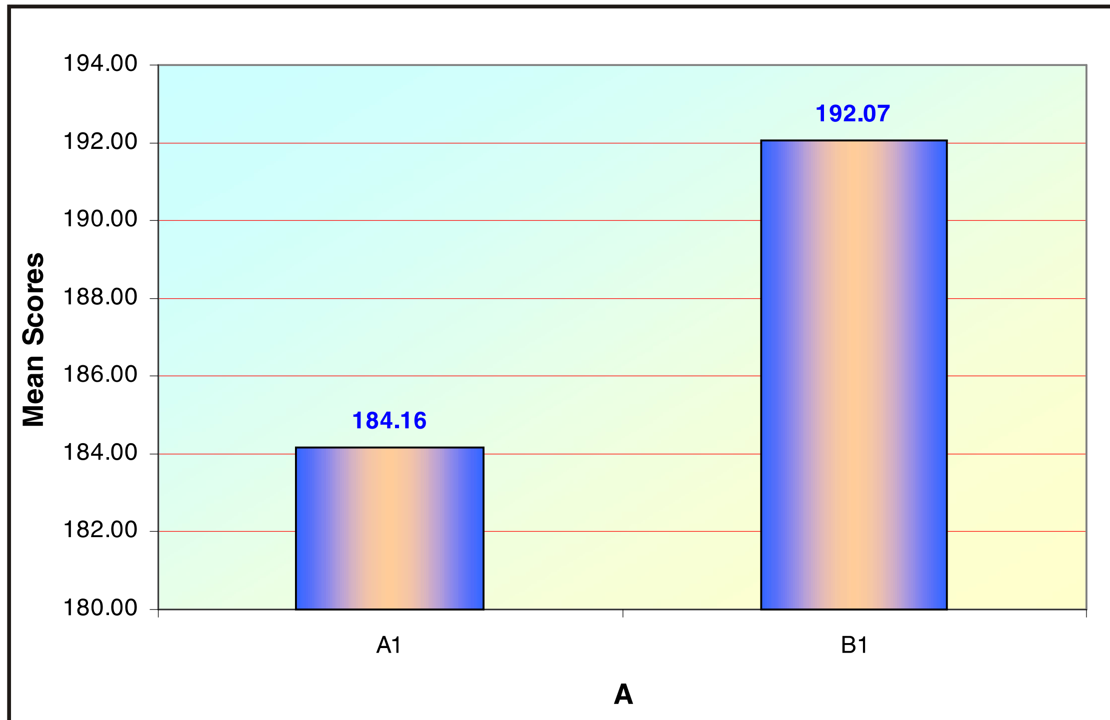


Figure : 4.2

Showing Mean Scores of Self Concept -B (Age Group)

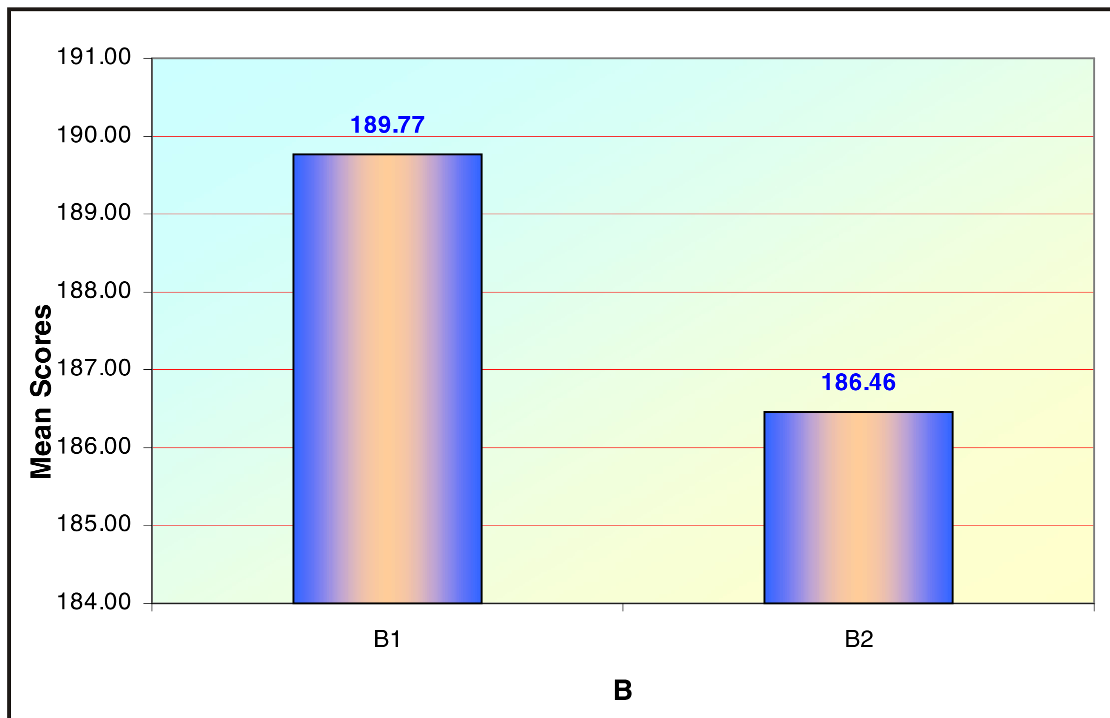


Figure : 4.3

Showing Mean Scores of Self Concept -C (SES)

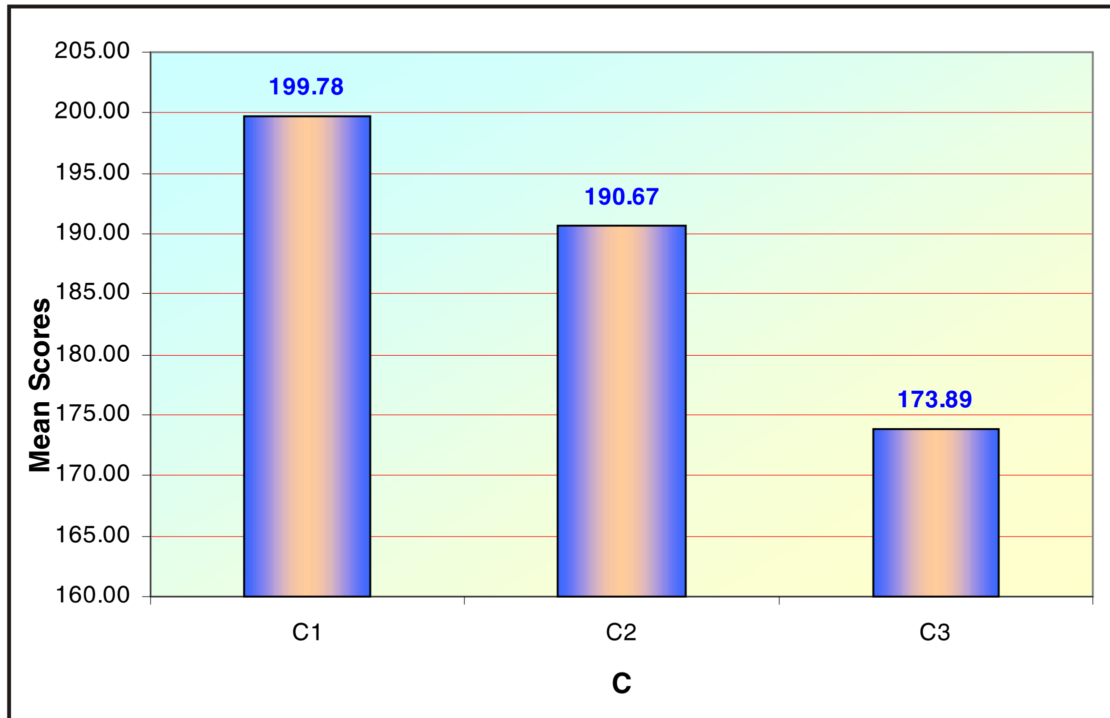


Figure : 4.4

Showing Mean Scores of Self Concept -A x B (Women x Age Group)

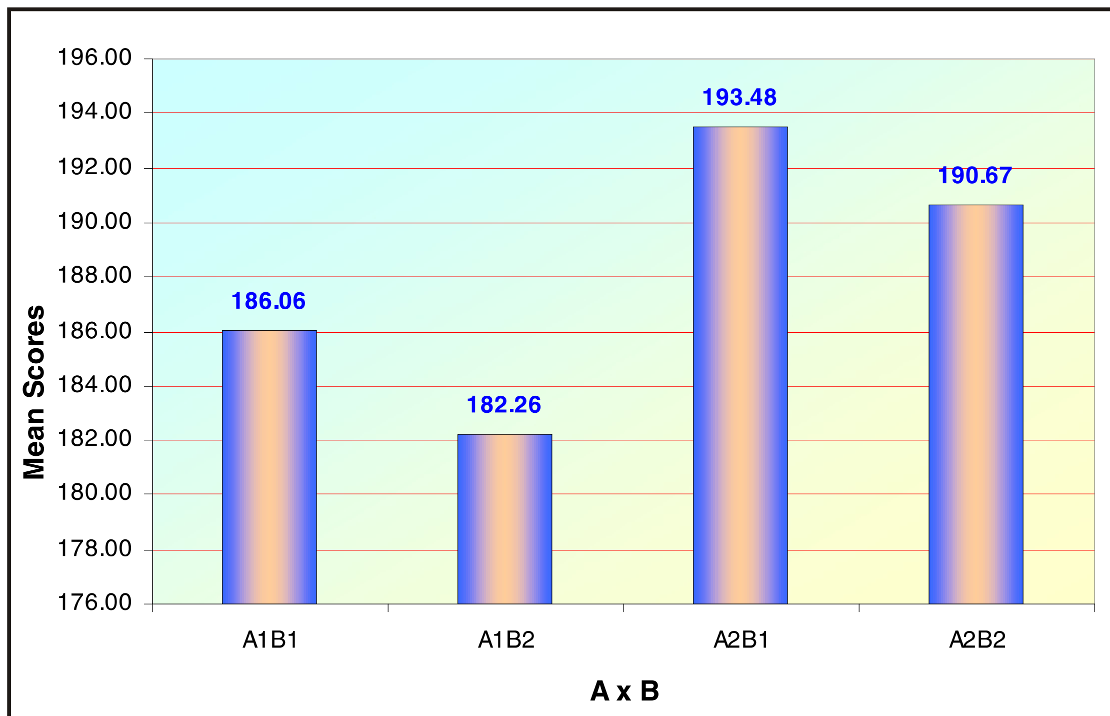


Figure : 4.5

Showing Mean Scores of Self Concept - A x C (Women x SES)

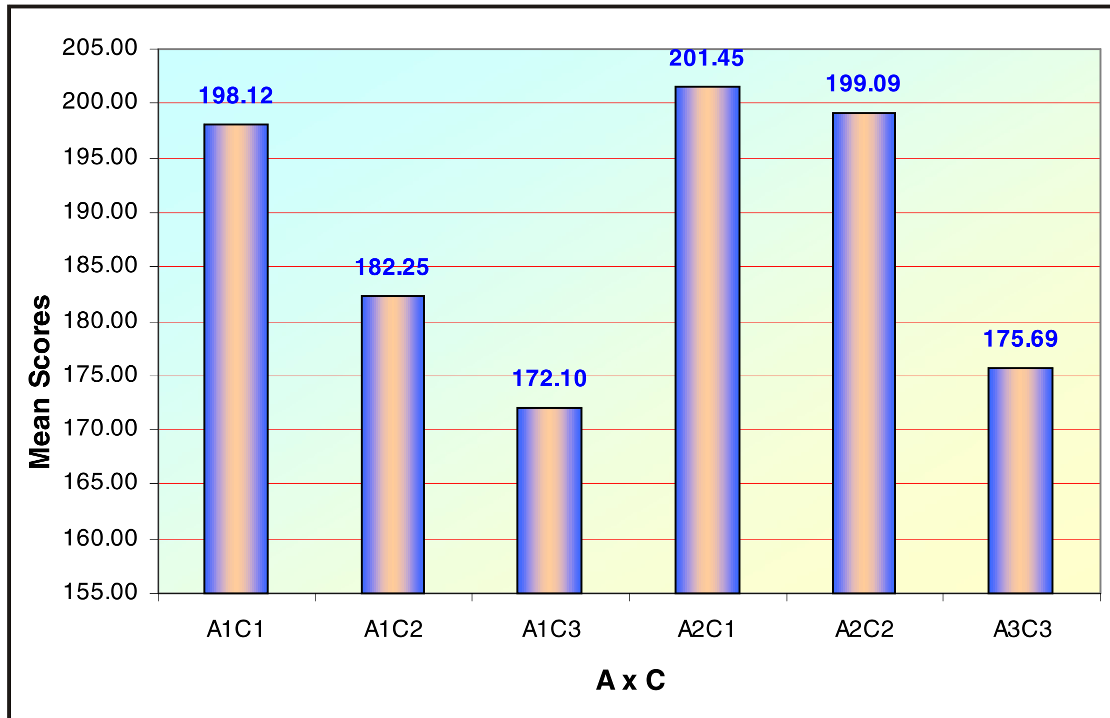


Figure : 4.6

Showing Mean Scores of Self Concept - B x C (Age Group x SES)

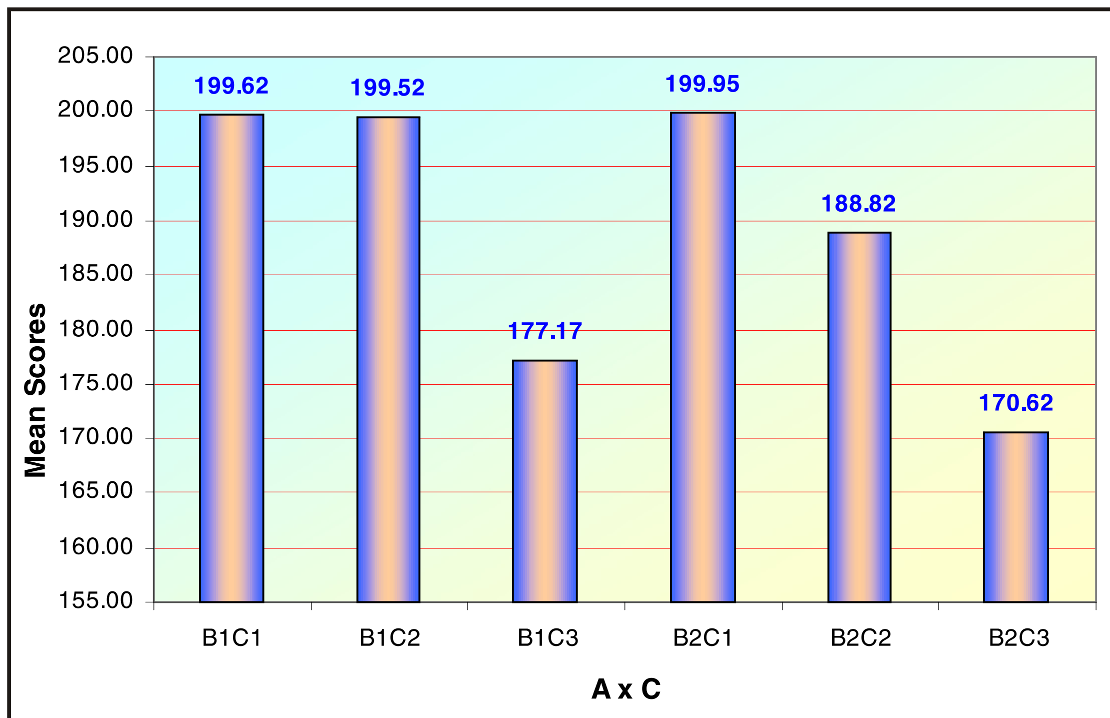
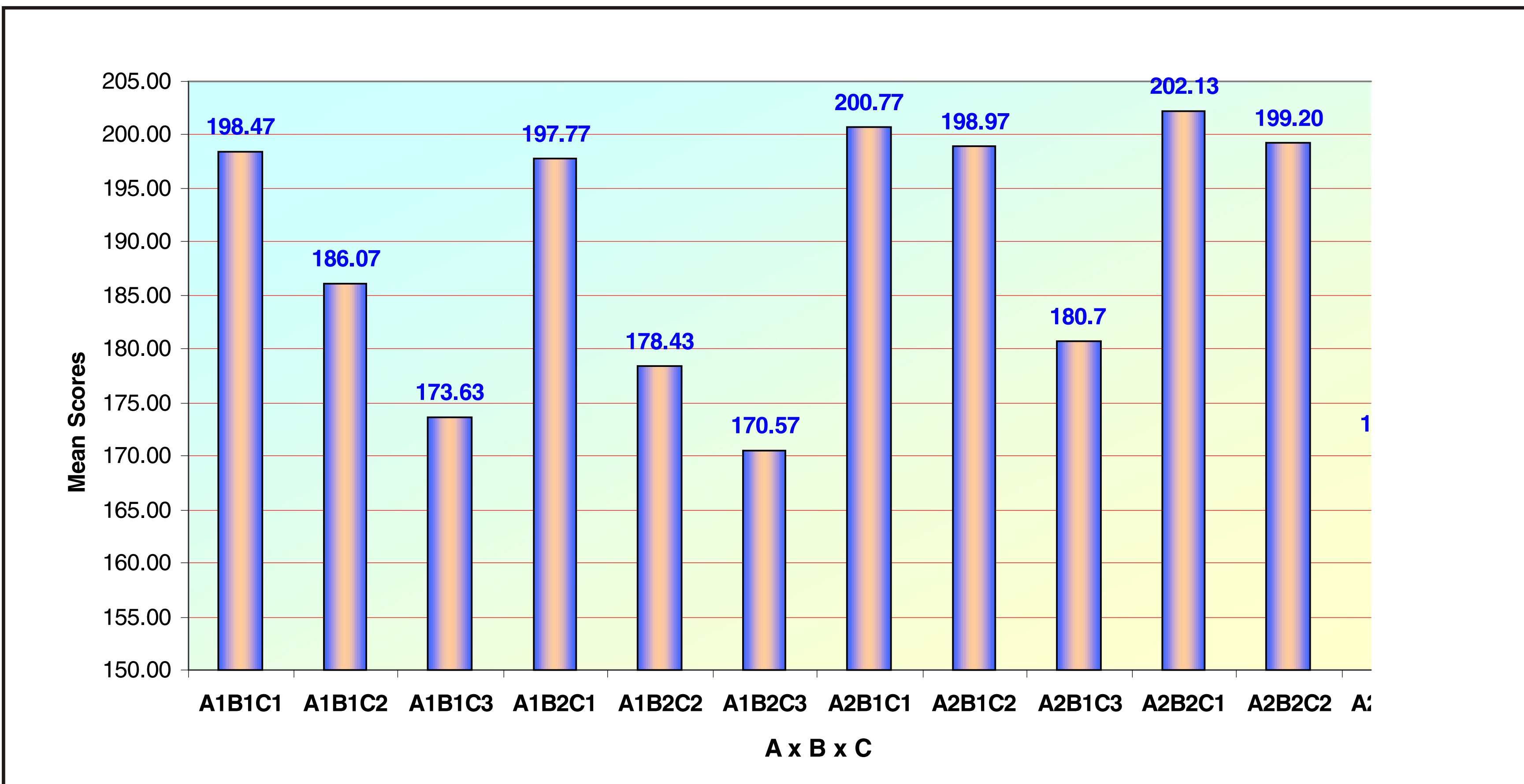


Figure : 4.7

Showing Mean Scores of Self Concept - A x B x C (Women x Age Group x SES)



The results of ANOVA on self-concept score Table No. 4.1 is consulted and it is found that F ratio for women is 6.32 which is significant at .05 level. That means women suffering from eating disorder significantly differ on self-concept score as compare to normal women. Table No. 4.2 the mean score of women suffering from eating disorder is 184.16 and normal women is 192.07. it is clearly said that significant difference s existed between women suffering from eating disorder and normal women on self concept score.

Women suffering from eating disorder have shown poor self-concept as compare to the normal women. Normal Women develop proper self-concept while those suffering from eating disorders are not psychologically normal. The reason is that women with eating disorders have low self-esteem, feeling worthlessness and always underestimate them in society. They need acceptance and approval from others. These are the reasons why women with eating disorders have poor self-concept. They make self-defeating statements after food consumption.

The F ratio for age is 1.10, which is not significant. That means 15 to25 yrs women do not differ on self-concept score as compare to 30 to 40 yrs women. Table No. 4.3 shows that mean score of 15 to 25 yrs women is189.77 and 30 to 40 yrs women is186.46. It can be said that significant difference does not existed between 15 to 25 yrs women and 30 to 40 yrs women on self-concept score.

The F ratio for SES is 23.18, which is significant at .01 level. That means women of HSES higher socio economic status (higher socio economic status) significantly differ on self-concept score as compare to

women of MSES (middle socio economic status) and LSES (lower socio economic status). Table No. 4.4 shows that mean score of HSES women is 199.78, MSES women is 190.67 and LSES women is 173.89. It can be said that significant difference existed among various group of SES on self-concept score.

Women of MSES and LSES have shown poor self-concept as compare to HSES women. It has been concluded that women belonging to middle socio economic status and lower socio economic status have poor self-concept than the women belonging to higher socio economic status. It is quite natural and acceptable that women of middle and lower socio economic status get very few opportunities to develop their self fully. In comparison with higher social class women, career orientation and opportunities for self-enhancement are very few in middle and lower class. Moreover, the women of higher social class are more ambitious and they have high achievement motivation than the women of middle and lower class women.

The F ratio for women and age is .02, which is not significant. That means women and age do not interact each other on self-concept score. Table No.4.5 shows that mean score of 15 to 25 yrs women suffering from eating disorder is 186.06 , 30 to 40 yrs women suffering from eating disorder is 182.26,15 to 25 yrs normal women is 193.48 and 30 to 40 yrs normal women is 190.67.

The F ratio for women and SES is 2.00, which is not significant. That means women and SES do not interact each other on self-concept score. Table No. 4.6 shows that score of HSES women suffering from eating

disorder is 198.12 and MSES women suffering from eating disorder is 182.25,LSES women suffering from eating disorder is 172.10, HSES normal women is 201.45, MSES normal women is 199.09 and LSES normal women is 175.69.

The F ratio for age and SES is 0.40, which is not significant. That means age and SES do not interact each other on self-concept score. Table No. 4.7 shows that mean score of 15 to 25 yrs HSES women is 199.62, 15 to 25 MSES women is 192.52, 15 to 25 LSES women is 177.17, 30 to 40 yrs HSES women is 199.95, 30 to 40 yrs MSES women is 188.82 and 30 to 40 yrs LSES women is 170.62.

The F ratio for women, age and SES is 0.47, which is not significant. That means women age and SES do not interact each other on self-concept score. Table No. 4.8 shows that mean score of 15 to 25 yrs HSES women suffering from eating disorder is 198.47, 15 to 25 yrs MSES women suffering from eating disorder is 186.07, 15 to 25 yrs LSES women suffering from eating disorder is 173.63, 30 to 40 yrs HSES women suffering from eating disorder is 197.77, 30 to 40 yrs MSES women suffering from eating disorder is 178.43, 30 to 40 yrs LSES women suffering from eating disorder is 170.57, 15 to 25 yrs HSES normal women is 200.77, 15 to 25 yrs MSES normal women is 198.97, 15 to 25 yrs LSES normal women is 180.70, 30 to 40 yrs HSES normal women is 202.13, 30 to 40 yrs MSES normal women is 199.20 and 30 to 40 yrs LSES normal women is 170.67.

A1B1C1-A1B1C3 women suffering from eating disorder of 15 to 25 yrs HSES - women suffering from eating disorder of 15 to 25 yrs LSES. The mean score of women suffering from eating disorder of 15 to 25 yrs

HSES is 198.47 and women suffering from eating disorder of 15 to 25 yrs LSES is 173.63. Difference between two mean groups is 24.84. That means women suffering from eating disorder of 15 to 25 yrs HSES significantly differ on self-concept score as compare to women suffering from eating disorder of 15 to 25 yrs LSES.

A1B1C1-A1B2C2 women suffering from eating disorder of 15 to 25 yrs HSES - women suffering from eating disorder of 30 to 40 yrs MSES. The mean score of women suffering from eating disorder of 15 to 25 yrs HSES is 198.47 and women suffering from eating disorder of 30 to 40 yrs MSES is 178.43. Difference between two mean groups is 20.04. That means women suffering from eating disorder of 15 to 25 yrs HSES significantly differ on self-concept score as compare to women suffering from eating disorder of 30 to 40 yrs MSES.

A1B1C1-A1B2C3 women suffering from eating disorder of 15 to 25 yrs HSES - women suffering from eating disorder of 30 to 40 yrs LSES. The mean score of women suffering from eating disorder of 15 to 25 yrs HSES is 198.47 and women suffering from eating disorder of 30 to 40 yrs LSES is 170.57. Difference between two mean groups is 27.90. That means women suffering from eating disorder of 15 to 25 yrs HSES significantly differ on self-concept score as compare to women suffering from eating disorder of 30 to 40 yrs LSES.

A1B1C1-A2B1C1 women suffering from eating disorder of 15 to 25 yrs HSES - normal women of 15 to 25 yrs HSES. The mean score of women suffering from eating disorder of 15 to 25 yrs HSES is 198.47 and normal women of 15 to 25 yrs HSES is 180.70. Difference between two

mean groups is 17.77. That means women suffering from eating disorder of 15 to 25 yrs HSES significantly differ on self-concept score as compare to normal women of 15 to 25 yrs HSES.

A1B1C1-A2B2C3 women suffering from eating disorder of 15 to 25 yrs HSES – normal women 30 to 40 yrs LSES. The mean score of women suffering from eating disorder of 15 to 25 yrs HSES is 198.47 and normal women 30 to 40 yrs LSES is 170.67. Difference between two mean groups is 27.80. That means women suffering from eating disorder of 15 to 25 yrs HSES significantly differ on self-concept score as compare to normal women 30 to 40 yrs LSES.

A1B1C2-A2B2C1 women suffering from eating disorder of 15 to 25 yrs MSES – normal women 30 to 40 yrs HSES. The mean score of women suffering from eating disorder of 15 to 25 yrs MSES is 186.07 and normal women 30 to 40 yrs HSES is 202.13. Difference between two mean groups is 16.06. That means women suffering from eating disorder of 15 to 25 yrs MSES significantly differ on self-concept score as compare to normal women 30 to 40 yrs HSES.

A1B1C3-A1B2C1 women suffering from eating disorder of 15 to 25 yrs LSES – women suffering from eating disorder of 30 to 40 yrs HSES. The mean score of women suffering from eating disorder of 15 to 25 yrs LSES is 173.63 and women suffering from eating disorder of 30 to 40 yrs HSES is 197.77. Difference between two mean groups is 24.14. That means women suffering from eating disorder of 15 to 25 yrs LSES significantly differ on self-concept score as compare to women suffering from eating disorder of 30 to 40 yrs HSES.

A1B1C3-A2B1C1 women suffering from eating disorder of 15 to 25 yrs LSES – normal women of 15 to 25 yrs HSES. The mean score of women suffering from eating disorder of 15 to 25 yrs LSES is 173.63 and normal women of 15 to 25 yrs HSES is 200.77. Difference between two mean groups is 27.14. That means women suffering from eating disorder of 15 to 25 yrs LSES significantly differ on self-concept score as compare to normal women of 15 to 25 yrs HSES.

A1B1C3-A2B1C2 women suffering from eating disorder of 15 to 25 yrs LSES – normal women of 15 to 25 yrs MSES. The mean score of women suffering from eating disorder of 15 to 25 yrs LSES is 173.63 and normal women of 15 to 25 yrs MSES is 198.97. Difference between two mean groups is 25.34. That means women suffering from eating disorder of 15 to 25 yrs LSES significantly differ on self-concept score as compare to normal women of 15 to 25 yrs MSES.

A1B1C3-A2B2C1 women suffering from eating disorder of 15 to 25 yrs LSES – normal women of 30 to 40 yrs HSES. The mean score of women suffering from eating disorder of 15 to 25 yrs LSES is 173.63 and normal women of 30 to 40 yrs HSES is 202.13. Difference between two mean groups is 28.50. That means women suffering from eating disorder of 15 to 25 yrs LSES significantly differ on self-concept score as compare to normal women of 30 to 40 yrs HSES.

A1B1C3-A2B2C2 women suffering from eating disorder of 15 to 25 yrs LSES – normal women of 30 to 40 yrs MSES. The mean score of women suffering from eating disorder of 15 to 25 yrs LSES is 173.63 and normal women of 30 to 40 yrs MSES is 199.20. Difference between two

mean groups is 25.27. That means women suffering from eating disorder of 15 to 25 yrs LSES significantly differ on self-concept score as compare to normal women of 30 to 40 yrs MSES.

A1B2C1-A1B2C2 women suffering from eating disorder of 30 to 40 yrs HSES - women suffering from eating disorder of 30 to 40 yrs MSES. The mean score of women suffering from eating disorder of 30 to 40 yrs HSES is 197.77 and women suffering from eating disorder of 30 to 40 yrs MSES is 178.43. Difference between two mean groups is 19.34. That means women suffering from eating disorder of 30 to 40 yrs HSES significantly differ on self-concept score as compare to women suffering from eating disorder of 30 to 40 yrs MSES.

A1B2C1-A1B2C3 women suffering from eating disorder of 30 to 40 yrs HSES - women suffering from eating disorder of 30 to 40 yrs LSES. The mean score of women suffering from eating disorder of 30 to 40 yrs HSES is 197.77 and women suffering from eating disorder of 30 to 40 yrs LSES is 170.57. Difference between two mean groups is 27.20. That means women suffering from eating disorder of 30 to 40 yrs HSES significantly differ on self-concept score as compare to women suffering from eating disorder of 30 to 40 yrs LSES.

A1B2C1-A2B1C3 women suffering from eating disorder of 30 to 40 yrs HSES -normal women of 15 to 25 yrs LSES. The mean score of women suffering from eating disorder of 30 to 40 yrs HSES is 197.77 and normal women of 15 to 25 yrs LSES is 180.70. Difference between two mean groups is 17.07. That means women suffering from eating disorder of 30 to 40 yrs HSES significantly differ on self-concept score as compare to normal women of 15 to 25 yrs LSES.

A1B2C1-A2B2C3 women suffering from eating disorder of 30 to 40 yrs HSES -normal women of 30 to 40 yrs LSES. The mean score of women suffering from eating disorder of 30 to 40 yrs HSES is 197.77 and normal women of 30 to 40 yrs LSES is 170.67. Difference between two mean groups is 27.10. That means women suffering from eating disorder of 30 to 40 yrs HSES significantly differ on self-concept score as compare to normal women of 30 to 40 yrs LSES.

A1B2C2-A2B1C1 women suffering from eating disorder of 30 to 40 yrs MSES – normal women of 15 to 25 yrs HSES. The mean score of women suffering from eating disorder of 30 to 40 yrs MSES is 178.43 and normal women of 15 to 25 yrs HSES is 200.77. Difference between two mean groups is 22.34. That means women suffering from eating disorder of 30 to 40 yrs MSES significantly differ on self-concept score as compare to normal women of 15 to 25 yrs HSES.

A1B2C2-A2B1C2 women suffering from eating disorder of 30 to 40 yrs MSES – normal women of 15 to 25 yrs MSES. The mean score of women suffering from eating disorder of 30 to 40 yrs MSES is 178.43 and normal women of 15 to 25 yrs MSES is 198.97. Difference between two mean groups is 20.54. That means women suffering from eating disorder of 30 to 40 yrs MSES significantly differ on self-concept score as compare to normal women of 15 to 25 yrs MSES.

A1B2C2-A2B2C1 women suffering from eating disorder of 30 to 40 yrs MSES – normal women of 30 to 40 yrs HSES. The mean score of women suffering from eating disorder of 30 to 40 yrs MSES is 178.43 and normal women of 30 to 40 yrs HSES is 202.13. Difference between two

mean groups is 23.70. That means women suffering from eating disorder of 30 to 40 yrs MSES significantly differ on self-concept score as compare to normal women of 30 to 40 yrs HSES.

A1B2C2-A2B2C2 women suffering from eating disorder of 30 to 40 yrs MSES – normal women of 30 to 40 yrs MSES. The mean score of women suffering from eating disorder of 30 to 40 yrs MSES is 178.43 and normal women of 30 to 40 yrs MSES is 199.20. Difference between two mean groups is 20.77. That means women suffering from eating disorder of 30 to 40 yrs MSES significantly differ on self-concept score as compare to normal women of 30 to 40 yrs MSES.

A1B2C3-A2B1C1 women suffering from eating disorder of 30 to 40 yrs LSES – normal women of 15 to 25 yrs HSES. The mean score of women suffering from eating disorder of 30 to 40 yrs LSES is 170.57 and normal women of 15 to 25 yrs HSES is 200.77. Difference between two mean groups is 30.20. That means women suffering from eating disorder of 30 to 40 yrs LSES significantly differ on self-concept score as compare to normal women of 15 to 25 yrs HSES.

A1B2C3-A2B1C2 women suffering from eating disorder of 30 to 40 yrs LSES – normal women of 15 to 25 yrs MSES. The mean score of women suffering from eating disorder of 30 to 40 yrs LSES is 170.57 and normal women of 15 to 25 yrs MSES is 198.97. Difference between two mean groups is 28.40. That means women suffering from eating disorder of 30 to 40 yrs LSES significantly differ on self-concept score as compare to normal women of 15 to 25 yrs MSES.

A1B2C3-A2B2C1 women suffering from eating disorder of 30 to 40 yrs LSES – normal women of 30 to 40 yrs HSES. The mean score of women suffering from eating disorder of 30 to 40 yrs LSES is 170.57 and normal women of 30 to 40 yrs HSES is 202.13. Difference between two mean groups is 31.56. That means women suffering from eating disorder of 30 to 40 yrs LSES significantly differ on self-concept score as compare to normal women of 30 to 40 yrs HSES.

A1B2C3-A2B2C2 women suffering from eating disorder of 30 to 40 yrs LSES – normal women of 30 to 40 yrs MSES. The mean score of women suffering from eating disorder of 30 to 40 yrs LSES is 170.57 and normal women of 30 to 40 yrs MSES is 199.20. Difference between two mean groups is 28.63. That means women suffering from eating disorder of 30 to 40 yrs LSES significantly differ on self-concept score as compare to normal women of 30 to 40 yrs MSES.

A2B1C1-A2B1C3 normal women of 15 to 25 yrs HSES -normal women of 15 to 25 yrs LSES. The mean score of normal women of 15 to 25 yrs HSES is 200.77 and normal women of 15 to 25 yrs LSES is 180.70. Difference between two mean groups is 20.07. That means normal women of 15 to 25 yrs HSES significantly differ on self-concept score as compare to normal women of 15 to 25 yrs LSES.

A2B1C1-A2B2C3 normal women of 15 to 25 yrs HSES -normal women of 30 to 40 yrs LSES. The mean score of normal women of 15 to 25 yrs HSES is 200.77 and normal women of 30 to 40 f yrs LSES is170.67. Difference between two mean groups is 30.10. That means normal women of 15 to 25 yrs HSES significantly differ on self-concept score as compare to normal women of 30 to 40 yrs LSES.

A2B1C2-A2B1C3 normal women of 15 to 25 yrs MSES -normal women of 15 to 25 yrs LSES. The mean score of normal women of 15 to 25 yrs MSES is 198.97 and normal women of 15 to 25 yrs LSES is 180.70. Difference between two mean groups is 18.27. That means normal women of 15 to 25 yrs MSES significantly differ on self-concept score as compare to normal women of 15 to 25 yrs LSES.

A2B1C2-A2B2C3 normal women of 15 to 25 yrs MSES -normal women of 30 to 40 yrs LSES. The mean score of normal women of 15 to 25 yrs MSES is 198.97 and normal women of 30 to 40 f yrs LSES is170.67. Difference between two mean groups is 28.30. That means normal women of 15 to 25 yrs MSES significantly differ on self-concept score as compare to normal women of 30 to 40 yrs LSES.

A2B1C3-A2B2C1 normal women of 15 to 25 yrs LSES – normal women of 30 to 40 yrs HSES. The mean score of normal women of 15 to 25 yrs LSES is 180.70 and normal women of 30 to 40 yrs HSES is 202.13. Difference between two mean groups is 21.43. That means normal women of 15 to 25 yrs LSES significantly differ on self-concept score as compare to normal women of 30 to 40 yrs HSES.

A2B1C3-A2B2C2 normal women of 15 to 25 yrs LSES – normal women of 30 to 40 yrs MSES. The mean score of normal women of 15 to 25 yrs LSES is 180.70 and normal women of 30 to 40 yrs MSES is 199.20. Difference between two mean groups is 18.50. That means normal women of 15 to 25 yrs LSES significantly differ on self-concept score as compare to normal women of 30 to 40 yrs MSES.

A2B2C1-A2B2C3 normal women of 30 to 40 yrs HSES -normal women of 30 to 40 yrs LSES. The mean score of normal women of 30 to 40 yrs HSES is 202.13 and normal women of 30 to 40 f yrs LSES is 170.67. Difference between two mean groups is 31.46. That means normal women of 30 to 40 yrs HSES significantly differ on self-concept score as compare to normal women of 30 to 40 yrs LSES.

A2B2C2-A2B2C3 normal women of 30 to 40 yrs MSES -normal women of 30 to 40 yrs LSES. The mean score of normal women of 30 to 40 yrs MSES is 199.20 and normal women of 30 to 40 f yrs LSES is 170.67. Difference between two mean groups is 28.53. That means normal women of 30 to 40 yrs MSES significantly differ on self-concept score as compare to normal women of 30 to 40 yrs LSES.

2.2 Results and discussion of Anxiety :

Table 4.10

Showing Results of ANOVA on Score of Anxiety

Source of Variation	SS	DF	MS	F	Level of Significant
Ass	8801.11	1	8801.11	117.18	.01
Bss	1.88	1	1.88	0.03	NS
Css	1214.51	2	607.26	8.08	.01
A x B	41.34	1	41.34	0.55	NS
A x C	536.70	2	268.35	3.57	.05
B x C	483.67	2	241.83	3.22	.05
A x B x C	52.28	2	26.14	0.35	NS
Wss	26139.80	348	75.11		
Tss	37271.29	359			

Table : 4.11

Showing Mean Scores of Anxiety - A (Women)

	A1	A2
M	73.60	63.71
N	180	180

Table : 4.12

Showing Mean Scores of Self Anxiety - B (Age Group)

	B1	B2
M	68.73	68.58
N	180	180

Table : 4.13

Showing Mean Scores of Anxiety - C (SES)

	C1	C2	C3
M	69.13	70.63	66.21
N	120	120	120

Table : 4.14

Showing Mean Scores of Amxiety - A x B (Women x Age Group)

		A1	A2
B1	M	74.01	63.44
	N	90	90
B2	M	73.19	63.98
	N	90	90

Table : 4.15

Showing Mean Scores of Anxiety - A x C (Women x SES)

		A1	A2
C1	**M**	72.82	65.44
	N	60	60
C2	**M**	77.24	64.03
	N	60	60
C3	**M**	70.75	61.67
	N	60	60

Table : 4.16

Showing Mean Scores of Anxiety - B x C (Age Group x SES)

		B1	B2
C1	**M**	69.87	68.39
	N	60	60
C2	**M**	71.67	69.60
	N	60	60
C3	**M**	64.65	67.77
	N	60	60

Table : 4.17

Showing Mean Scores of Anxiety - A x B x C

(Women x Age Group x SES)

		A1		A2	
		B1	**B2**	**B1**	**B2**
C1	**M**	74.37	71.27	65.37	65.50
	N	30	30	30	30
C2	**M**	78.60	75.87	64.73	63.33
	N	30	30	30	30
C3	**M**	69.07	72.43	60.23	63.10
	N	30	30	30	30

Table : 4.18

LSD Results of Anxiety (Simple effect)

Pair			Mean			Diff.	.01	.05	Level of Sig.
A1B1C1	-	A1B1C2	74.37	-	78.60	4.23	4.57	6.15	NS
A1B1C1	-	A1B1C3	74.37	-	69.07	5.30	4.57	6.15	*
A1B1C1	-	A1B2C1	74.37	-	71.27	3.10	4.57	6.15	NS
A1B1C1	-	A1B2C2	74.37	-	75.87	1.50	4.57	6.15	NS
A1B1C1	-	A1B2C3	74.37	-	72.43	1.94	4.57	6.15	NS
A1B1C1	-	A2B1C1	74.37	-	65.37	9.00	4.57	6.15	**
A1B1C1	-	A2B1C2	74.37	-	64.73	9.64	4.57	6.15	**
A1B1C1	-	A2B1C3	74.37	-	60.23	14.14	4.57	6.15	**
A1B1C1	-	A2B2C1	74.37	-	65.50	8.87	4.57	6.15	**
A1B1C1	-	A2B2C2	74.37	-	63.33	11.04	4.57	6.15	**
A1B1C1	-	A2B2C3	74.37	-	63.10	11.27	4.57	6.15	**
A1B1C2	-	A1B1C3	78.60	-	69.07	9.53	4.57	6.15	**
A1B1C2	-	A1B2C1	78.60	-	71.27	7.33	4.57	6.15	**
A1B1C2	-	A1B2C2	78.60	-	75.87	2.73	4.57	6.15	NS
A1B1C2	-	A1B2C3	78.60	-	72.43	6.17	4.57	6.15	**
A1B1C2	-	A2B1C1	78.60	-	65.37	13.23	4.57	6.15	**
A1B1C2	-	A2B1C2	78.60	-	64.73	13.87	4.57	6.15	**
A1B1C2	-	A2B1C3	78.60	-	60.23	18.37	4.57	6.15	**
A1B1C2	-	A2B2C1	78.60	-	65.50	13.10	4.57	6.15	**
A1B1C2	-	A2B2C2	78.60	-	63.33	15.27	4.57	6.15	**
A1B1C2	-	A2B2C3	78.60	-	63.10	15.50	4.57	6.15	**
A1B1C3	-	A1B2C1	69.07	-	71.27	2.20	4.57	6.15	NS
A1B1C3	-	A1B2C2	69.07	-	75.87	6.80	4.57	6.15	**
A1B1C3	-	A1B2C3	69.07	-	72.43	3.36	4.57	6.15	NS
A1B1C3		A2B1C1	69.07		65.37	3.70	4.57	6.15	NS
A1B1C3	-	A2B1C2	69.07	-	64.73	4.34	4.57	6.15	NS
A1B1C3	-	A2B1C3	69.07	-	60.23	8.84	4.57	6.15	**
A1B1C3	-	A2B2C1	69.07	-	65.50	3.57	4.57	6.15	NS
A1B1C3	-	A2B2C2	69.07	-	63.33	5.74	4.57	6.15	*
A1B1C3	-	A2B2C3	69.07	-	63.10	5.97	4.57	6.15	*
A1B2C1	-	A1B2C2	71.27	-	75.87	4.60	4.57	6.15	*

A1B2C1	-	A1B2C3	71.27	-	72.43	1.16	4.57	6.15	NS
A1B2C1	-	A2B1C1	71.27	-	65.37	5.90	4.57	6.15	*
A1B2C1	-	A2B1C2	71.27	-	64.73	6.54	4.57	6.15	**
A1B2C1	-	A2B1C3	71.27	-	60.23	11.04	4.57	6.15	**
A1B2C1	-	A2B2C1	71.27	-	65.50	5.77	4.57	6.15	*
A1B2C1	-	A2B2C2	71.27	-	63.33	7.94	4.57	6.15	**
A1B2C1		A2B2C3	71.27		63.10	8.17	4.57	6.15	**
A1B2C2	-	A1B2C3	75.87	-	72.43	3.44	4.57	6.15	NS
A1B2C2	-	A2B1C1	75.87	-	65.37	10.50	4.57	6.15	**
A1B2C2	-	A2B1C2	75.87	-	64.73	11.14	4.57	6.15	**
A1B2C2	-	A2B1C3	75.87	-	60.23	15.64	4.57	6.15	**
A1B2C2	-	A2B2C1	75.87	-	65.50	10.37	4.57	6.15	**
A1B2C2	-	A2B2C2	75.87	-	63.33	12.54	4.57	6.15	**
A1B2C2	-	A2B2C3	75.87	-	63.10	12.77	4.57	6.15	**
A1B2C3	-	A2B1C1	72.43	-	65.37	7.06	4.57	6.15	**
A1B2C3	-	A2B1C2	72.43	-	64.73	7.70	4.57	6.15	**
A1B2C3	-	A2B1C3	72.43	-	60.23	12.20	4.57	6.15	**
A1B2C3	-	A2B2C1	72.43	-	65.50	6.93	4.57	6.15	**
A1B2C3	-	A2B2C2	72.43	-	63.33	9.10	4.57	6.15	**
A1B2C3	-	A2B2C3	72.43	-	63.10	9.33	4.57	6.15	**
A2B1C1	-	A2B1C2	65.37	-	64.73	0.64	4.57	6.15	NS
A2B1C1	-	A2B1C3	65.37	-	60.23	5.14	4.57	6.15	*
A2B1C1	-	A2B2C1	65.37	-	65.50	0.13	4.57	6.15	NS
A2B1C1	-	A2B2C2	65.37	-	63.33	2.04	4.57	6.15	NS
A2B1C1	-	A2B2C3	65.37	-	63.10	2.27	4.57	6.15	NS
A2B1C2	-	A2B1C3	64.73	-	60.23	4.50	4.57	6.15	NS
A2B1C2		A2B2C1	64.73		65.50	0.77	4.57	6.15	NS
A2B1C2	-	A2B2C2	64.73	-	63.33	1.40	4.57	6.15	NS
A2B1C2	-	A2B2C3	64.73	-	63.10	1.63	4.57	6.15	NS
A2B1C3	-	A2B2C1	60.23	-	65.50	5.27	4.57	6.15	*
A2B1C3	-	A2B2C2	60.23	-	63.33	3.10	4.57	6.15	NS
A2B1C3	-	A2B2C3	60.23	-	63.10	2.87	4.57	6.15	NS
A2B2C1	-	A2B2C2	65.50	-	63.33	2.17	4.57	6.15	NS
A2B2C1	-	A2B2C3	65.50	-	63.10	2.40	4.57	6.15	NS
A2B2C2		A2B2C3	63.33		63.10	0.23	4.57	6.15	NS

Figure : 4.8

Showing Mean Scores of Anxiety -A (Women)

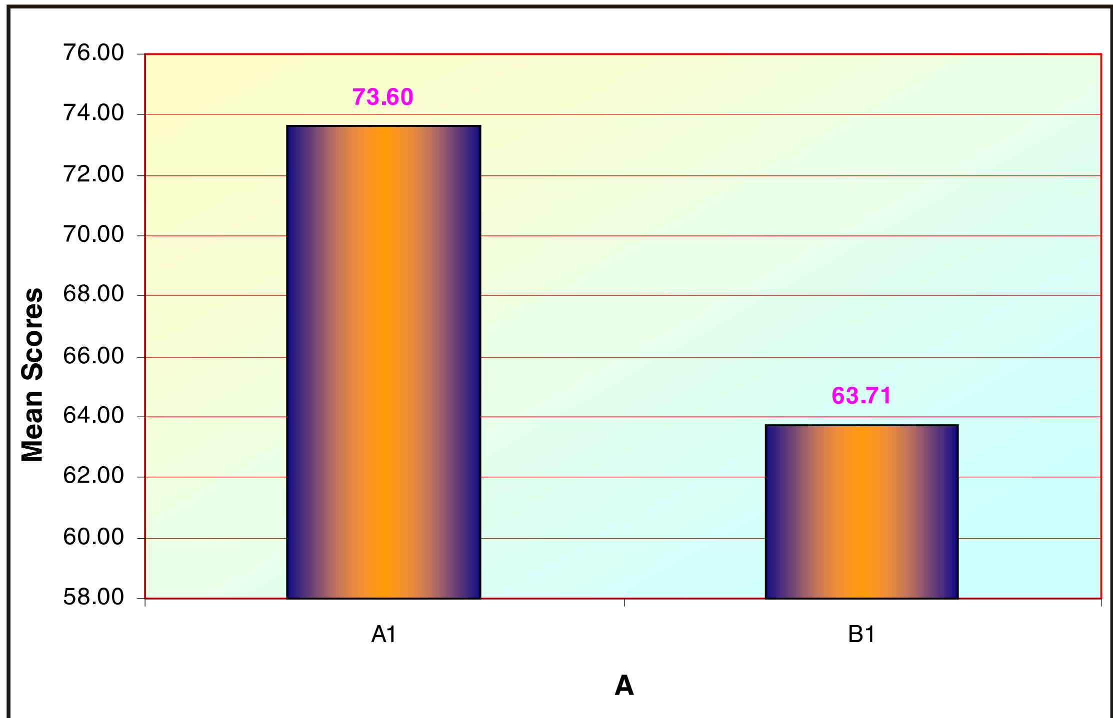


Figure : 4.9

Showing Mean Scores of Anxiety -B (Age Group)

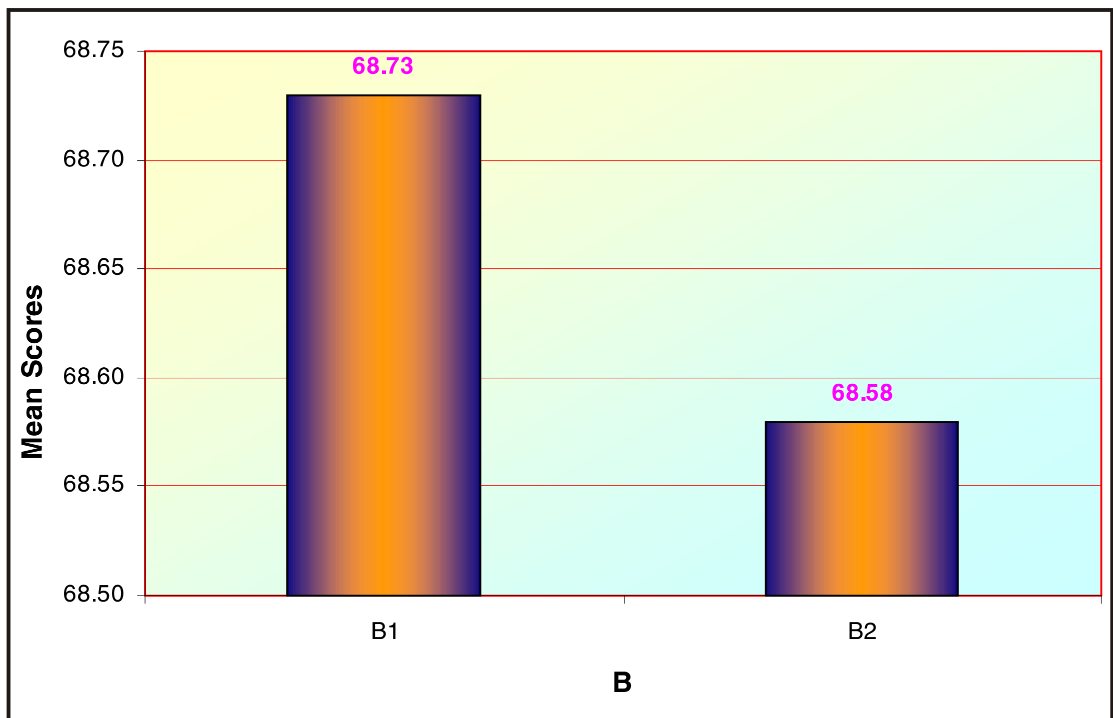


Figure : 4.10

Showing Mean Scores of Anxiety -C (SES)

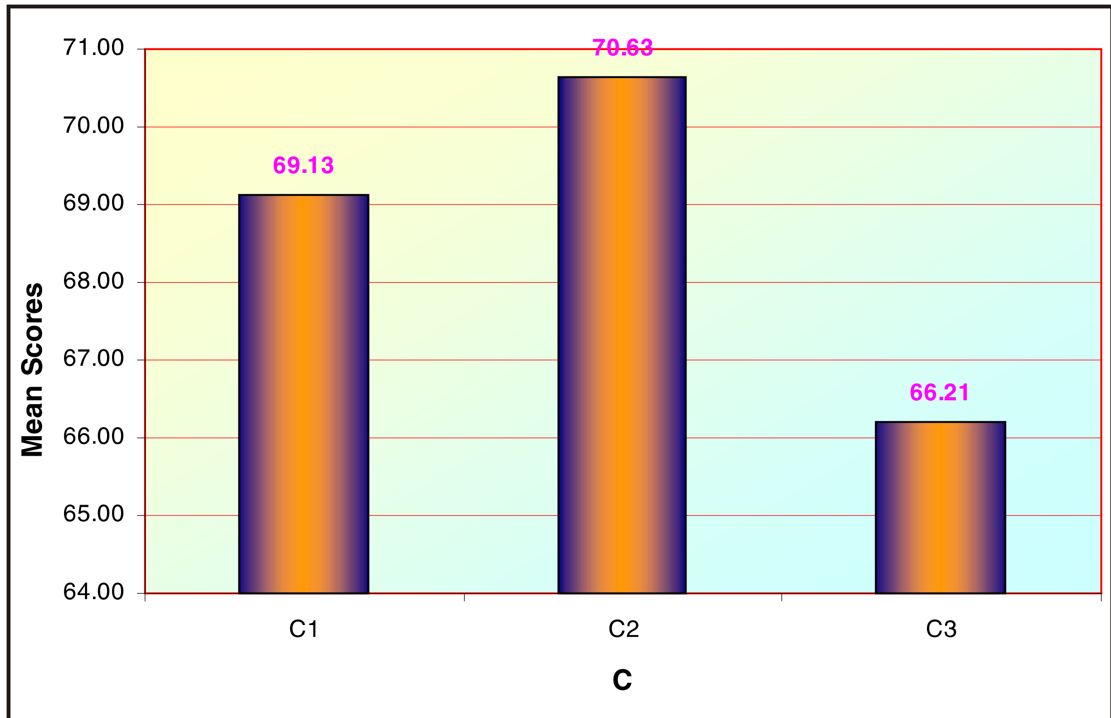


Figure : 4.11

Showing Mean Scores of Anxiety -A x B (Women x Age Group)

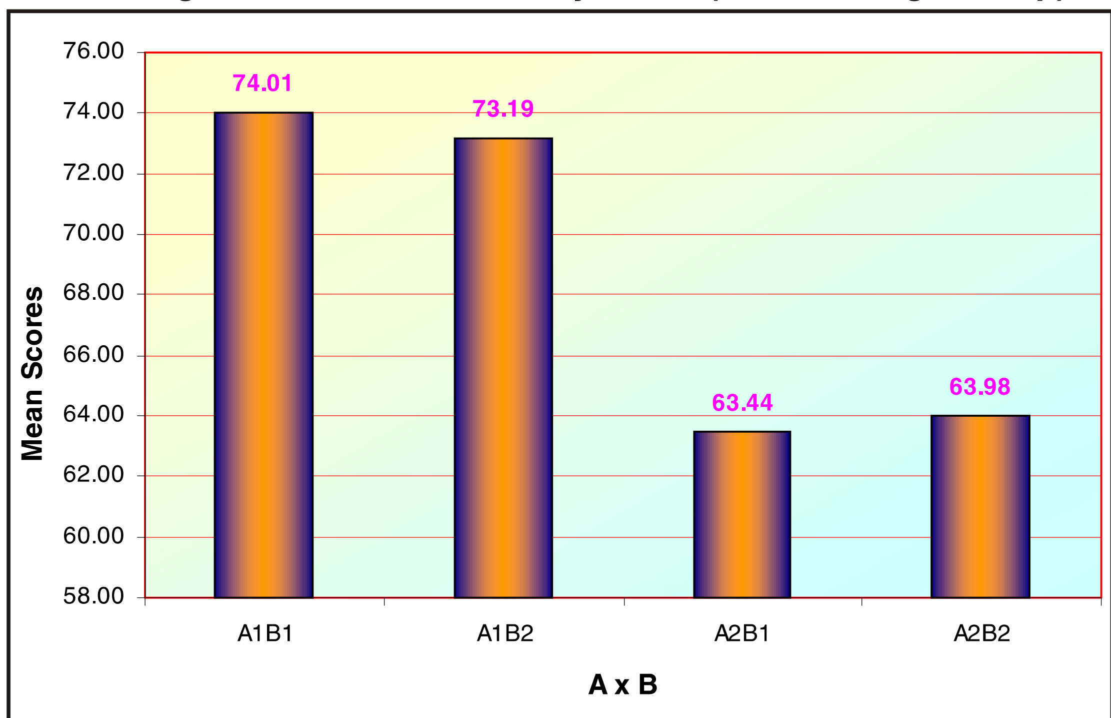


Figure : 4.12

Showing Mean Scores of Anxiety -A x C (Women SES)

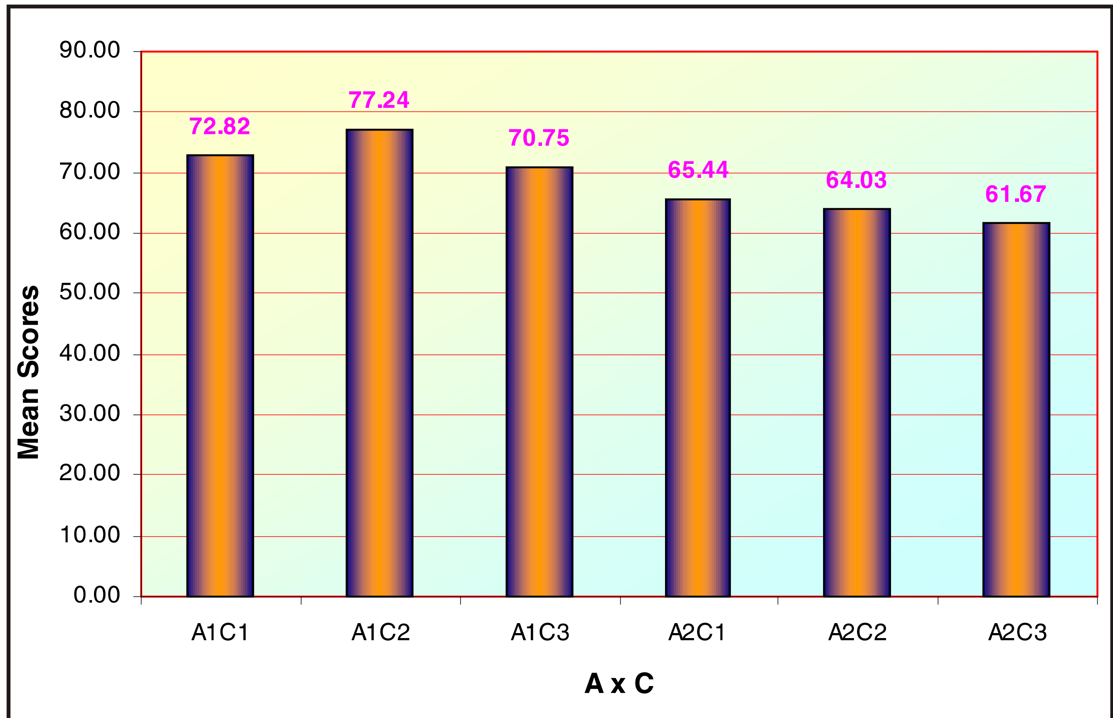


Figure : 4.13

Showing Mean Scores of Anxiety - B x C (Age Group x SES)

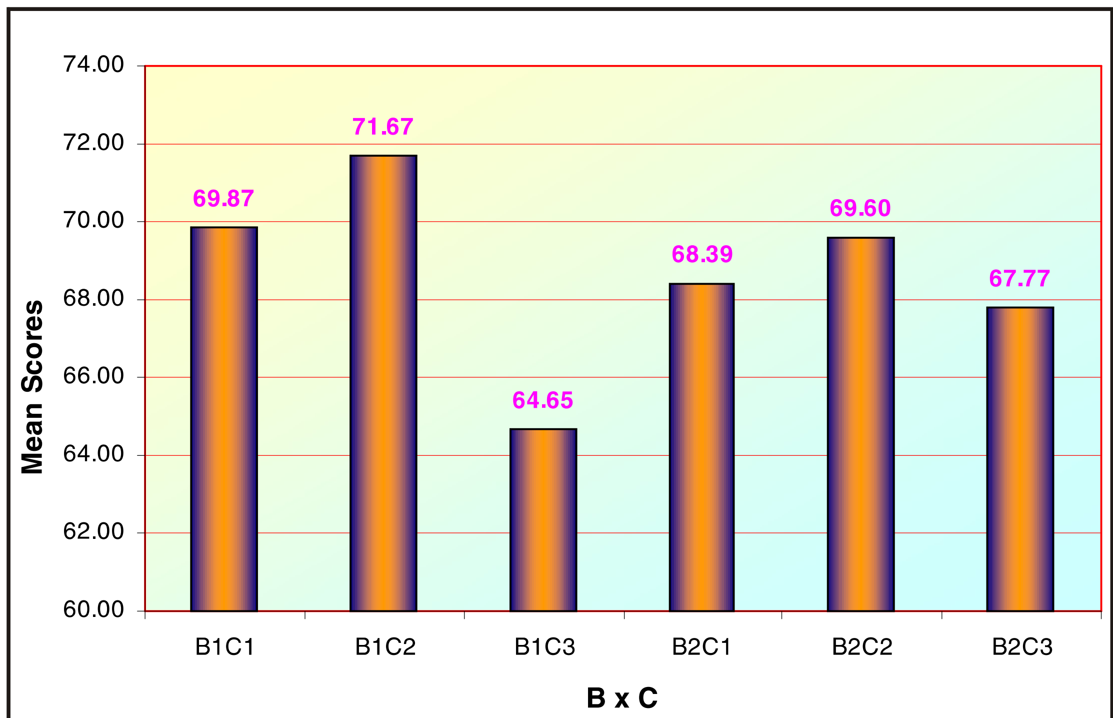
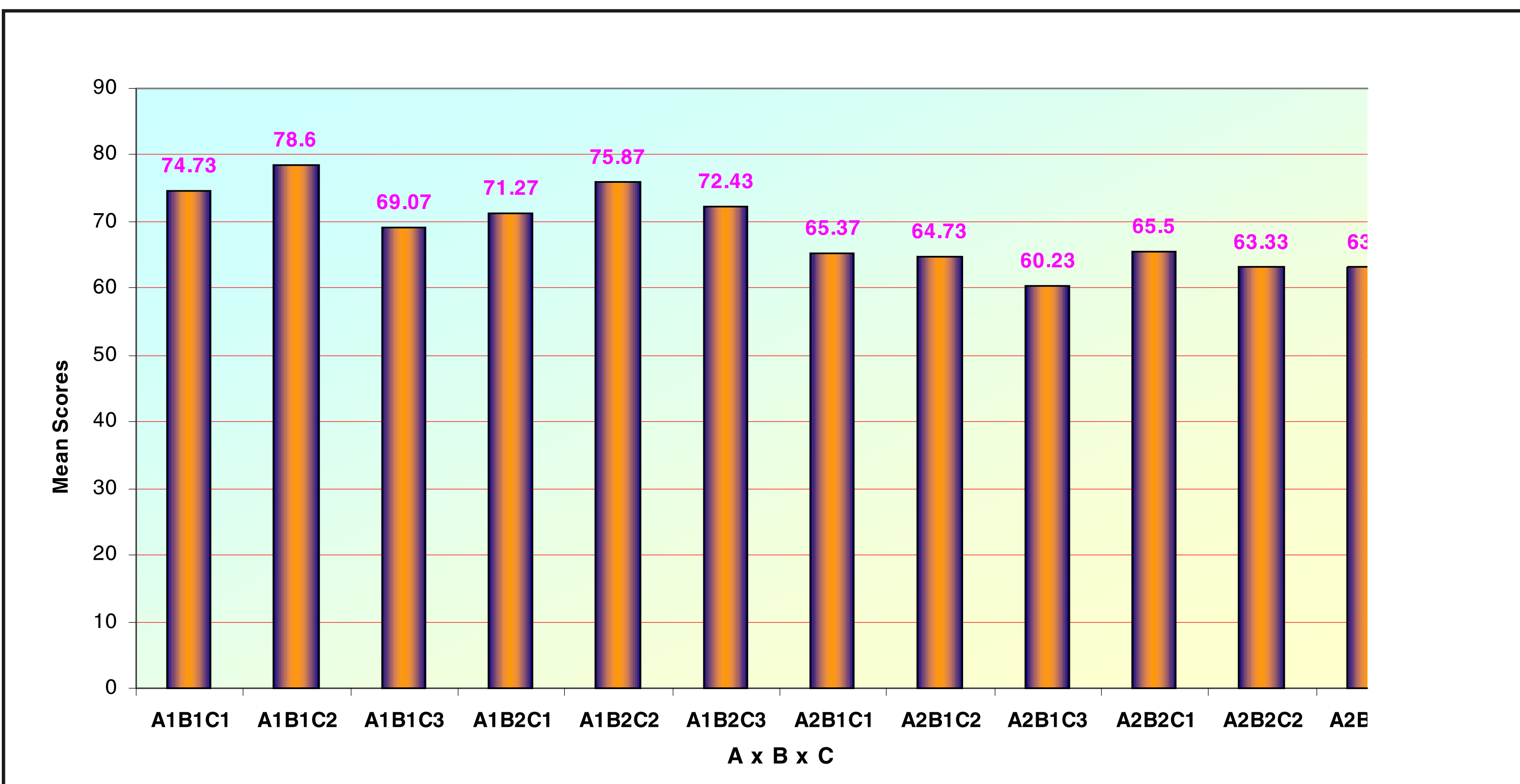


Figure : 4.14

Showing Mean Scores of Anxiety - A x B x C (Women x Age Group x SES)



The results of ANOVA on anxiety score Table No. 4.10 is consulted and it is found that F ratio for women is 117.18 which is significant at .01 level. That means women suffering from eating disorder significantly differ on anxiety score as compare to normal women. Table No. 4.11 the mean score of women suffering from eating disorder is 73.60 and normal women is 63.71. it is clearly said that significant differences existed between women suffering from eating disorder and normal women on anxiety score.

Women suffering from eating disorder have shown more anxiety as compare to the normal women. It is generally true that those men and women eat more or less when they are severely frustrate or depressed. Normal women have less anxiety as compare to the women of the class with eating disorder. It has been established that people with eating disorder have an indefinable personality. Studies have also shown that some women suffering from anorexia nervosa are indeed more neurotic or obsessional. The studies also saddest that those women who have lost weight by dieting and excessive exercise are more introverted, more anxious and more dependent than normal women. Thus, women with eating disorder show more anxiety than normal women, just because they are more neurotic and anxious.

The F ratio for age is 0.03, which is not significant. That means 15 to25 yrs women do not differ on anxiety score as compare to 30 to 40 yrs women. Table No. 4.12 shows that mean score of 15 to 25 yrs women is 68.73 and 30 to 40 yrs women is 68.58. It can be said that significant difference does not existed between 15 to 25 yrs women and 30 to 40 yrs women on anxiety score.

The F ratio for SES is 8.08, which is significant at .01 level. That means HSES women significantly differ on anxiety score as compare to MSES women and LSES women. Table No. 4.13 shows that mean score of HSES women is 69.13, MSES women is 70.63 and LSES women is 66.21. It can be said that significant difference existed among various group of SES on anxiety score.

Women of HSES and MSES have shown more anxiety as compare to LSES women. Women of HSES and MSES show more anxiety than LSES women because women belonging to HSES and MSES live in competitive world with many ambitions Compared to them. Women belonging to lower class do not have much demand from life. They are happier and less anxious about future. women belonging to higher economic status and middle socio economic status are more career oriented and desire more from life than the normal women belonging to lower economic class. In general, it can be said that anxiety is a virtue of higher class and middle class than lower class. Those who live with very few needs have less anxiety than the persons with large fortune.

The F ratio for women and age is .0.55, which is not significant. That means women and age do not interact each other on anxiety score. Table No.4.14 shows that mean score of 15 to 25 yrs women suffering from eating disorder is 74.01, 30 to 40 yrs women suffering from eating disorder is 73.19, 15 to 25 yrs normal women is 63.44 and 30 to 40 yrs normal women is 63.98.

The F ratio for women and SES is 3.57, which is significant at .05 level. That means women and SES significantly interact each other on

anxiety score. Table No. 4.15 shows that score of HSES women suffering from eating disorder is 72.82 and MSES women suffering from eating disorder is 77.24, LSES women suffering from eating disorder is 70.75, HSES normal women is 65.44, MSES normal women is 64.03 and LSES normal women is 61.67.

The F ratio for age and SES is 3.22, which is significant at .05 level. That means age and SES significantly interact each other on anxiety score. Table No. 4.16 shows that mean score of 15 to 25 yrs HSES women is 69.87, 15 to 25 MSES women is 71.67, 15 to 25 LSES women is 64.65, 30 to 40 yrs HSES women is 68.39, 30 to 40 yrs MSES women is 69.60 and 30 to 40 yrs LSES women is 67.77.

The F ratio for women, age and SES is 0.35, which is not significant. That means women age and SES do not interact each other on anxiety score. Table No. 4.17 shows that mean score of 15 to 25 yrs HSES women suffering from eating disorder is 74.37, 15 to 25 yrs MSES women suffering from eating disorder is 78.60, 15 to 25 yrs LSES women suffering from eating disorder is 69.07, 30 to 40 yrs HSES women suffering from eating disorder is 71.27, 30 to 40 yrs MSES women suffering from eating disorder is 75.87, 30 to 40 yrs LSES women suffering from eating disorder is 72.43, 15 to 25 yrs HSES normal women is 65.37, 15 to 25 yrs MSES normal women is 64.73, 15 to 25 yrs LSES normal women is 60.23, 30 to 40 yrs HSES normal women is 65.50, 30 to 40 yrs MSES normal women is 63.33 and 30 to 40 yrs LSES normal women is 63.10.

A1B1C1-A1B1C3 women suffering from eating disorder of 15 to 25 yrs HSES - women suffering from eating disorder of 15 to 25 yrs LSES.

The mean score of women suffering from eating disorder of 15 to 25 yrs HSES is 74.37 and women suffering from eating disorder of 15 to 25 yrs LSES is 69.07. Difference between two mean groups is 5.30. That means women suffering from eating disorder of 15 to 25 yrs HSES significantly differ on anxiety score as compare to women suffering from eating disorder of 15 to 25 yrs LSES.

A1B1C1-A2B1C1 women suffering from eating disorder of 15 to 25 yrs HSES -normal women of 15 to 25 yrs HSES. The mean score of women suffering from eating disorder of 15 to 25 yrs HSES is 74.37 and normal women of 15 to 25 yrs HSES is 65.37. Difference between two mean groups is 9.00. That means women suffering from eating disorder of 15 to 25 yrs HSES significantly differ on anxiety score as compare to normal women of 15 to 25 yrs HSES.

A1B1C1-A2B1C2 women suffering from eating disorder of 15 to 25 yrs HSES -normal women of 15 to 25 yrs MSES. The mean score of women suffering from eating disorder of 15 to 25 yrs HSES is 74.37 and normal women of 15 to 25 yrs MSES is 64.73. Difference between two mean groups is 9.64. That means women suffering from eating disorder of 15 to 25 yrs HSES significantly differ on anxiety score as compare to normal women of 15 to 25 yrs MSES.

A1B1C1-A2B1C3 women suffering from eating disorder of 15 to 25 yrs HSES -normal women of 15 to 25 yrs LSES. The mean score of women suffering from eating disorder of 15 to 25 yrs HSES is 74.37 and normal women of 15 to 25 yrs LSES is 60.23. Difference between two mean groups is 14.14. That means women suffering from eating disorder of 15 to 25 yrs

HSES significantly differ on anxiety score as compare to normal women of 15 to 25 yrs LSES.

A1B1C1-A2B2C1 women suffering from eating disorder of 15 to 25 yrs HSES -normal women of 30 to 40 yrs HSES. The mean score of women suffering from eating disorder of 15 to 25 yrs HSES is 74.37 and normal women of 30 to 40 yrs HSES is 65.50. Difference between two mean groups is 8.87. That means women suffering from eating disorder of 15 to 25 yrs HSES significantly differ on anxiety score as compare to normal women of 30 to 40 yrs HSES.

A1B1C1-A2B2C2 women suffering from eating disorder of 15 to 25 yrs HSES -normal women of 30 to 40 yrs MSES. The mean score of women suffering from eating disorder of 15 to 25 yrs HSES is 74.37 and normal women of 30 to 40 yrs MSES is 63.33. Difference between two mean groups is 11.04. That means women suffering from eating disorder of 15 to 25 yrs HSES significantly differ on anxiety score as compare to normal women of 30 to 40 yrs MSES.

A1B1C1-A2B2C3 women suffering from eating disorder of 15 to 25 yrs HSES -normal women of 30 to 40 yrs LSES. The mean score of women suffering from eating disorder of 15 to 25 yrs HSES is 74.37 and normal women of 30 to 40 yrs LSES is 63.10. Difference between two mean groups is 11.27. That means women suffering from eating disorder of 15 to 25 yrs HSES significantly differ on anxiety score as compare to normal women of 30 to 40 yrs LSES.

A1B1C2-A1B1C3 women suffering from eating disorder of 15 to 25 yrs MSES –women suffering from eating disorder of 15 to 25 yrs LSES.

The mean score of women suffering from eating disorder of 15 to 25 yrs MSES is 78.60 and women suffering from eating disorder of 15 to 25 yrs LSES is 69.07. Difference between two mean groups is 9.53. That means women suffering from eating disorder of 15 to 25 yrs MSES significantly differ on anxiety score as compare to women suffering from eating disorder of 15 to 25 yrs LSES.

A1B1C2-A1B2C1 women suffering from eating disorder of 15 to 25 yrs MSES –women suffering from eating disorder of 30 to 40 yrs HSES. The mean score of women suffering from eating disorder of 15 to 25 yrs MSES is 78.60 and women suffering from eating disorder of 30 to 40 yrs HSES is 71.27. Difference between two mean groups is 7.33. That means women suffering from eating disorder of 15 to 25 yrs MSES significantly differ on anxiety score as compare to women suffering from eating disorder of 30 to 40 yrs HSES.

A1B1C2-A1B2C3 women suffering from eating disorder of 15 to 25 yrs MSES –women suffering from eating disorder of 30 to 40 yrs LSES. The mean score of women suffering from eating disorder of 15 to 25 yrs MSES is 78.60 and women suffering from eating disorder of 30 to 40 yrs LSES is 69.07. Difference between two mean groups is 9.53. That means women suffering from eating disorder of 15 to 25 yrs MSES significantly differ on anxiety score as compare to women suffering from eating disorder of 30 to 40 yrs LSES.

A1B1C2-A2B1C1 women suffering from eating disorder of 15 to 25 yrs MSES -normal women of 15 to 25 yrs HSES. The mean score of women suffering from eating disorder of 15 to 25 yrs MSES is 78.60 and normal

women of 15 to 25 yrs HSES is 65.37. Difference between two mean groups is 13.23. That means women suffering from eating disorder of 15 to 25 yrs MSES significantly differ on anxiety score as compare to normal women of 15 to 25 yrs HSES.

A1B1C2-A2B1C2 women suffering from eating disorder of 15 to 25 yrs MSES -normal women of 15 to 25 yrs MSES. The mean score of women suffering from eating disorder of 15 to 25 yrs MSES is 78.60 and normal women of 15 to 25 yrs MSES is 64.73. Difference between two mean groups is 13.87. That means women suffering from eating disorder of 15 to 25 yrs MSES significantly differ on anxiety score as compare to normal women of 15 to 25 yrs MSES.

A1B1C2-A2B1C3 women suffering from eating disorder of 15 to 25 yrs MSES -normal women of 15 to 25 yrs LSES. The mean score of women suffering from eating disorder of 15 to 25 yrs MSES is 78.60 and normal women of 15 to 25 yrs LSES is 60.23. Difference between two mean groups is 18.37. That means women suffering from eating disorder of 15 to 25 yrs MSES significantly differ on anxiety score as compare to normal women of 15 to 25 yrs LSES.

A1B1C2-A2B2C1 women suffering from eating disorder of 15 to 25 yrs MSES -normal women of 30 to 40 yrs HSES. The mean score of women suffering from eating disorder of 15 to 25 yrs MSES is 78.60 and normal women of 30 to 40 yrs HSES is 65.50. Difference between two mean groups is 13.10. That means women suffering from eating disorder of 15 to 25 yrs MSES significantly differ on anxiety score as compare to normal women of 30 to 40 yrs HSES.

A1B1C2-A2B2C2 women suffering from eating disorder of 15 to 25 yrs MSES -normal women of 30 to 40 yrs MSES. The mean score of women suffering from eating disorder of 15 to 25 yrs MSES is 78.60 and normal women of 30 to 40 yrs MSES is 63.33. Difference between two mean groups is 15.27. That means women suffering from eating disorder of 15 to 25 yrs MSES significantly differ on anxiety score as compare to normal women of 30 to 40 yrs MSES.

A1B1C2-A2B2C3 women suffering from eating disorder of 15 to 25 yrs MSES -normal women of 30 to 40 yrs LSES. The mean score of women suffering from eating disorder of 15 to 25 yrs MSES is 78.60 and normal women of 30 to 40 yrs LSES is 63.10. Difference between two mean groups is 15.50. That means women suffering from eating disorder of 15 to 25 yrs MSES significantly differ on anxiety score as compare to normal women of 30 to 40 yrs LSES.

A1B1C3-A1B2C2 women suffering from eating disorder of 15 to 25 yrs LSES –women suffering from eating disorder of 30 to 40 yrs MSES. The mean score of women suffering from eating disorder of 15 to 25 yrs LSES is 69.07 and women suffering from eating disorder of 30 to 40 yrs MSES is 75.87. Difference between two mean groups is 6.80. That means women suffering from eating disorder of 15 to 25 yrs LSES significantly differ on anxiety score as compare to women suffering from eating disorder of 30 to 40 yrs MSES.

A1B1C3-A1B1C3 women suffering from eating disorder of 15 to 25 yrs LSES –women suffering from eating disorder of 15 to 25 yrs LSES. The mean score of women suffering from eating disorder of 15 to 25 yrs

LSES is 69.07 and women suffering from eating disorder of 15 to 25 yrs LSES is 60.23. Difference between two mean groups is 8.84. That means women suffering from eating disorder of 15 to 25 yrs LSES significantly differ on anxiety score as compare to women suffering from eating disorder of 15 to 25 yrs LSES.

A1B1C3-A2B2C2 women suffering from eating disorder of 15 to 25 yrs LSES -normal women of 30 to 40 yrs MSES. The mean score of women suffering from eating disorder of 15 to 25 yrs LSES is 69.07 and normal women of 30 to 40 yrs MSES is 63.33. Difference between two mean groups is 5.74. That means women suffering from eating disorder of 15 to 25 yrs LSES significantly differ on anxiety score as compare to normal women of 30 to 40 yrs MSES.

A1B1C3-A2B2C3 women suffering from eating disorder of 15 to 25 yrs LSES -normal women of 30 to 40 yrs LSES. The mean score of women suffering from eating disorder of 15 to 25 yrs LSES is 69.07 and normal women of 30 to 40 yrs LSES is 63.10. Difference between two mean groups is 5.97. That means women suffering from eating disorder of 15 to 25 yrs LSES significantly differ on anxiety score as compare to normal women of 30 to 40 yrs LSES.

A1B2C1-A1B2C2 women suffering from eating disorder of 30 to 40 yrs HSES - women suffering from eating disorder of 30 to 40 yrs MSES. The mean score of women suffering from eating disorder of 30 to 40 yrs HSES is 71.27 and women suffering from eating disorder of 30 to 40 yrs MSES is 75.87. Difference between two mean groups is 4.60. That means women suffering from eating disorder of 30 to 40 yrs HSES significantly

differ on anxiety score as compare to women suffering from eating disorder of 30 to 40 yrs MSES.

A1B2C1-A2B1C1 women suffering from eating disorder of 30 to 40 yrs HSES -normal women of 15 to 25 yrs HSES. The mean score of women suffering from eating disorder of 30 to 40 yrs HSES is 71.27 and normal women of 15 to 25 yrs HSES is 65.37. Difference between two mean groups is 5.90. That means women suffering from eating disorder of 30 to 40 yrs HSES significantly differ on anxiety score as compare to normal women of 15 to 25 yrs HSES.

A1B2C1-A2B1C2 women suffering from eating disorder of 30 to 40 yrs HSES -normal women of 15 to 25 yrs MSES. The mean score of women suffering from eating disorder of 30 to 40 yrs HSES is 71.27 and normal women of 15 to 25 yrs MSES is 64.73. Difference between two mean groups is 6.54. That means women suffering from eating disorder of 30 to 40 yrs HSES significantly differ on anxiety score as compare to normal women of 15 to 25 yrs MSES.

A1B2C1-A2B1C3 women suffering from eating disorder of 30 to 40 yrs HSES -normal women of 15 to 25 yrs LSES. The mean score of women suffering from eating disorder of 30 to 40 yrs HSES is 71.27 and normal women of 15 to 25 yrs LSES is 60.23. Difference between two mean groups is 11.04. That means women suffering from eating disorder of 30 to 40 yrs HSES significantly differ on anxiety score as compare to normal women of 15 to 25 yrs LSES.

A1B2C1-A2B2C1 women suffering from eating disorder of 30 to 40 yrs HSES -normal women of 30 to 40 yrs HSES. The mean score of women

suffering from eating disorder of 30 to 40 yrs HSES is 71.27 and normal women of 30 to 40 yrs HSES is 65.50. Difference between two mean groups is 5.77. That means women suffering from eating disorder of 30 to 40 yrs HSES significantly differ on anxiety score as compare to normal women of 30 to 40 yrs HSES.

A1B2C1-A2B2C2 women suffering from eating disorder of 30 to 40 yrs HSES -normal women of 30 to 40 yrs MSES. The mean score of women suffering from eating disorder of 30 to 40 yrs HSES is 71.27 and normal women of 30 to 40 yrs MSES is 63.33. Difference between two mean groups is 7.94. That means women suffering from eating disorder of 30 to 40 yrs HSES significantly differ on anxiety score as compare to normal women of 30 to 40 yrs MSES.

A1B2C1-A2B2C3 women suffering from eating disorder of 30 to 40 yrs HSES -normal women of 30 to 40 yrs LSES. The mean score of women suffering from eating disorder of 30 to 40 yrs HSES is 71.27 and normal women of 30 to 40 yrs LSES is 63.10. Difference between two mean groups is 8.17. That means women suffering from eating disorder of 30 to 40 yrs HSES significantly differ on anxiety score as compare to normal women of 30 to 40 yrs LSES.

A1B2C2-A2B1C1 women suffering from eating disorder of 30 to 40 yrs MSES – normal women of 15 to 25 yrs HSES. The mean score of women suffering from eating disorder of 30 to 40 yrs MSES is 75.87 and normal women of 15 to 25 yrs HSES is 65.37. Difference between two mean groups is 10.50. That means women suffering from eating disorder of 30 to 40 yrs MSES significantly differ on anxiety score as compare to normal women of 15 to 25 yrs HSES.

A1B2C2-A2B1C2 women suffering from eating disorder of 30 to 40 yrs MSES – normal women of 15 to 25 yrs MSES. The mean score of women suffering from eating disorder of 30 to 40 yrs MSES is 75.87 and normal women of 15 to 25 yrs MSES is 64.73. Difference between two mean groups is 11.14. That means women suffering from eating disorder of 30 to 40 yrs MSES significantly differ on anxiety score as compare to normal women of 15 to 25 yrs MSES.

A1B2C2-A2B1C3 women suffering from eating disorder of 30 to 40 yrs MSES – normal women of 15 to 25 yrs LSES. The mean score of women suffering from eating disorder of 30 to 40 yrs MSES is 75.87 and normal women of 15 to 25 yrs LSES is 60.23. Difference between two mean groups is 15.64. That means women suffering from eating disorder of 30 to 40 yrs MSES significantly differ on anxiety score as compare to normal women of 15 to 25 yrs LSES.

A1B2C2-A2B2C1 women suffering from eating disorder of 30 to 40 yrs MSES – normal women of 30 to 40 yrs HSES. The mean score of women suffering from eating disorder of 30 to 40 yrs MSES is 75.87 and normal women of 30 to 40 yrs HSES is 65.50. Difference between two mean groups is 10.37. That means women suffering from eating disorder of 30 to 40 yrs MSES significantly differ on anxiety score as compare to normal women of 30 to 40 yrs HSES.

A1B2C2-A2B2C2 women suffering from eating disorder of 30 to 40 yrs MSES – normal women of 30 to 40 yrs MSES. The mean score of women suffering from eating disorder of 30 to 40 yrs MSES is 75.87 and normal women of 30 to 40 yrs MSES is 63.33. Difference between two

mean groups is 12.54. That means women suffering from eating disorder of 30 to 40 yrs MSES significantly differ on anxiety score as compare to normal women of 30 to 40 yrs MSES.

A1B2C2-A2B2C3 women suffering from eating disorder of 30 to 40 yrs MSES – normal women of 30 to 40 yrs LSES. The mean score of women suffering from eating disorder of 30 to 40 yrs MSES is 75.87 and normal women of 30 to 40 yrs LSES is 63.10. Difference between two mean groups is 12.77. That means women suffering from eating disorder of 30 to 40 yrs MSES significantly differ on anxiety score as compare to normal women of 30 to 40 yrs LSES.

A1B2C3-A2B1C1 women suffering from eating disorder of 30 to 40 yrs LSES – normal women of 15 to 25 yrs HSES. The mean score of women suffering from eating disorder of 30 to 40 yrs LSES is 72.43 and normal women of 15 to 25 yrs HSES is 65.37. Difference between two mean groups is 7.06. That means women suffering from eating disorder of 30 to 40 yrs LSES significantly differ on anxiety score as compare to normal women of 15 to 25 yrs HSES.

A1B2C3-A2B1C2 women suffering from eating disorder of 30 to 40 yrs LSES – normal women of 15 to 25 yrs MSES. The mean score of women suffering from eating disorder of 30 to 40 yrs LSES is 72.43 and normal women of 15 to 25 yrs MSES is 64.73. Difference between two mean groups is 7.70. That means women suffering from eating disorder of 30 to 40 yrs LSES significantly differ on anxiety score as compare to normal women of 15 to 25 yrs MSES.

A1B2C3-A2B1C3 women suffering from eating disorder of 30 to 40 yrs LSES – normal women of 15 to 25 yrs MSES. The mean score of women suffering from eating disorder of 30 to 40 yrs LSES is 72.43 and normal women of 15 to 25 yrs LSES is 60.23. Difference between two mean groups is 12.20. That means women suffering from eating disorder of 30 to 40 yrs LSES significantly differ on anxiety score as compare to normal women of 15 to 25 yrs LSES.

A1B2C3-A2B2C1 women suffering from eating disorder of 30 to 40 yrs LSES – normal women of 30 to 40 yrs HSES. The mean score of women suffering from eating disorder of 30 to 40 yrs LSES is 72.43 and normal women of 30 to 40 yrs HSES is 65.50. Difference between two mean groups is 6.93. That means women suffering from eating disorder of 30 to 40 yrs LSES significantly differ on anxiety score as compare to normal women of 30 to 40 yrs HSES.

A1B2C3-A2B2C2 women suffering from eating disorder of 30 to 40 yrs LSES – normal women of 30 to 40 yrs MSES. The mean score of women suffering from eating disorder of 30 to 40 yrs LSES is 72.43 and normal women of 30 to 40 yrs MSES is 63.33. Difference between two mean groups is 9.10. That means women suffering from eating disorder of 30 to 40 yrs LSES significantly differ on anxiety score as compare to normal women of 30 to 40 yrs MSES.

A1B2C3-A2B2C3 women suffering from eating disorder of 30 to 40 yrs LSES – normal women of 30 to 40 yrs LSES. The mean score of women suffering from eating disorder of 30 to 40 yrs LSES is 72.43 and normal women of 30 to 40 yrs LSES is 63.10. Difference between two mean groups is 9.33. That means women suffering from eating disorder of 30 to 40 yrs

LSES significantly differ on anxiety score as compare to normal women of 30 to 40 yrs LSES.

A2B1C1-A2B1C3 normal women of 15 to 25 yrs HSES -normal women of 15 to 25 yrs LSES. The mean score of normal women of 15 to 25 yrs HSES is 65.37 and normal women of 15 to 25 yrs LSES is 60.23. Difference between two mean groups is 5.14. That means normal women of 15 to 25 yrs HSES significantly differ on anxiety score as compare to normal women of 15 to 25 yrs LSES.

A2B1C3-A2B2C1 normal women of 15 to 25 yrs LSES – normal women of 30 to 40 yrs HSES. The mean score of normal women of 15 to 25 yrs LSES is 60.23 and normal women of 30 to 40 yrs HSES is 65.50. Difference between two mean groups is 5.27. That means normal women of 15 to 25 yrs LSES significantly differ on anxiety score as compare to normal women of 30 to 40 yrs HSES.

2.3 Results and discussion of Body Image :

Table 4.19

Showing Results of ANOVA on Score of Body Image

Source of Variation	SS	DF	MS	F	Level of Significant
Ass	44600.13	1	44600.13	166.79	.01
Bss	323.00	1	323.00	1.21	NS
Css	8481.80	2	4240.90	15.86	.01
A x B	13.23	1	13.23	0.05	NS
A x C	1801.69	2	900.84	3.37	.05
B x C	3117.09	2	1558.54	5.83	.01
A x B x C	1053.27	2	526.63	1.97	NS
Wss	93054.17	348	267.40		
Tss	152444.37	359			

Table : 4.20

Showing Mean Scores of Body Image - A (Women)

	A1	A2
M	73.76	51.49
N	180	180

Table : 4.21

Showing Mean Scores of Body Image - B (Age Group)

	B1	B2
M	61.88	63.57
N	180	180

Table : 4.22

Showing Mean Scores of Body Image - C (SES)

	C1	C2	C3
M	69.39	60.24	58.24
N	120	120	120

Table : 4.23

Showing Mean Scores of Body Image - A x B (Women x Age Group)

		A1	A2
B1	**M**	73.00	50.36
	N	90	90
B2	**M**	74.51	52.63
	N	90	90

Table : 4.24

Showing Mean Scores of Body Image - A x C (Women x SES)

		A1	A2
C1	M	83.03	55.75
	N	60	60
C2	M	71.79	48.70
	N	60	60
C3	M	66.45	50.04
	N	60	60

Table : 4.25

Showing Mean Scores of Body Image - B x C (Age Group x SES)

		B1	B2
C1	M	64.28	74.50
	N	60	60
C2	M	61.34	59.15
	N	60	60
C3	M	59.42	57.07
	N	60	60

Table : 4.26

Showing Mean Scores of Body Image - A x B x C

(Women x Age Group x SES)

		A1		A2	
		B1	B2	B1	B2
C1	M	75.73	90.33	52.83	58.67
	N	30	30	30	30
C2	M	73.90	69.67	48.77	48.63
	N	30	30	30	30
C3	M	69.37	65.53	49.47	50.60
	N	30	30	30	30

Table : 4.27

LSD Results of Body Image (Simple effect)

Pair			Mean			Diff.	.01	.05	Level of Sig.
A1B1C1	-	A1B1C2	75.73	-	73.90	1.83	8.62	11.61	NS
A1B1C1	-	A1B1C3	75.73	-	69.37	6.36	8.62	11.61	NS
A1B1C1	-	A1B2C1	75.73	-	90.33	14.60	8.62	11.61	**
A1B1C1	-	A1B2C2	75.73	-	69.67	6.06	8.62	11.61	NS
A1B1C1	-	A1B2C3	75.73	-	63.53	12.20	8.62	11.61	**
A1B1C1	-	A2B1C1	75.73	-	52.83	22.90	8.62	11.61	**
A1B1C1	-	A2B1C2	75.73	-	48.77	26.96	8.62	11.61	**
A1B1C1	-	A2B1C3	75.73	-	49.47	26.26	8.62	11.61	**
A1B1C1	-	A2B2C1	75.73	-	58.67	17.06	8.62	11.61	**
A1B1C1	-	A2B2C2	75.73	-	48.63	27.10	8.62	11.61	**
A1B1C1	-	A2B2C3	75.73	-	50.60	25.13	8.62	11.61	**
A1B1C2	-	A1B1C3	73.90	-	69.37	4.53	8.62	11.61	NS
A1B1C2	-	A1B2C1	73.90	-	90.33	16.43	8.62	11.61	**
A1B1C2	-	A1B2C2	73.90	-	69.67	4.23	8.62	11.61	NS
A1B1C2	-	A1B2C3	73.90	-	63.53	10.37	8.62	11.61	*
A1B1C2	-	A2B1C1	73.90	-	52.83	21.07	8.62	11.61	**
A1B1C2	-	A2B1C2	73.90	-	48.77	25.13	8.62	11.61	**
A1B1C2	-	A2B1C3	73.90	-	49.47	24.43	8.62	11.61	**
A1B1C2	-	A2B2C1	73.90	-	58.67	15.23	8.62	11.61	**
A1B1C2	-	A2B2C2	73.90	-	48.63	25.27	8.62	11.61	**
A1B1C2	-	A2B2C3	73.90	-	50.60	23.30	8.62	11.61	**
A1B1C3	-	A1B2C1	69.37	-	90.33	20.96	8.62	11.61	**
A1B1C3	-	A1B2C2	69.37	-	69.67	0.30	8.62	11.61	NS
A1B1C3	-	A1B2C3	69.37	-	63.53	5.84	8.62	11.61	NS
A1B1C3		A2B1C1	69.37		52.83	16.54	8.62	11.61	**
A1B1C3	-	A2B1C2	69.37	-	48.77	20.60	8.62	11.61	**
A1B1C3	-	A2B1C3	69.37	-	49.47	19.90	8.62	11.61	**
A1B1C3	-	A2B2C1	69.37	-	58.67	10.70	8.62	11.61	*
A1B1C3	-	A2B2C2	69.37	-	48.63	20.74	8.62	11.61	**
A1B1C3	-	A2B2C3	69.37	-	50.60	18.77	8.62	11.61	**
A1B2C1	-	A1B2C2	90.33	-	69.67	20.66	8.62	11.61	**

A1B2C1	-	A1B2C3	90.33	-	63.53	26.80	8.62	11.61	**
A1B2C1	-	A2B1C1	90.33	-	52.83	37.50	8.62	11.61	**
A1B2C1	-	A2B1C2	90.33	-	48.77	41.56	8.62	11.61	**
A1B2C1	-	A2B1C3	90.33	-	49.47	40.86	8.62	11.61	**
A1B2C1	-	A2B2C1	90.33	-	58.67	31.66	8.62	11.61	**
A1B2C1	-	A2B2C2	90.33	-	48.63	41.70	8.62	11.61	**
A1B2C1		A2B2C3	90.33		50.60	39.73	8.62	11.61	**
A1B2C2	-	A1B2C3	69.67	-	63.53	6.14	8.62	11.61	NS
A1B2C2	-	A2B1C1	69.67	-	52.83	16.84	8.62	11.61	**
A1B2C2	-	A2B1C2	69.67	-	48.77	20.90	8.62	11.61	**
A1B2C2	-	A2B1C3	69.67	-	49.47	20.20	8.62	11.61	**
A1B2C2	-	A2B2C1	69.67	-	58.67	11.00	8.62	11.61	*
A1B2C2	-	A2B2C2	69.67	-	48.63	21.04	8.62	11.61	**
A1B2C2	-	A2B2C3	69.67	-	50.60	19.07	8.62	11.61	**
A1B2C3	-	A2B1C1	63.53	-	52.83	10.70	8.62	11.61	*
A1B2C3	-	A2B1C2	63.53	-	48.77	14.76	8.62	11.61	**
A1B2C3	-	A2B1C3	63.53	-	49.47	14.06	8.62	11.61	**
A1B2C3	-	A2B2C1	63.53	-	58.67	4.86	8.62	11.61	NS
A1B2C3	-	A2B2C2	63.53	-	48.63	14.90	8.62	11.61	**
A1B2C3	-	A2B2C3	63.53	-	50.60	12.93	8.62	11.61	**
A2B1C1	-	A2B1C2	52.83	-	48.77	4.06	8.62	11.61	NS
A2B1C1	-	A2B1C3	52.83	-	49.47	3.36	8.62	11.61	NS
A2B1C1	-	A2B2C1	52.83	-	58.67	5.84	8.62	11.61	NS
A2B1C1	-	A2B2C2	52.83	-	48.63	4.20	8.62	11.61	NS
A2B1C1	-	A2B2C3	52.83	-	50.60	2.23	8.62	11.61	NS
A2B1C2	-	A2B1C3	48.77	-	49.47	0.70	8.62	11.61	NS
A2B1C2		A2B2C1	48.77	-	58.67	9.90	8.62	11.61	*
A2B1C2	-	A2B2C2	48.77	-	48.63	0.14	8.62	11.61	NS
A2B1C2	-	A2B2C3	48.77	-	50.60	1.83	8.62	11.61	NS
A2B1C3	-	A2B2C1	49.47	-	58.67	9.20	8.62	11.61	*
A2B1C3	-	A2B2C2	49.47	-	48.63	0.84	8.62	11.61	NS
A2B1C3	-	A2B2C3	49.47	-	50.60	1.13	8.62	11.61	NS
A2B2C1	-	A2B2C2	58.67	-	48.63	10.04	8.62	11.61	*
A2B2C1	-	A2B2C3	58.67	-	50.60	8.07	8.62	11.61	NS
A2B2C2		A2B2C3	48.63	-	50.60	1.97	8.62	11.61	NS

Figure : 4.15

Showing Mean Scores of Body Image -A (Women)

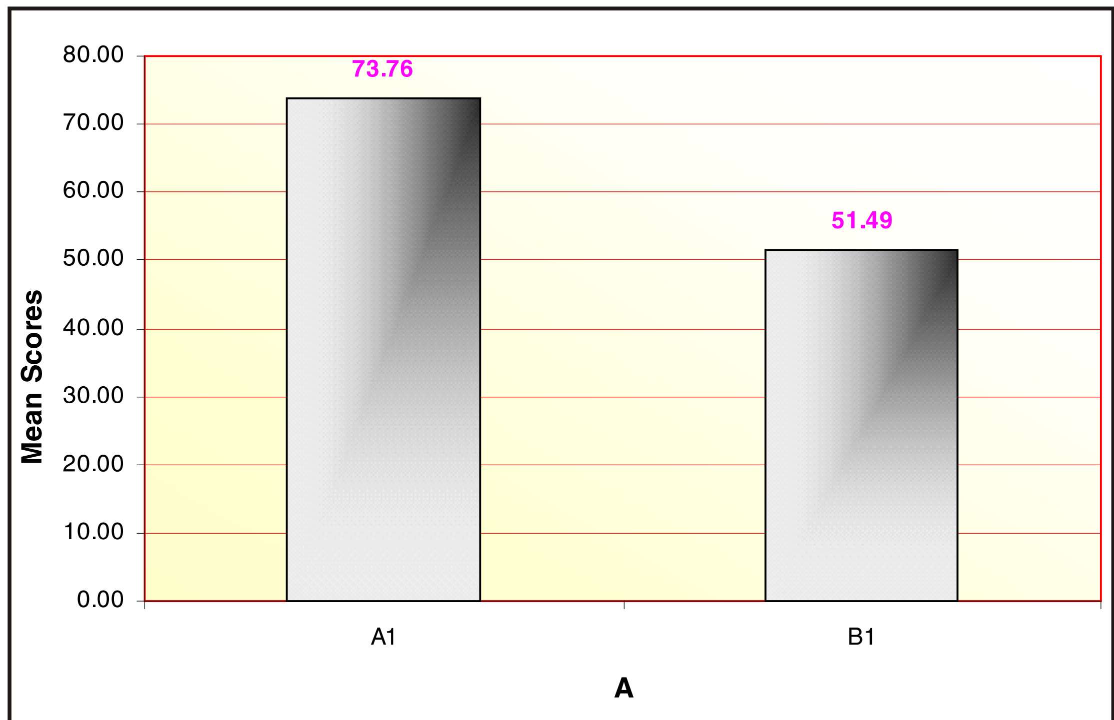


Figure : 4.16

Showing Mean Scores of Body Image -B (Age Group)

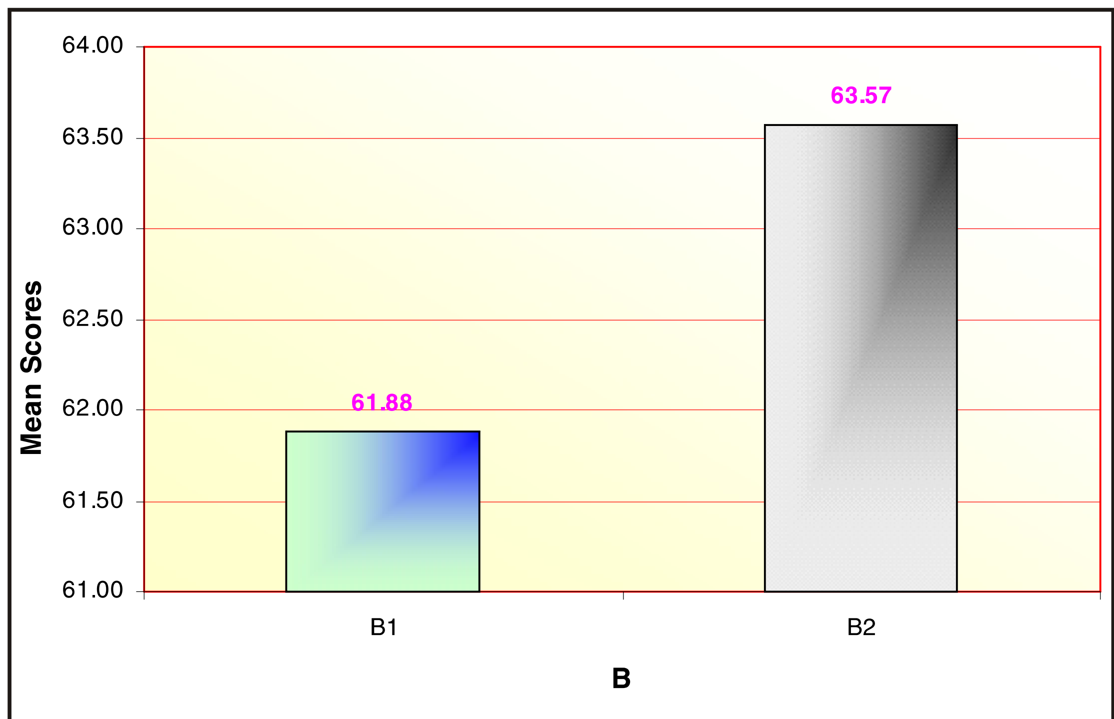


Figure : 4.17

Showing Mean Scores of Body Image -C (SES)

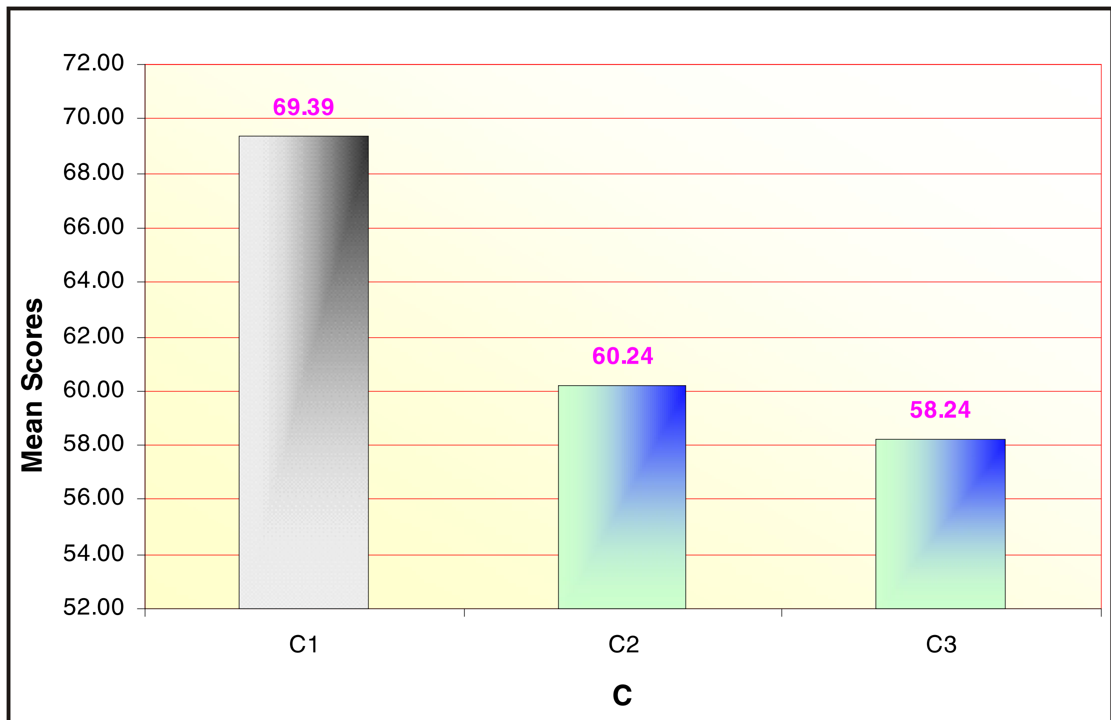


Figure : 4.18

Showing Mean Scores of Body Image - A x B (Women x Age Group)

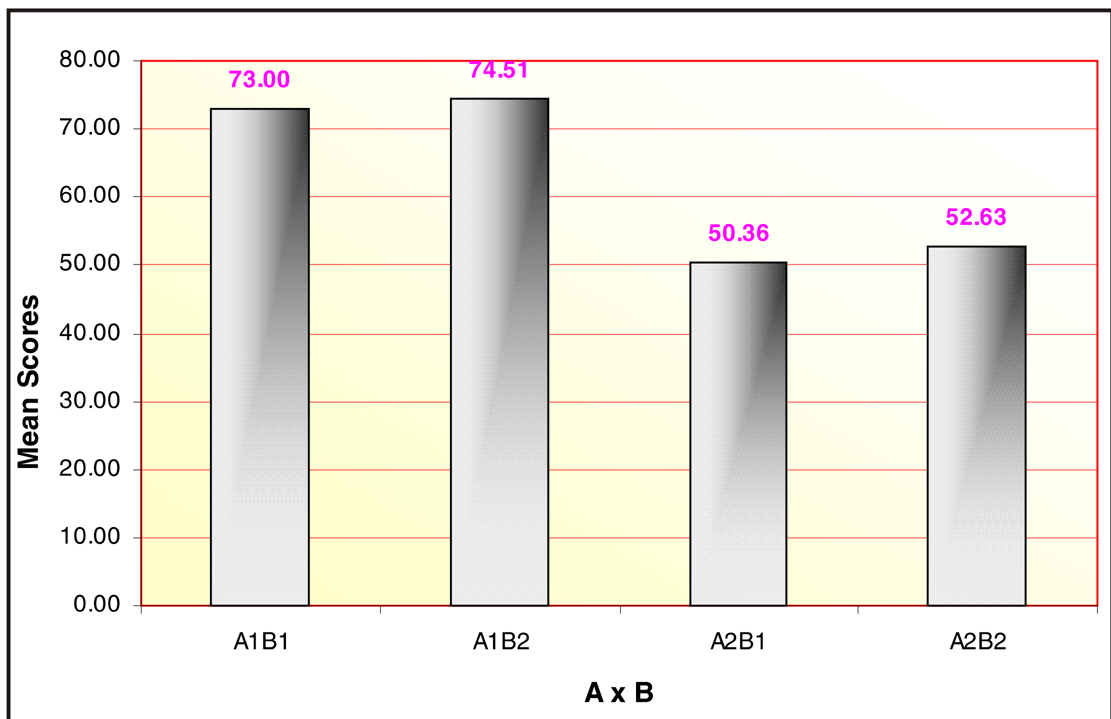


Figure : 4.19

Showing Mean Scores of Body Image - A x C (Women x SES)

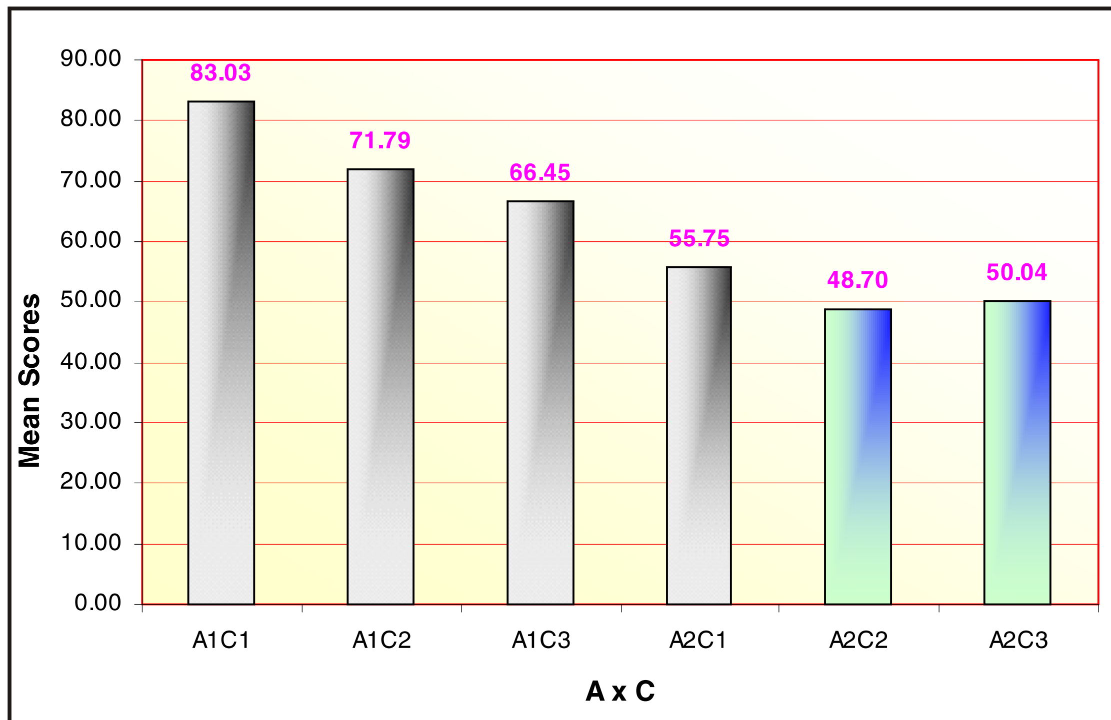


Figure : 4.20

Showing Mean Scores of Body Image - B x C (Age Group x SES)

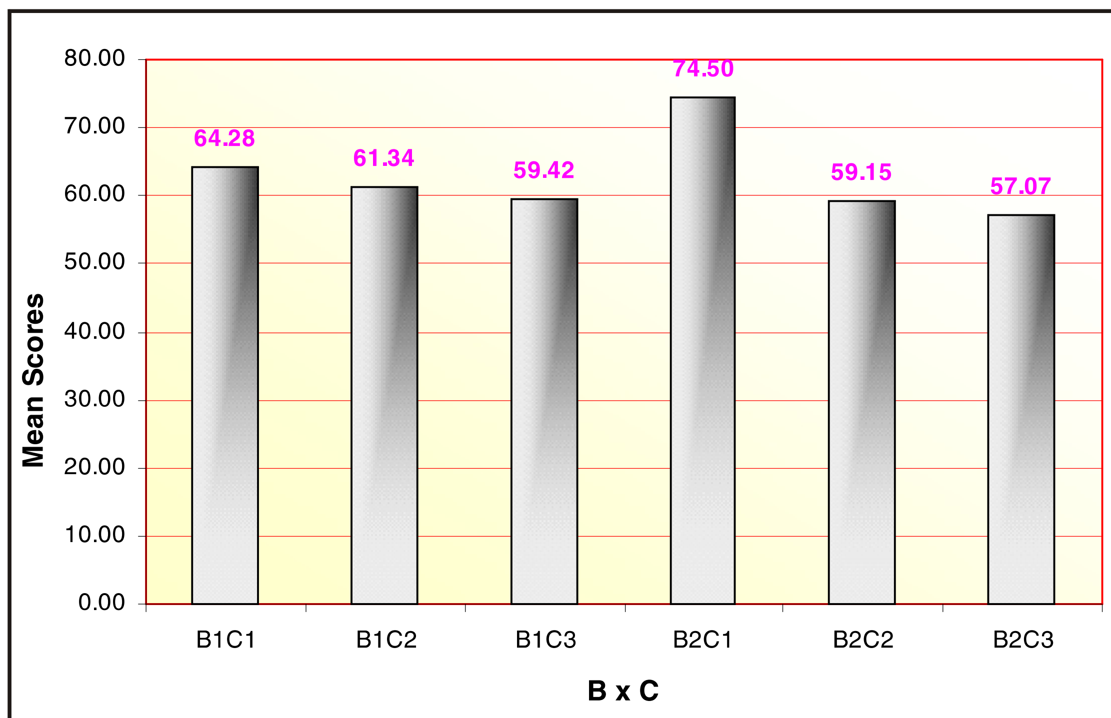
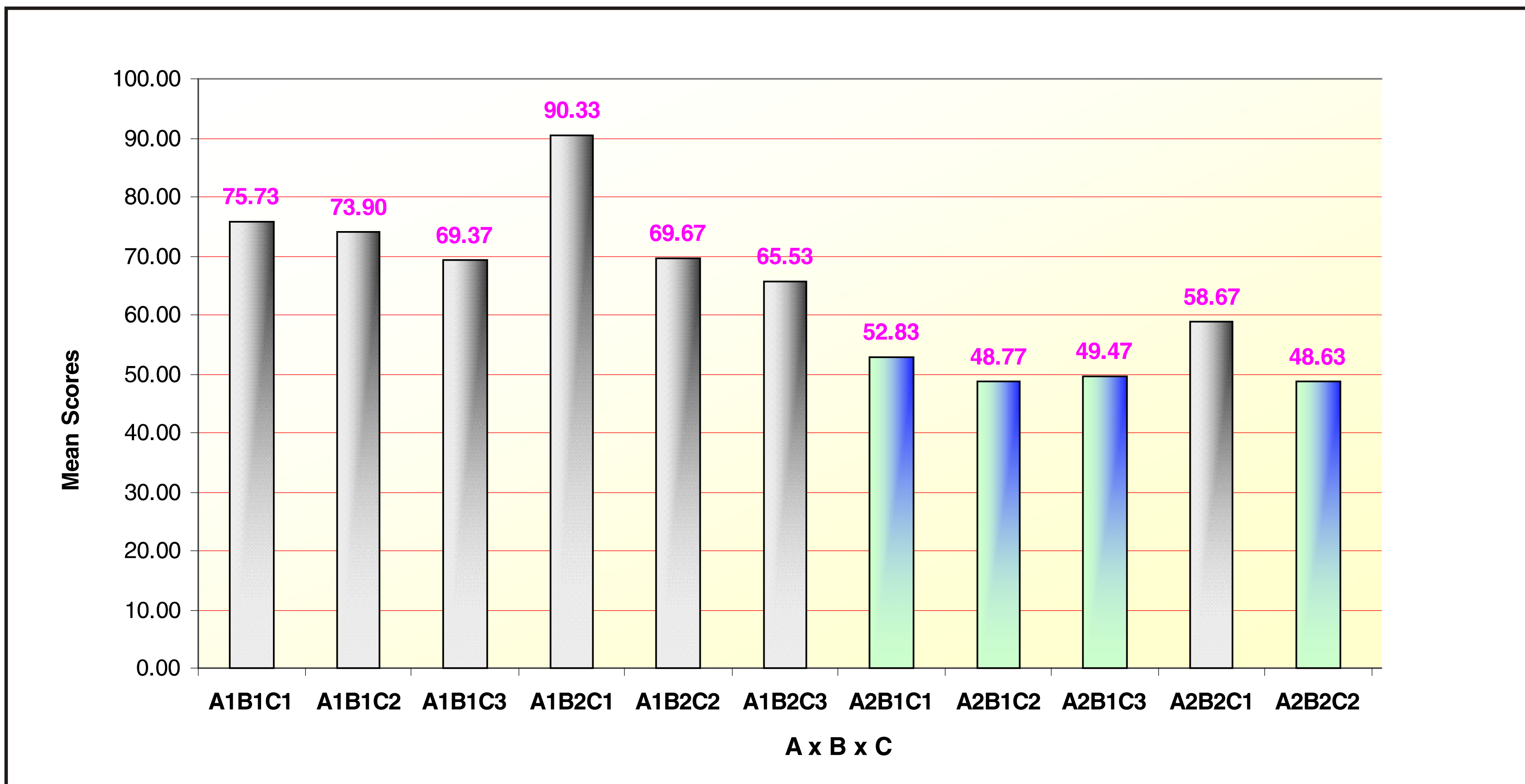


Figure : 4.21

Showing Mean Scores of Body Image - A x B x C (Women x Age Group x SES)



The results of ANOVA on body image score (Body Shape Questionnaire score) score Table No. 4.19 is consulted and it is found that F ratio for women is 166.79 which is significant at .01 level. That means women suffering from eating disorder significantly differ on body image score as compare to normal women. Table No. 4.20 the mean score of women suffering from eating disorder is 73.76 and normal women is 51.49. It is clearly said that significant differences existed between women suffering from eating disorder and normal women on body image score.

Women suffering from eating disorder are more worried and dissatisfaction with their body image as compare to the normal women. Women suffering from eating disorder have negative body image. Women suffering from bulimia nervosa and anorexia nervosa do not have a positive body image. Women with over eating habits or under eating habits do not have positive body image because women with bulimia generally obese and anorexia nervosa are extremely thin, not having positive bogy image. If you have a positive body image, you are satisfied with what you see. Your body image is negative; women suffering from eating disorders do not see their body in a Norman sense.

The F ratio for age is 1.21, which is not significant. That means 15 to25 yrs women do not differ on body image score as compare to 30 to 40 yrs women. Table No. 4.21 shows that mean score of 15 to 25 yrs women is 61.68 and 30 to 40 yrs women is 63.57. It can be said that significant difference does not existed between 15 to 25 yrs women and 30 to 40 yrs women on body image score.

The F ratio for SES is 15.86, which is significant at .01 level. That means HSES women significantly differ on body image score as compare to MSES women and LSES women. Table No. 4.22 shows that mean score of HSES women is 69.39, MSES women is 60.24 and LSES women is 58.24. It can be said that significant difference existed among various group of SES on body image score.

HSES women are more worried and dissatisfaction with their body image as compare to MSES and LSES women. Women belonging to higher economic class are more conscious about their appearance, beauty, dress and social recognition. They are so much worried about their daily diet that they are always afraid of eating more or vitamin foods.

They worry that they would grow fat and obesity would make them socially unacceptable. Thus, women belonging to higher economic class are more worried that they would loose their social recognition if they grow abnormally fat. Such anxiety is not at we found in the women of middle or lower economic class. MSES and LSES women do not have ample opportunities for keeping themselves physically fit and therefore they are not much worried about their body image, compare to HSES women.

The F ratio for women and age is .0.05, which is not significant. That means women and age do not interact each other on body image score. Table No.4.23 shows that mean score of 15 to 25 yrs women suffering from eating disorder is 73.00, 30 to 40 yrs women suffering from eating disorder is 74.51, 15 to 25 yrs normal women is 50.36 and 30 to 40 yrs normal women is 52.63.

The F ratio for women and SES is 3.37, which is significant at .05 level. That means women and SES significantly interact each other on body image score. Table No. 4.24 shows that score of HSES women suffering from eating disorder is 83.03 and MSES women suffering from eating disorder is 71.79, LSES women suffering from eating disorder is 66.45, HSES normal women is 55.75, MSES normal women is 48.70 and LSES normal women is 50.04.

The F ratio for age and SES is 5.83, which is significant at .01 level. That means age and SES significantly interact each other on body image score. Table No. 4.25 shows that mean score of 15 to 25 yrs HSES women is 64.28, 15 to 25 MSES women is 61.34, 15 to 25 LSES women is 59.42, 30 to 40 yrs HSES women is 74.50, 30 to 40 yrs MSES women is 59.15 and 30 to 40 yrs LSES women is 57.07.

The F ratio for women, age and SES is 1.97, which is not significant. That means women age and SES do not interact each other on body image score. Table No. 4.26 shows that mean score of 15 to 25 yrs HSES women suffering from eating disorder is 75.73, 15 to 25 yrs MSES women suffering from eating disorder is 73.90, 15 to 25 yrs LSES women suffering from eating disorder is 69.37, 30 to 40 yrs HSES women suffering from eating disorder is 90.33, 30 to 40 yrs MSES women suffering from eating disorder is 69.67, 30 to 40 yrs LSES women suffering from eating disorder is 63.53, 15 to 25 yrs HSES normal women is 52.83, 15 to 25 yrs MSES normal women is 48.77, 15 to 25 yrs LSES normal women is 49.47, 30 to 40 yrs HSES normal women is 58.67, 30 to 40 yrs MSES normal women is 48.63 and 30 to 40 yrs LSES normal women is 50.60.

Similarly following pairs of **LSD** results also found to be significant Table No. 4.27.

A1B1C1-A1B2C1 women suffering from eating disorder of 15 to 25 yrs HSES - women suffering from eating disorder of 30 to 40 yrs HSES. The mean score of women suffering from eating disorder of 15 to 25 yrs HSES is 75.73 and women suffering from eating disorder of 30 to 40 yrs HSES is 90.33. Difference between two mean groups is 14.60. That means women suffering from eating disorder of 15 to 25 yrs HSES significantly differ on body image score as compare to women suffering from eating disorder of 30 to 40 yrs HSES.

A1B1C1-A1B2C3 women suffering from eating disorder of 15 to 25 yrs HSES - women suffering from eating disorder of 30 to 40 yrs LSES. The mean score of women suffering from eating disorder of 15 to 25 yrs HSES is 75.73 and women suffering from eating disorder of 30 to 40 yrs LSES is 63.53. Difference between two mean groups is 12.20. That means women suffering from eating disorder of 15 to 25 yrs HSES significantly differ on body image score as compare to women suffering from eating disorder of 30 to 40 yrs LSES.

A1B1C1-A2B1C1 women suffering from eating disorder of 15 to 25 yrs HSES -normal women of 15 to 25 yrs HSES. The mean score of women suffering from eating disorder of 15 to 25 yrs HSES is 75.73 and normal women of 15 to 25 yrs HSES is 52.83. Difference between two mean groups is 22.90. That means women suffering from eating disorder of 15 to 25 yrs HSES significantly differ on body image score as compare to normal women of 15 to 25 yrs HSES.

A1B1C1-A2B1C2 women suffering from eating disorder of 15 to 25 yrs HSES -normal women of 15 to 25 yrs MSES. The mean score of women suffering from eating disorder of 15 to 25 yrs HSES is 75.73 and normal women of 15 to 25 yrs MSES is 48.77. Difference between two mean groups is 26.96. That means women suffering from eating disorder of 15 to 25 yrs HSES significantly differ on body image score as compare to normal women of 15 to 25 yrs MSES.

A1B1C1-A2B1C3 women suffering from eating disorder of 15 to 25 yrs HSES -normal women of 15 to 25 yrs LSES. The mean score of women suffering from eating disorder of 15 to 25 yrs HSES is 75.73 and normal women of 15 to 25 yrs LSES is 49.47. Difference between two mean groups is 26.26. That means women suffering from eating disorder of 15 to 25 yrs HSES significantly differ on body image score as compare to normal women of 15 to 25 yrs LSES.

A1B1C1-A2B2C1 women suffering from eating disorder of 15 to 25 yrs HSES -normal women of 30 to 40 yrs HSES. The mean score of women suffering from eating disorder of 15 to 25 yrs HSES is 75.73 and normal women of 30 to 40 yrs HSES is 58.67. Difference between two mean groups is 17.06. That means women suffering from eating disorder of 15 to 25 yrs HSES significantly differ on body image score as compare to normal women of 30 to 40 yrs HSES.

A1B1C1-A2B2C2 women suffering from eating disorder of 15 to 25 yrs HSES -normal women of 30 to 40 yrs MSES. The mean score of women suffering from eating disorder of 15 to 25 yrs HSES is 75.73 and normal women of 30 to 40 yrs MSES is 48.63. Difference between two mean groups

is 27.10. That means women suffering from eating disorder of 15 to 25 yrs HSES significantly differ on body image score as compare to normal women of 30 to 40 yrs MSES.

A1B1C1-A2B2C3 women suffering from eating disorder of 15 to 25 yrs HSES -normal women of 30 to 40 yrs LSES. The mean score of women suffering from eating disorder of 15 to 25 yrs HSES is 75.73 and normal women of 30 to 40 yrs LSES is 50.60. Difference between two mean groups is 25.13. That means women suffering from eating disorder of 15 to 25 yrs HSES significantly differ on body image score as compare to normal women of 30 to 40 yrs LSES.

A1B1C2-A1B2C1 women suffering from eating disorder of 15 to 25 yrs MSES –women suffering from eating disorder of 30 to 40 yrs HSES. The mean score of women suffering from eating disorder of 15 to 25 yrs MSES is 73.90 and women suffering from eating disorder of 30 to 40 yrs HSES is 90.33. Difference between two mean groups is 16.43. That means women suffering from eating disorder of 15 to 25 yrs MSES significantly differ on body image score as compare to women suffering from eating disorder of 30 to 40 yrs HSES.

A1B1C2-A1B2C3 women suffering from eating disorder of 15 to 25 yrs MSES –women suffering from eating disorder of 30 to 40 yrs LSES. The mean score of women suffering from eating disorder of 15 to 25 yrs MSES is 73.90 and women suffering from eating disorder of 30 to 40 yrs LSES is 63.53. Difference between two mean groups is 10.37. That means women suffering from eating disorder of 15 to 25 yrs MSES significantly differ on body image score as compare to women suffering from eating disorder of 30 to 40 yrs LSES.

A1B1C2-A2B1C1 women suffering from eating disorder of 15 to 25 yrs MSES -normal women of 15 to 25 yrs HSES. The mean score of women suffering from eating disorder of 15 to 25 yrs MSES is 73.90 and normal women of 15 to 25 yrs HSES is 52.83. Difference between two mean groups is 21.07. That means women suffering from eating disorder of 15 to 25 yrs MSES significantly differ on body image score as compare to normal women of 15 to 25 yrs HSES.

A1B1C2-A2B1C2 women suffering from eating disorder of 15 to 25 yrs MSES -normal women of 15 to 25 yrs MSES. The mean score of women suffering from eating disorder of 15 to 25 yrs MSES is 73.90 and normal women of 15 to 25 yrs MSES is 48.77. Difference between two mean groups is 25.13. That means women suffering from eating disorder of 15 to 25 yrs MSES significantly differ on body image score as compare to normal women of 15 to 25 yrs MSES.

A1B1C2-A2B1C3 women suffering from eating disorder of 15 to 25 yrs MSES -normal women of 15 to 25 yrs LSES. The mean score of women suffering from eating disorder of 15 to 25 yrs MSES is 73.90 and normal women of 15 to 25 yrs LSES is 49.47. Difference between two mean groups is 24.43. That means women suffering from eating disorder of 15 to 25 yrs MSES significantly differ on body image score as compare to normal women of 15 to 25 yrs LSES.

A1B1C2-A2B2C1 women suffering from eating disorder of 15 to 25 yrs MSES -normal women of 30 to 40 yrs HSES. The mean score of women suffering from eating disorder of 15 to 25 yrs MSES is 73.90 and normal women of 30 to 40 yrs HSES is 58.67. Difference between two mean groups

is 15.23. That means women suffering from eating disorder of 15 to 25 yrs MSES significantly differ on body image score as compare to normal women of 30 to 40 yrs HSES.

A1B1C2-A2B2C2 women suffering from eating disorder of 15 to 25 yrs MSES -normal women of 30 to 40 yrs MSES. The mean score of women suffering from eating disorder of 15 to 25 yrs MSES is 73.90 and normal women of 30 to 40 yrs MSES is 48.63. Difference between two mean groups is 25.27. That means women suffering from eating disorder of 15 to 25 yrs MSES significantly differ on body image score as compare to normal women of 30 to 40 yrs MSES.

A1B1C2-A2B2C3 women suffering from eating disorder of 15 to 25 yrs MSES -normal women of 30 to 40 yrs LSES. The mean score of women suffering from eating disorder of 15 to 25 yrs MSES is 73.90 and normal women of 30 to 40 yrs LSES is 50.60. Difference between two mean groups is 23.30. That means women suffering from eating disorder of 15 to 25 yrs MSES significantly differ on body image score as compare to normal women of 30 to 40 yrs LSES.

A1B1C3-A1B2C1 women suffering from eating disorder of 15 to 25 yrs LSES –women suffering from eating disorder of 30 to 40 yrs HSES. The mean score of women suffering from eating disorder of 15 to 25 yrs LSES is 69.37 and women suffering from eating disorder of 30 to 40 yrs HSES is 90.33. Difference between two mean groups is 20.96. That means women suffering from eating disorder of 15 to 25 yrs LSES significantly differ on body image score as compare to women suffering from eating disorder of 30 to 40 yrs HSES.

A1B1C3-A2B1C1 women suffering from eating disorder of 15 to 25 yrs LSES -normal women of 15 to 25 yrs HSES. The mean score of women suffering from eating disorder of 15 to 25 yrs LSES is 69.37 and normal women of15 to 25 yrs HSES is 52.83. Difference between two mean groups is 16.54. That means women suffering from eating disorder of 15 to 25 yrs LSES significantly differ on body image score as compare to normal women of 15 to 25 yrs HSES.

A1B1C3-A2B1C2 women suffering from eating disorder of 15 to 25 yrs LSES -normal women of 15 to 25 yrs MSES. The mean score of women suffering from eating disorder of 15 to 25 yrs LSES is 69.37 and normal women of15 to 25 yrs MSES is 48.77. Difference between two mean groups is 20.60. That means women suffering from eating disorder of 15 to 25 yrs LSES significantly differ on body image score as compare to normal women of 15 to 25 yrs MSES.

A1B1C3-A2B1C3 women suffering from eating disorder of 15 to 25 yrs LSES -normal women of 15 to 25 yrs LSES. The mean score of women suffering from eating disorder of 15 to 25 yrs LSES is 69.37 and normal women of15 to 25 yrs LSES is 49.47. Difference between two mean groups is 19.90. That means women suffering from eating disorder of 15 to 25 yrs LSES significantly differ on body image score as compare to normal women of 15 to 25 yrs LSES.

A1B1C3-A2B2C1 women suffering from eating disorder of 15 to 25 yrs LSES -normal women of 30 to 40 yrs HSES. The mean score of women suffering from eating disorder of 15 to 25 yrs LSES is 69.37 and normal women of 30 to 40 yrs HSES is 58.67. Difference between two mean groups

is 10.70. That means women suffering from eating disorder of 15 to 25 yrs LSES significantly differ on body image score as compare to normal women of 30 to 40 yrs HSES.

A1B1C3-A2B2C2 women suffering from eating disorder of 15 to 25 yrs LSES -normal women of 30 to 40 yrs MSES. The mean score of women suffering from eating disorder of 15 to 25 yrs LSES is 69.37 and normal women of 30 to 40 yrs MSES is 48.63. Difference between two mean groups is 20.74. That means women suffering from eating disorder of 15 to 25 yrs LSES significantly differ on body image score as compare to normal women of 30 to 40 yrs MSES.

A1B1C3-A2B2C3 women suffering from eating disorder of 15 to 25 yrs LSES -normal women of 30 to 40 yrs LSES. The mean score of women suffering from eating disorder of 15 to 25 yrs LSES is 69.37 and normal women of 30 to 40 yrs LSES is 50.60. Difference between two mean groups is 18.77. That means women suffering from eating disorder of 15 to 25 yrs LSES significantly differ on body image score as compare to normal women of 30 to 40 yrs LSES.

A1B2C1-A1B2C2 women suffering from eating disorder of 30 to 40 yrs HSES - women suffering from eating disorder of 30 to 40 yrs MSES. The mean score of women suffering from eating disorder of 30 to 40 yrs HSES is 90.33 and women suffering from eating disorder of 30 to 40 yrs MSES is 69.67. Difference between two mean groups is 20.66. That means women suffering from eating disorder of 30 to 40 yrs HSES significantly differ on body image score as compare to women suffering from eating disorder of 30 to 40 yrs MSES.

A1B2C1-A1B2C3 women suffering from eating disorder of 30 to 40 yrs HSES - women suffering from eating disorder of 30 to 40 yrs LSES. The mean score of women suffering from eating disorder of 30 to 40 yrs HSES is 90.33 and women suffering from eating disorder of 30 to 40 yrs LSES is 63.53. Difference between two mean groups is 26.80. That means women suffering from eating disorder of 30 to 40 yrs HSES significantly differ on body image score as compare to women suffering from eating disorder of 30 to 40 yrs LSES.

A1B2C1-A2B1C1 women suffering from eating disorder of 30 to 40 yrs HSES -normal women of 15 to 25 yrs HSES. The mean score of women suffering from eating disorder of 30 to 40 yrs HSES is 90.33 and normal women of 15 to 25 yrs HSES is 52.83. Difference between two mean groups is 37.50. That means women suffering from eating disorder of 30 to 40 yrs HSES significantly differ on body image score as compare to normal women of 15 to 25 yrs HSES.

A1B2C1-A2B1C2 women suffering from eating disorder of 30 to 40 yrs HSES -normal women of 15 to 25 yrs MSES. The mean score of women suffering from eating disorder of 30 to 40 yrs HSES is 90.33 and normal women of 15 to 25 yrs MSES is 48.77. Difference between two mean groups is 41.56. That means women suffering from eating disorder of 30 to 40 yrs HSES significantly differ on body image score as compare to normal women of 15 to 25 yrs MSES.

A1B2C1-A2B1C3 women suffering from eating disorder of 30 to 40 yrs HSES -normal women of 15 to 25 yrs LSES. The mean score of women suffering from eating disorder of 30 to 40 yrs HSES is 90.33 and normal

women of 15 to 25 yrs LSES is 49.47. Difference between two mean groups is 40.86. That means women suffering from eating disorder of 30 to 40 yrs HSES significantly differ on body image score as compare to normal women of 15 to 25 yrs LSES.

A1B2C1-A2B2C1 women suffering from eating disorder of 30 to 40 yrs HSES -normal women of 30 to 40 yrs HSES. The mean score of women suffering from eating disorder of 30 to 40 yrs HSES is 90.33 and normal women of 30 to 40 yrs HSES is 58.67. Difference between two mean groups is 31.66. That means women suffering from eating disorder of 30 to 40 yrs HSES significantly differ on body image score as compare to normal women of 30 to 40 yrs HSES.

A1B2C1-A2B2C2 women suffering from eating disorder of 30 to 40 yrs HSES -normal women of 30 to 40 yrs MSES. The mean score of women suffering from eating disorder of 30 to 40 yrs HSES is 90.33 and normal women of 30 to 40 yrs MSES is 48.63. Difference between two mean groups is 41.70. That means women suffering from eating disorder of 30 to 40 yrs HSES significantly differ on body image score as compare to normal women of 30 to 40 yrs MSES.

A1B2C1-A2B2C3 women suffering from eating disorder of 30 to 40 yrs HSES -normal women of 30 to 40 yrs LSES. The mean score of women suffering from eating disorder of 30 to 40 yrs HSES is 90.33 and normal women of 30 to 40 yrs LSES is 50.60. Difference between two mean groups is 39.73. That means women suffering from eating disorder of 30 to 40 yrs HSES significantly differ on body image score as compare to normal women of 30 to 40 yrs LSES.

A1B2C2-A2B1C1 women suffering from eating disorder of 30 to 40 yrs MSES – normal women of 15 to 25 yrs HSES. The mean score of women suffering from eating disorder of 30 to 40 yrs MSES is 69.67 and normal women of 15 to 25 yrs HSES is 52.83. Difference between two mean groups is 16.84. That means women suffering from eating disorder of 30 to 40 yrs MSES significantly differ on body image score as compare to normal women of 15 to 25 yrs HSES.

A1B2C2-A2B1C2 women suffering from eating disorder of 30 to 40 yrs MSES – normal women of 15 to 25 yrs MSES. The mean score of women suffering from eating disorder of 30 to 40 yrs MSES is 69.67 and normal women of 15 to 25 yrs MSES is 48.77. Difference between two mean groups is 20.90. That means women suffering from eating disorder of 30 to 40 yrs MSES significantly differ on body image score as compare to normal women of 15 to 25 yrs MSES.

A1B2C2-A2B1C3 women suffering from eating disorder of 30 to 40 yrs MSES – normal women of 15 to 25 yrs LSES. The mean score of women suffering from eating disorder of 30 to 40 yrs MSES is 69.67 and normal women of 15 to 25 yrs LSES is 49.47. Difference between two mean groups is 20.20. That means women suffering from eating disorder of 30 to 40 yrs MSES significantly differ on body image score as compare to normal women of 15 to 25 yrs LSES.

A1B2C2-A2B2C1 women suffering from eating disorder of 30 to 40 yrs MSES – normal women of 30 to 40 yrs HSES. The mean score of women suffering from eating disorder of 30 to 40 yrs MSES is 69.67 and normal women of 30 to 40 yrs HSES is 58.67. Difference between two

mean groups is 11.00. That means women suffering from eating disorder of 30 to 40 yrs MSES significantly differ on body image score as compare to normal women of 30 to 40 yrs HSES.

A1B2C2-A2B2C2 women suffering from eating disorder of 30 to 40 yrs MSES – normal women of 30 to 40 yrs MSES. The mean score of women suffering from eating disorder of 30 to 40 yrs MSES is 69.67 and normal women of 30 to 40 yrs MSES is 48.63. Difference between two mean groups is 21.04. That means women suffering from eating disorder of 30 to 40 yrs MSES significantly differ on body image score as compare to normal women of 30 to 40 yrs MSES.

A1B2C2-A2B2C3 women suffering from eating disorder of 30 to 40 yrs MSES – normal women of 30 to 40 yrs LSES. The mean score of women suffering from eating disorder of 30 to 40 yrs MSES is 69.67 and normal women of 30 to 40 yrs LSES is 50.60. Difference between two mean groups is 19.07. That means women suffering from eating disorder of 30 to 40 yrs MSES significantly differ on body image score as compare to normal women of 30 to 40 yrs LSES.

A1B2C3-A2B1C1 women suffering from eating disorder of 30 to 40 yrs LSES – normal women of 15 to 25 yrs HSES. The mean score of women suffering from eating disorder of 30 to 40 yrs LSES is 63.53 and normal women of 15 to 25 yrs HSES is 52.83. Difference between two mean groups is 10.70. That means women suffering from eating disorder of 30 to 40 yrs LSES significantly differ on body image score as compare to normal women of 15 to 25 yrs HSES.

A1B2C3-A2B1C2 women suffering from eating disorder of 30 to 40 yrs LSES – normal women of 15 to 25 yrs MSES. The mean score of women suffering from eating disorder of 30 to 40 yrs LSES is 63.53 and normal women of 15 to 25 yrs MSES is 48.77. Difference between two mean groups is 14.76. That means women suffering from eating disorder of 30 to 40 yrs LSES significantly differ on body image score as compare to normal women of 15 to 25 yrs MSES.

A1B2C3-A2B1C3 women suffering from eating disorder of 30 to 40 yrs LSES – normal women of 15 to 25 yrs MSES. The mean score of women suffering from eating disorder of 30 to 40 yrs LSES is 63.53 and normal women of 15 to 25 yrs LSES is 49.47. Difference between two mean groups is 14.06. That means women suffering from eating disorder of 30 to 40 yrs LSES significantly differ on body image score as compare to normal women of 15 to 25 yrs LSES.

A1B2C3-A2B2C2 women suffering from eating disorder of 30 to 40 yrs LSES – normal women of 30 to 40 yrs MSES. The mean score of women suffering from eating disorder of 30 to 40 yrs LSES is 63.53 and normal women of 30 to 40 yrs MSES is 48.63. Difference between two mean groups is 14.90. That means women suffering from eating disorder of 30 to 40 yrs LSES significantly differ on body image score as compare to normal women of 30 to 40 yrs MSES.

A1B2C3-A2B2C3 women suffering from eating disorder of 30 to 40 yrs LSES – normal women of 30 to 40 yrs LSES. The mean score of women suffering from eating disorder of 30 to 40 yrs LSES is 63.53 and normal women of 30 to 40 yrs LSES is 50.60. Difference between two mean groups

is 12.93. That means women suffering from eating disorder of 30 to 40 yrs LSES significantly differ on body image score as compare to normal women of 30 to 40 yrs LSES.

A2B1C2-A2B2C1 normal women of 15 to 25 yrs MSES – normal women of 30 to 40 yrs HSES. The mean score of normal women of 15 to 25 yrs MSES is 48.77 and normal women of 30 to 40 yrs HSES is 58.67. Difference between two mean groups is 9.90. That means normal women of 15 to 25 yrs MSES significantly differ on body image score as compare to normal women of 30 to 40 yrs HSES.

A2B1C3-A2B2C1 normal women of 15 to 25 yrs LSES – normal women of 30 to 40 yrs HSES. The mean score of normal women of 15 to 25 yrs LSES is 49.47 and normal women of 30 to 40 yrs HSES is 58.67. Difference between two mean groups is 9.20. That means normal women of 15 to 25 yrs LSES significantly differ on body image score as compare to normal women of 30 to 40 yrs HSES.

A1B2C1-A2B2C2 women suffering from eating disorder of 30 to 40 yrs HSES – normal women of 30 to 40 yrs MSES. The mean score of women suffering from eating disorder of 30 to 40 yrs HSES is 58.67 and normal women of 30 to 40 yrs MSES is 48.63. Difference between two mean groups is 10.04. That means women suffering from eating disorder of 30 to 40 yrs HSES significantly differ on body image score as compare to normal women of 30 to 40 yrs MSES.

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CHAPTER : 5

SUMMARY, CONCLUSIONS, SUGGESTIONS AND LIMITATIONS

1. Summary
2. Conclusions
3. Suggestions for further study
4. Limitations of the study

CHAPTER : 5

SUMMARY, CONCLUSIONS, SUGGESTIONS AND LIMITATIONS

1. Summary:

In the present research, the attempt has been made to make comparative study of self-concept, anxiety and body image of women suffering from eating disorder and Normal Women between age 15 to 25 age and 30 to 40 years.

The problem of the present research study was as under.

“A study of self-concept, anxiety and body image among normal women and women suffering from eating disorder”

Major objectives of the present research work were as under:

1. To study and compare women suffering from eating disorder and normal women with regard to their self-concept, anxiety and body image.
2. To study and compare 15 to 25 years old and 30 to 40 years old age groups of women suffering from eating disorder and normal women with regard to their self-concept, anxiety and body image.
3. To study and compare HSES, MSES, LSES women suffering from eating disorder and normal women with regard to their self-concept, anxiety and body image.

Major Hypotheses of the present research work were as under:

1. There will be no significant difference between women suffering from eating disorder and normal women in relation to self-concept.

2. There will be no significant difference between 15 to 25 years and 30 to 40 years women In relation to self-concept.
3. There will be no significant difference among HSES, MSES and LSES women in relation to self- concept.
4. There will be on significant difference between women suffering from eating disorder and normal women in relation to anxiety.
5. There will be no significant difference between 15 to 25 years and 30 to 40 years women In relation to anxiety.
6. There will be no significant difference among HSES, MSES and LSES women in relation to anxiety.
7. There will be no significant difference between women suffering from eating disorder and normal women in relation to body image.
8. There will be no significant difference between 15 to 25 years and 30 to 40 years women In relation to body image.
9. There will be no significant difference among HSES, MSES and LSES women in relation to body image.

In the present study, 2x2x3 factorial design was used. Two types of women, (1) women suffering from eating disorder (2) normal women, two types of age group, (1) 15 to 25 yrs (2) 30 to 40 yrs, three SES groups, (1) HSES (2) MSES (3) LSES were taken as independent variables. Score of self-concept, anxiety and body image were taken as dependent variables.

The present research work conducted on 360 women. The purposive sampling technique used for the selection of samples. The women were selected from various areas of Gujarat such as Ahmedabad, Surat, Gandhinagar and Vallabh-Vidyanagar.

Following tools used in present study.

1. Eating Aptitude Test (EAT-26) by Dr. D Garner.
2. Socio-economic Status Scale (SESS) by Dr. D. J. Bhatt
3. Self-Concept Questionnaire (SCQ) by V K Mittal and S Abrol.
4. Anxiety Measurement Scale (AMS) by S D Kapoor.
5. Body Shape Questionnaire (BSQ) by Cooper et.al.

In the present study, with the help of EAT-26, identified the women suffering from eating disorder and normal women, with regard to their SES (HSES, MSES, and LSES) and age (15 to 25, 30 to 40). After identification of ED and normal women, three tests, self-concept questionnaire by V. K. Mittal and S. Abrol, anxiety measurement scale by S. D. Kapoor and body shape questionnaire by Copper et. Al. were administered individually. Scoring was done as par scoring key of each test.

After tabulation of scores following statistical techniques were used for testing the hypothesis such as analysis of variance (ANOVA), least significant difference (LSD).

The results of ANOVA on self-concept score indicate that women suffering from eating disorder significantly differ as compare to normal women. 15 to25 yrs women do not differ as compare to 30 to 40 yrs women of HSES (higher socio economic status) significantly differ as compare to women of MSES (middle socio economic status) and LSES (lower socio economic status). Women and age do not interact each other. Women and SES do not interact each other. Age and SES do not interact each other. Women age and SES do not interact each other.

The results of ANOVA on anxiety score indicate that women suffering from eating disorder significantly differ as compare to normal women. 15 to 25 yrs women do not differ on anxiety score as compare to 30 to 40 yrs women. HSES women significantly differ on anxiety score as compare to MSES women and LSES women. Women and age do not interact each other on anxiety score. Women and SES significantly interact each other on anxiety score. Age and SES significantly interact each other on anxiety score. Age and SES significantly interact each other on anxiety score.

The results of ANOVA on body image score indicate that women suffering from eating disorder significantly differ on body image score as compare to normal women. 15 to 25 yrs women do not differ on body image score as compare to 30 to 40 yrs women. HSES women significantly differ on body image score as compare to MSES women and LSES women. Women and age do not interact each other on body image score. Women and SES significantly interact each other on body image score. Age and SES significantly interact each other on body image score. Women age and SES do not interact each other on body image score.

5.2 Conclusions:

On the besis of the results and discussion following conclusions can be drawn.

1. Women suffering from eating disorder significantly differ on self-concept score as compare to normal women. Women suffering from eating disorder have shown poor self-concept as compare to the normal women.

2. 15 to 25 yrs women do not differ on self-concept score as compare to 30 to 40 yrs women.
3. Women of HSES (higher socio economic status) significantly differ on self-concept score as compare to women of MSES (middle socio economic status) and LSES (lower socio economic status).
4. Women suffering from eating disorder significantly differ on anxiety score as compare to normal women. Women suffering from eating disorder have shown more anxiety as compare to the normal women.
5. 15 to 25 yrs women do not differ on anxiety score as compare to 30 to 40 yrs women.
6. HSES women significantly differ on anxiety score as compare to MSES women and LSES women. Women of MSES and LSES have shown more anxiety as compare to HSES women.
7. Women and SES significantly interact each other on anxiety score. HSES women suffering from eating disorder have shown more anxiety.
8. Age and SES significantly interact each other on anxiety score.15 to 25 MSES women have shown more anxiety.
9. Women suffering from eating disorder significantly differ on body image score as compare to normal women. Women suffering from eating disorder are more worried and dissatisfaction with their body image as compare to the normal women.
10. 15 to 25 yrs women do not differ on body image score as compare to 30 to 40 yrs women.

11. HSES women significantly differ on body image score as compare to MSES women and LSES women. HSES women are more worried and dissatisfaction with their body image as compare to MSES and LSES women.
12. Women and SES significantly interact each other on body image score. HSES women suffering from eating disorder are more worried and dissatisfaction with their body image.
13. Age and SES significantly interact each other on body image score. 30 to 40 yrs HSES women are more worried and dissatisfaction with their body image.

3. Suggestions for further study:
   1. Study of mental health and Adjustment of women suffering from eating disorder and normal women would throw additional light.
   2. A comparative study of occupations of women suffering from eating disorder and normal women need to be studied.
   3. A study of marital status of women suffering from eating disorder and normal women would also throw additional light.
   4. Effect of literacy, religious and caste of women suffering from eating disorder and normal women could be a challenging area of research.

4. Limitations of the study:
   1. The sample size of each sub group was very small (n=30) so that findings of this study cannot to be generalized on large population.
   2. Type of family, religious, caste etc., are not controlled in present study.

3. Educational status has not studied in present investigation.
4. The sample of each group was taken from only urban area.
5. Women suffering from severe eating disorder were not taken in this study.

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P.D.S.

સંશોધક	માર્ગદર્શક
પ્રા. વૈશાલી પંચાલ	**ડૉ. ગંધર્વ આર. જોષી**
અમદાવાદ આર્ટ્સ કોલેજ,	પ્રોફેસર,
અમદાવાદ	સૌરાષ્ટ્ર યુનિવર્સિટી, રાજકોટ

નામ : ______________________________ ઉંમર : __________

ધર્મ : __________ જ્ઞાતિ : __________ શહેર/ગ્રામ્ય : __________

હાલનું વજન : ______ સૌથી વધુ વજન : ______ સૌથી ઓછુંવજન : ______

ઉંચાઈ : ______________________ પરિણીત / અપરિણીત : __________

અભ્યાસ : ______________________ વ્યવસાય : ______________

કુટુંબ : સંયુક્ત / વિભક્ત ________________

EAT-26

(સૂચના)

નામ : ______________________________ ઉંમર : ______________

વર્તમાન વજન : ______________________ સૌથી વધુ વજન : __________

ગર્ભાવસ્થા : __________ સૌથી નીચું વજન : __________ શહેર/ગ્રામ્ય : __________

આદર્શ વજન : ____________ જાતિ : ____________ ઉંચાઈ : ______________

નીચેના વિધાનોની સામે આપેલ વિકલ્પોમાંથી એકની પસંદગી કરીને તેની સામે (√) ની નિશાની કરશો.

	હંમેશા	ક્યારેક	વારંવાર	અમુક વખત	ભાગ્યેજ	કદી નહીં	કુલ પ્રાપ્તાંક
૧. વજન વધી જવાની બીક લાગે છે.	( )	( )	( )	( )	( )	( )	( )
૨. જ્યારે ભૂખ લાગી હોય ત્યારે જમવાથી દૂર રહું છું.	( )	( )	( )	( )	( )	( )	( )
૩. હંમેશા ખોરાકના વિચારો આવ્યા કરે છે.							
૪. અમુક વસ્તુ ખાધા જ કરૂં છું જ્યારે મને એમ લાગે છે કે હું તેપ્રવૃત્તિને અટકાવી નહીં શકું.	( )	( )	( )	( )	( )	( )	( )
૫. ખાદ્ય વસ્તુઓને નાના ટૂંકડામાં કાપી નાખું છું.	( )	( )	( )	( )	( )	( )	( )
૬. હું જે ખોરાક લઈ છું તેમાં રહેલી કેલેરીથી હું સભાન છું.	( )	( )	( )	( )	( )	( )	( )
૭. ખાસ કરીને વધુ કાર્બોહાઈડ્રેટ્સ ધરાવતા પદાર્થોથી દૂર રહું છું. (દા.ત. બ્રેડ, ભાત, બટાકા વગેરે)	( )	( )	( )	( )	( )	( )	( )
૮. મને એમ લાગે છે કે હું વધારે જમું તે બીજાને ગમશે.	( )	( )	( )	( )	( )	( )	( )
૯. જમ્યા પછી ઉલ્ટી થાય છે.	( )	( )	( )	( )	( )	( )	( )
૧૦. જમ્યા પછી એકદમ અપરાધની લાગણી અનુભવું છું.	( )	( )	( )	( )	( )	( )	( )
૧૧. પાતળા થઈ જવાના વિચારો મનનો કબજો લઈ છે.	( )	( )	( )	( )	( )	( )	( )
૧૨. જ્યારે કસરત કરૂ છું ત્યારે કેલરી બાળી-નાંખવા વિચારૂં છું.	( )	( )	( )	( )	( )	( )	( )
૧૩. બીજા લોકો એમ માને છે કે હું ખૂબ પાતળો છું.	( )	( )	( )	( )	( )	( )	( )
૧૪. મારા શરીર પર ખૂબ ચરબી છે.	( )	( )	( )	( )	( )	( )	( )
૧૫. મને જમવામાં બીજા કરતાં વધારે સમય લાગે છે.	( )	( )	( )	( )	( )	( )	( )
૧૬. ખાંડવાળા પદાર્થો ખાવાથી દૂર રહું છું.	( )	( )	( )	( )	( )	( )	( )

૧૭. નિયત કરેલો આહાર લઈ છું.	( )	( )	( )	( )	( )	( )	( )
૧૮. એમ લાગે છે કે ખોરાક મારા જીવનને નિયંત્રણમાં રાખે છે.	( )	( )	( )	( )	( )	( )	( )
૧૯. ખોરાકની બાબતમાં હું સ્વ-નિયંત્રણ રાખું છું.	( )	( )	( )	( )	( )	( )	( )
૨૦. મને એમ લાગે છે કે બીજા લોકો મને વધારે ખાવાનું દબાણ કરે છે.	( )	( )	( )	( )	( )	( )	( )
૨૧. ખોરાક બાબતમાં હું વધુ સમય લ. છુ અને વધુ વિચારૂં છું.	( )	( )	( )	( )	( )	( )	( )
૨૨. ગળી વસ્તુઓ ખાવાથી મને થોડી મૂશ્કેલી લાગે છે.	( )	( )	( )	( )	( )	( )	( )
૨૩. આહારને નિયંત્રણ કરવાના વર્તનમાં રોકાયેલો રહું છું.	( )	( )	( )	( )	( )	( )	( )
૨૪. મારા પેટને ખાલી રાખવાનું ગમે છે.	( )	( )	( )	( )	( )	( )	( )
૨૫. જમ્યા પછી ઉલ્ટી થવાનું સંવેદન થાય છે.	( )	( )	( )	( )	( )	( )	( )
૨૬. નવો સમૃદ્ધ ખોરાક લઈને આનંદ અનુભવું છું.	( )	( )	( )	( )	( )	( )	( )

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સૂચના

પ્રસ્તુત સામાજિક, આર્થિક દરજ્જા માપદંડનો મુખ્ય હેતુ તમારા કુટુંબની સામાજીક, આર્થિક સ્થિતિ અંગે માહિતી એકઠી કરવાનો છે. આ માપદંડમાં તમારા કુટુંબના સંદર્ભમાં કેટલીક માહિતી પુછવામાં આવી છે. તમને પૂછેલી માહિતી તમે જે કુટુંબના સભ્યો છો તેને ધ્યાનમાં રાખીને આપવાની છે.

આ માપદંડની દરેક કોલમ વાંચો અને તમારા કુટુંબના સંદર્ભમાં જે ખરેખર સત્ય છે તેને ધ્યાનમાં રાખો ને યોગ્ય સ્થળે ખરાનું ચિહ્ન(✓) જણાવો. તમે અહીં જે માહિતી આપશ તેન ખાનગી રાખવામાં આવશે તેનો માત્ર સંશોધનના સંદર્ભમાં જ ઉપયોગ કરાશે. માટે કોઈપણ સંકોચ વિના પ્રમાણિકપણે માહિતી આપો. આ માપદંડ માટે કોઈ સમય મર્યાદા નથી. તેમ છતાં માહિતી સમજીને ઝડપથી પ્રત્યુત્તર આપો તે ઈચ્છનીય છે.

૧. વ્યક્તિગત માહિતી :

કુટુંબની મુખ્ય વ્યક્તિ (વાલી/પિતા)નું નામ : ________________________

કુટુંબની જ્ઞાતિ : ____________________ પેટા જ્ઞાતિ : ____________________

કુટુંબની મુખ્ય વ્યક્તિનું શિક્ષણ : ________________________

૨. કુટુંબ અંગે માહિતી :

I. મારા કુટુંબની દર મહિને કુલ આવક નીચે મુજબ છે. (યોગ્ય સ્થળે ચિહ્ન કરો)

- માસિક રૂા. ૩૦,૦૦૦ થી વધુ ( ) • માસિક રૂા. ૨૫,૦૦૦ થી ૩૦,૦૦૦ ( )
- માસિક રૂા. ૨૦,૦૦૦ થી ૨૫,૦૦૦ ( ) • માસિક રૂા. ૧૫,૦૦૦ થી ૨૦,૦૦૦ ( )
- માસિક રૂા. ૧૦,૦૦૦ થી ૧૫,૦૦૦ ( ) • માસિક રૂા. ૫,૦૦૦ થી ૧૦૦૦૦ ( )
- માસિક રૂા. ૨,૦૦૦ થી ૫,૦૦૦ ( ) • માસિક રૂા. ૧,૦૦૦ થી ૨,૦૦૦ ( )
- માસિક રૂા. ૫૦૦ થી ૧,૦૦૦ ( ) • માસિક રૂા. ૫૦૦ થી ઓછી ( )

II. મારા કુટુંબનું કદ નીચે પ્રમાણે છે. (યોગ્ય સ્થળે ચિહ્ન કરો)

- બાળકોની સંખ્યા ૧ અથવા એક પણ નહીં( ) • બાળકોની સંખ્યા ૧ થી ૨ ( )
- બાળકોની સંખ્યા ૩ થી ૪ ( ) • બાળકોની સંખ્યા ૫ થી ૬ ( )
- બાળકોની સંખ્યા ૭ કે તથી વધુ ( )

III. મારા કુટુંબના સભ્યો નીચે પ્રમાણે અખબાર/મેગેઝીન ખરીદે છે.
(એક કરતા વધુ ખરીદતા હોય તો તે પ્રમાણે ચિહ્ન કરો)

- દૈનિક ( ) • અઠવાડિક ( ) • માસિક ( )
- ત્રિમાસિક ( ) • ક્યારેક ( ) • કદાપી નહીં ( )

IV. મારા કુટુંબનું માસિક ખર્ચ અખબાર કે મેગેઝીન માટે નીચે મુજબ છે.

(એક કરતા વધુ ખરીદતા હોય તો તે પ્રમાણે ચિહ્ન કરો)

- રૂા. ૪૦૦ કે તેથી વધુ ( ) • રૂા. ૩૦૦ થી ૪૦૦ ( ) • રૂા. ૨૦૦ થી ૩૦૦ ( )
- રૂા. ૧૦૦ થી ૨૦૦ ( ) • રૂા. ૯૦ થી ૯૯ ( ) • રૂા. ૫૦ થી ૯૦ ( )
- રૂા. ૫૦ કે તેથી ઓછું કે બિલકુલ નહીં. ( )

V. મારા કુટુંબના દરજ્જા અંગે અન્યનો અભિપ્રાય નીચે પ્રમાણે છે.

- અત્યંત શ્રીમંત કુટુંબ ( ) • શ્રીમંત કુટુંબ ( ) • ઉચ્ચ મધ્યમ કુટુંબ ( )
- મધ્યમ કુટુંબ ( ) • સામાન્ય કુટુંબ ( ) • નિમ્ન સ્તર કુટુંબ ( )
- અત્યંત નિમ્ન સ્તર કુટુંબ ( )

૩. કુટુંબના મનોરંજન અંગેની માહિતી :

I. કુટુંબના સભ્યો નીચેના માધ્યમ વડે મોટાભાગે મનોરંજન પ્રાપ્ત કરે છે.

(એક કરતાં વધુ માધ્યમ વડે મનોરંજન મળતું હોય)

- વિદેશી (સ્ટાર, ઝી, બી.બી.સી.) ટીવી જોડાણ વડે ( ) • ડીશ જોડાણ વડે ( )
- વી.સી.આર ભાડે લાવીને પિક્ચર જોવા ( ) • ટેલિવિઝન દ્વારા ( )
- સિનેમા દ્વારા ( ) • રેડિયો દ્વારા ( )
- અન્ય સાધનો દ્વારા ( )

૪. વાહનો અંગેની માહિતી :

મારા કુટુંબમાં નીચેના વાહનો છે. (એક કરતા વધુ વાહનો હોય તો તે પ્રમાણે ચિહ્ન કરો)

- એર-કંડીશન્ડ મોટરકાર/ જીપ ( ) •મોટરકાર અથવા જીપ ( )
- ટ્રક/ગાડી અથવા લકઝરી બસ ( ) • સ્કુટર અથવા મોટરસાઈકલ ( )
- પેટ્રોલ રીક્ષા અથવા ડીઝલ રીક્ષા ( ) • કોઈપણ પ્રકારનું મોપેડ વાહન ( )
- સાઈકલ ( )

૫. મકાન અંગેની માહિતી :

I. મારા કુટુંબ નીચે મુજબનું મકાન ધરાવે છે.

- પોતાની માલિકીનું મકાન ( ) • સંસ્થા દ્વારા પ્રાપ્ત થયેલ કમાન ( )
- ભાડા પેટે લીધેલું મકાન ( )
- રહેમ ભાવે સંસ્થા કે સગા દ્વારા મળેલું મકાન( )

II. મારા કુટુંબ નીચે પ્રમાણેના પ્રકારનું મકાન ધરાવે છે.

- એર-કંડીશન્ડ મોટો બંગલો બગીચા સાથે ( ) • મોટો બંગલો બગીચા સાથે ( )
- નાનો બંગલો અથવા મોટો ફ્લેટ ( ) • નાનો ફલેટ કે રો હાઉસ ( )
- પાકુ મકાન કે તદ્દન નાનું મકાન ( ) • પાકુ મકાન વિદ્યુત જોડાણ સાથે ( )

• કાચુ મકાન પણ દેશી / વિલાયતી નળીયાવાળુ ( ) • કાચુ કમાન પણ તદ્દન નાનુ ( )

• લોખંડના પતરા કે ઘાસનાં છાપરાવાળું ઝુંપડું ( )

III. મકાનમાં ફર્નીચર અંગેની માહિતી : (જે ફર્નીચર ધરાવતા હોય તે પ્રમાણે ચિહ્ન કરો.)

• એક કરતા વધુ ટેલીફોન દેશવિદેશ સાથે જોડાણ ( )

• ટેલિફોનનું દેશ વિદેશ સાથે જોડાણ ( )

• માંગેલ ટેલિફોન જોડાણ ( )

• ઉચ્ચ કક્ષાના સોફાસેટ અને સનમાઈકાના પલંગો ( )

• ડ્રેસિંગ ટેબલ, ડાઈનીંગ ટેબલ અને ખુરશીઓ ( )

• મોટા કદનું ઘડીયાલ, સ્ટીરીઓ સાથે ટેપ રેકોર્ડર અને રેડિયો (ઉંચી કિંમતનો) ( )

• વોટર ક્લિનર, ગેસ જોડાણ, પ્રેશર કુકર અને કેમેરો ( )

• કાંડાની ઘડિયાળ, સાદી ખુરશીઓ કે ટેબલ લોખંડની ખુરશીઓ અને પોકેટ રેડીયો ( )

• વિદ્યુત ઈસ્ત્રી, સિવણ મશીન, લેમન સેટ, પિકનીક સેટ, ટી સેટ, કોઈપણ પ્રકારનું ફર્નીચર( )

• કોઈપણ પ્રકારનું ફર્નીચર ( )

૬. વિદ્યુત સાધનો અંગેની માહિતી :

મારા કુટુંબમાં નીચે મુજબના વિદ્યુત સાધનો છે. (જુદા જુદા પ્રકારનાં એક થી વધુ સાધનો હોય તે રીતે ચિહ્ન કરો)

• પ્રોજેક્ટ ટેલીવિઝન / ઈંટર એકટીવ ટેલીવિઝન ( ) • વી.સી.આર સાથે ટેલીવિઝન ( )

• રંગીન ટેલીવિઝન સાથે રીમોટ કંટ્રોલ ( ) • રંગીન ટેલીવિઝન ( )

• રેફ્રીજરેટર / ફ્રીઝ ( ) • ઘરઘંટી ( )

• બ્લેક ઍન્ડ વ્હાઈટ ટેલીવિઝન ( ) • ગ્રાઈન્ડર મિક્ષ્ચર ( )

• વિદ્યુત હિટર / ગીઝર ( ) • વિદ્યુત પંખો કે રેડીયો સેટ ( )

• કોઈ પણ પ્રકારનું વિદ્યુત સાધન નહીં ( ) •વી.સી.આર સાથે ટેલીવિઝન ( )

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સૂચના

પ્રસ્તુત પ્રશ્નાવલીમાં વ્યક્તિત્વને સ્પર્શતી જુદી જુદી હકીકતોને લગતા વિધાનો આપ્યા છે. કૃપા કરી દરેક વિધાન ધ્યાનથી વાંચો અને ‘હા’, ‘?’, ‘ના’ એમ આપેલા ત્રણ વિકલ્પોમાંથી તમારા સ્વભાવ અનુસાર વિકલ્પ પર (√) ખરાની નિશાની કરો. જો તમે તમારા જવાબ આપવા માટે અસમર્થ હોવ ત્યારે જ પ્રશ્નાર્થ ચિન્હ્ પર ખરાની નિશાની કરશો.

– ઉદાહરણ :

	હા	?	ના
હું યોગ્ય રીતે મારા ગુસ્સાને અભિવ્યક્ત કરું છું.	( )	( )	( )

	હા	?	ના
૧. મંરં સ્નંયુએં ખુબ દુદઢ છે.	( )	( )	( )
૨. મંરં અંવેગેં અને લંગણીએં હામેશં ઉગ્ર બની જાય છે.	( )	( )	( )
૩. મંરી ઉંમરને અનુરૂપ મંરંમાં મંનદિક યેંગ્યસં છે.	( )	( )	( )
૪. મંરં દહકર્મચંરીએં પ્રત્યે મને વિશેષ દહંનુભૂસિ નથી.	( )	( )	( )
૫. દમંજમાં હુા મંરી જવંબતંરીએં દંરી રીસે પૂરી કરુા છુા.	( )	( )	( )
૬. મંરં જીવનનુા મુખ્ય ધ્યેય પૈદં કમંવવંનુા નથી.	( )	( )	( )
૭. હુા દમંજવંતમાં વિશ્વંદ કરસેં/કરસી નથી.	( )	( )	( )
૮. મને લંગે છે કે મંરુા વ્યક્સિત્વ દમંયેંજીસ છે.	( )	( )	( )
૯. હુા લંભતંયક દંમંજીક દાબાધેં બનંવવંમાં કુશળ છુ.	( )	( )	( )
૧૦. હુા જીવનમાં અહિંદંનુા પંલન કરવંનેં પ્રયત્ન કરુા છુા.	( )	( )	( )
૧૧. હુા વિવશ બનીને દંમંજીક પરિસ્થિંસિએં દંથે દમંયેંજન દંધુ છુા.	( )	( )	( )
૧૨. મંરં મનની ઈચ્છંએં મંરં મનમાં જ તબંયેલી રહે છે.	( )	( )	( )
૧૩. મંરંમાં મંરી ઉંમરને અનુદંર શંરીરિક કુશળસં છે.	( )	( )	( )
૧૪. મને હામેશં નકંમી ચિંસંએં દસંવસી નથી.	( )	( )	( )
૧૫. દંમંન્ય રીસે હુા નવી દમસ્યંએંનેં ઉકેલ શેંધવંમાં દુખ અનુભવુા છુા.	( )	( )	( )
૧૬. વ્યવદંયમાં રૂચિ હેંવંને કંરણે જ હુા અં શિક્ષણ પ્રંપ્ત કરુા છુા.	( )	( )	( )
૧૭. બીજા દંથે દહંનુભૂસિ પૂર્વક વ્યવહંર કરવેં એ મંરી અંતસ છે.	( )	( )	( )
૧૮. મને કેંઈને કેંઈ કળંનં મંધ્યમથી સ્વ-અભિવ્યક્સિ કરવંની અંતસ છે.	( )	( )	( )
૧૯. મંરં નિર્ણયને ધંર્મિક લંગણીએં અદર કરે છે.	( )	( )	( )
૨૦. મંરં ‘સ્વ’ નં કેટલાંક પંદંએં અવિક્દિસ છે.	( )	( )	( )
૨૧. પૈદંની બચસથી મંરંમાં અંત્મ-દુરક્ષંની ભંવનં વિકદે છે.	( )	( )	( )
૨૨. હુા મંરં જીવનનં અંતર્શે પર દ્રઢ રહુા છુ.	( )	( )	( )
૨૩. હામેશં નિર્ણય કર્ય પછી મને પસ્સંવેં થંય છે.	( )	( )	( )
૨૪. હુા મંરી વંસ ગમે સેટલી દમજાવીને કહુા સેં પણ સ્પષ્ટ કરી શકસેં/શકસી નથી.	( )	( )	( )
૨૫. મને ઉંડં શ્વંદ લેવંમાં અંનાત મળે છે.	( )	( )	( )

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૨૬. હામેશં મને એવુા લંગે છે કે મંરી લંગણીએં આતરને આતર ગુાટંયેલી રહે છે.	( )	( )	( )
૨૭. બૈંધ્ધિક દમસ્યંએં હુા એકાંસ ચિંસન દ્વંરં ઉકેલુા છુા.	( )	( )	( )
૨૮. અભ્યંદ મંટે મને પુસ્સકંલય જવંની અંતસ છે.	( )	( )	( )
૨૯. મને એ વંસ દસંવે છે કે વિજાસીય વ્યક્સિ મને અંનાત વિનેંત મંટે અંમત્રિંસ કરસેં/ કરસી નથી.	( )	( )	( )
૩૦. વિવશ બનીને મને કાઈ પણ કંર્ય કરવંનુા પદાત નથી.	( )	( )	( )
૩૧. હુા દંધનંથી મંનદિક શક્સિ પ્રંપ્ત કરુા છુા.	( )	( )	( )
૩૨. મંરં વ્યક્સિત્વનં વિવિધ પંદંએં એકબીજાનં પુરક નથી.	( )	( )	( )
૩૩. અંત્મરક્ષણની નબળી ક્ષ્મસંને કંરણે હામેશં મંરં કંર્યે બગડી જાય છે.	( )	( )	( )
૩૪. બીજાનં સિરસ્કંરનેં પ્રભંવ મંરી અહામ ભંવનં પર પડસેં નથી.	( )	( )	( )
૩૫. દંમંજીક ટીકં મંરં ઉત્‌શને ડગંવી શકસી નથી.	( )	( )	( )
૩૬. દંમંન્ય રીસે મને મંરં મિત્રે પંદેથી સ્નેહ પ્રંપ્સ થંય છે.	( )	( )	( )
૩૭. પર્વસની ટેંચ પર ચઢસં મને દુખનેં અનુભવ થંય છે.	( )	( )	( )
૩૮. હુા હામેશં કેટલીક બંબસેંથી ખીજાઈ જાઉ છુા.	( )	( )	( )
૩૯. ક્યંરેક ક્યંરેક મને મંનદિક તુર્બળસંનેં અંભંદ થંય છે.	( )	( )	( )
૪૦. મને વ્યવદંય દાબાધી નવી જાણકંરીથી ખુશી પ્રંપ્ત થંય છે.	( )	( )	( )
૪૧. દમુહમાં રહેવં છસાં મને ક્યંરેક એકલસં અનુભવંય છે.	( )	( )	( )
૪૨. હુા હામેશં મંરં વિચંરેંને મુક્સ રીસે પ્રગટ રીસે કરી શકસેં/શકસી નથી.	( )	( )	( )
૪૩. હામેશં મંરંથી જીવન મૂલ્યેંથી વિપરીસ કંર્યે થંઈ જાય છે.	( )	( )	( )
૪૪. હુા લેંકેં વચ્ચે મંરી જાસને અસડેં/અસડી અનુભવસેં/અનુભવસી નથી.	( )	( )	( )
૪૫. અંર્થિક દાકટ અંવે ત્યંરે હુા દફળસં પૂવક દાઘર્ષ કરી શકુા છુા.	( )	( )	( )
૪૬. મને મંરં મિત્રે વચ્ચે પેંસંપણુા અનુભવંસુા નથી.	( )	( )	( )
૪૭. મને મંરી જાસમાં દર્જનકળંનેં અભંવ અનુભવંય છે.	( )	( )	( )
૪૮. હુા હંવભંવ દ્વંરં મંરી લંગણીએંને દફળસં પૂર્વક અભિવ્યક્સ કરી લઉછુા.	( )	( )	( )
૪૯. મંરુા શરીર એટલુા લચીલુા છે કે હુા ઈચ્છુા સેમ સેને વંળી શકુા છુ.	( )	( )	( )
૫૦. દંમંન્ય રીસે ગભરંઈ જવંય સેવી પરિસ્થિસિમાં હુા ઉત્તેજીસ બની જસેં/ જસી નથી.	( )	( )	( )
૫૧. બીજાની દલંહ વગર હુા ભવિષ્યની યેંજનંએં બનંવી શકસેં/શકસી નથી.	( )	( )	( )
૫૨. વ્યવદંય દાબાધી અંતેશેં હુા દરળસંપૂર્વક સ્પષ્ટ કરી તઉ છુા.	( )	( )	( )
૫૩ હુા દંમંજીક દ્રષ્ટિએ લઘુસંનેં અનુભવ કરસેં/કરસી નથી.	( )	( )	( )
૫૪. હુા ક્યંરેક જ મંરં વ્યવદંયમાં રચનંત્મક વિચંરેં અંપુ છુા.	( )	( )	( )
૫૫. મંરંમાં દંરં અને ખેંટંનેં ભેત પંરખવંની ક્ષ્મસં છે.	( )	( )	( )
૫૬. હુા મંરં વિચંરેંને દંરી રીસે દમજવંનેં પ્રયત્ન કરુા છુ.	( )	( )	( )
૫૭. હુા મુશ્કેલીમાં દફળસંપુર્વક દાઘર્ષ કરુા છુ.	( )	( )	( )

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૫૮. બીજાનં હિસ મંટે પેંસંનં હિસનેં ત્યંગ કરવંનુા હુા યેંગ્ય મંનસેં/મંનસી નથી.	( )	( )	( )
૫૯. હુા બીજાની લંગણીએંને દરળસંથી દમજુા છુા.	( )	( )	( )
૬૦. મંરં મિત્રેં મંરી દંથે મુક્સ રીસે વિચંરેં અભિવ્યક્સ કરસં નથી.	( )	( )	( )
૬૧. મને જીવનમાં અંરંમનેં અભંવ અનુભવંય છે.	( )	( )	( )
૬૨. મને હામેશં પંપની લંગણી દસંવે છે.	( )	( )	( )
૬૩. દમસ્યંએંનં વ્યવહંરીક ઉકેલ મંટે હુા મંરં પૂર્વજ્ઞનનેં ઉપયેંગ કરુા છુ.	( )	( )	( )
૬૪. મૈલિક વિચંરકેંનં પુસ્સકેં વાંચવંમાં મને કેંઈ વિશેષ મુશ્કલી પડસી નથી.	( )	( )	( )
૬૫. મને લંગે છે કે મંરં મિત્રેંને મંરી એટલી જરૂરસ નથી જેટલી મને સેમની છે.	( )	( )	( )
૬૬. મને હામેશં નવી વસ્સુએંની રચનં કરવંમાં અંનાત પ્રંપ્ત થંય છે.	( )	( )	( )
૬૭. પરસ્પર વિશ્વંદ પર અંધંરીસ હેંવંને કંરણે મંરુા જીવન શાંસિમય છે.	( )	( )	( )
૬૮. મને લંગે છે કે હુા અપૂર્ણ છુા.	( )	( )	( )
૬૯. ઋસુ બતલંય ત્યંરે હુા હામેશં બિમંર પડી જાઉ છુા.	( )	( )	( )
૭૦. દમંયેંજીસ જીવન જીવવં મંટે હુા હામેશં બીજા દંથે હળીમળીને રહુા છુા.	( )	( )	( )
૭૧. વ્યક્સિત્વનં જુતં જુતં પંદંએં મંરંમાં દંરી રીસે વિકદીસ છે.	( )	( )	( )
૭૨. હુા મંરં મનનં ભંવેં દંરી રીસે પ્રગટ કરવં દક્ષમ છુા.	( )	( )	( )
૭૩. દવંરે ઉંઘીને ઉઠવં છસાં હુા થંકનેં અનુભવ કરુા છુ.	( )	( )	( )
૭૪. મને એવુ લંગે છે કે લંગણીએંનં અનુભવથી જ રદ ઉત્પન્ન થંય છે.	( )	( )	( )
૭૫. મને હામેશં અંવિષ્કંરંત્મક બુધ્ધિનેં અભંવ ખટકે છે.	( )	( )	( )
૭૬. જીવનની ઘણી ઉપયેંગી વંસેંની મને જાણકંરી નથી.	( )	( )	( )
૭૭. હુા હામેશં મંરં દંથીતંરેંનં રૂઅંબમાં અંવી જાઉં છુા.	( )	( )	( )
૭૮. મંરં જીવનનેં ઉત્ેશ જ્ઞંન પ્રંપ્તિ નથી.	( )	( )	( )
૭૯. હુા દતંચંરને દફળ જીવન મંટે મતતરૂપ મંનુા છુા.	( )	( )	( )
૮૦. ફિલ્મ કે ટી.વી.નં અંનાતતંયક કટંક્ષે મને દંરં લંગે છે.	( )	( )	( )
૮૧. યેંગ્ય દંમંજીક દાબાધેંનં અભંવને કંરણે હુા લઘુસંનેં અનુભવ કરુા છુા.	( )	( )	( )
૮૨. મંરં મનમાં બીજા પ્રત્યે પંરકંની લંગણી રહે છે.	( )	( )	( )
૮૩. મંરં કંર્ય મંટે હુા મંરી જાસને જવંબતંર મંનુા છુા.	( )	( )	( )
૮૪. મંરં લખંણમાં એક દુત્રંસંનેં અભંવ રહે છે.	( )	( )	( )
૮૫. હુા હામેશં કેંઈને કેંઈ બિમંરીથી પીડંઉ છુ.	( )	( )	( )
૮૬. જરૂર પડ્યે ત્યંરે સર્કનેં અભંવ હેંવં છસાં હુા જલ્તી નિર્ણય લઉ છુા.	( )	( )	( )
૮૭. મને એવુા લંગે છે કે મને મંરી જવંબતંરીએંની પૂરસી જાણકંરી નથી.	( )	( )	( )
૮૮. કેંઈ ખરંબ લંગણી વગર મને મજાક કરવંનુા ગમે છે.	( )	( )	( )
૮૯. હુા હામેશં અંત્મ દુરક્ષનેં અભંવ અનુભવુા છુા.	( )	( )	( )

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૯૦. મને મંરં જીવન લક્ષ્યનુા સ્પષ્ટ ૹ્ંન નથી.	( )	( )	( )
૯૧. મંરંમંા જીવનનં વિવિધ પંદંએંનેં યેંગ્ય વિકંદ થંઈ રહ્ંે છે.	( )	( )	( )
૯૨. હુા મંરેં મેંટંભંગનેં દમય અંનાતપૂર્વક પદંર કરુા છુા.	( )	( )	( )
૯૩. કેટલીક વ્યક્સિએં પ્રત્યે મંરં મનમંા ધૃણં રહે છે.	( )	( )	( )
૯૪. મંરંમંા બૈંધ્ધિક રીસે મંરં વ્યવદંયમંા દફળ થંવંની યેંગ્યસં છે.	( )	( )	( )
૯૫. હુા દાકુચિસ મનેંવૃત્ત્નિેં હેંવંનેં અનુભવ કરુા છુ.	( )	( )	( )
૯૬. મંરંમંા રેંગપ્રસિકંર શક્સિનેં અભંવ છે.	( )	( )	( )
૯૭. યેંગ્ય દમયે મંરં વિચંરેં અભિવ્યક્સ ન કરી શકવંને કંરણે લઘુસંભંવ અનુભવુાછુા.	( )	( )	( )
૯૮. કેંઈને કેંઈ દમસ્યંનં ઉકેલ મંટે હુા હામેશં બેચેન રહુા છુા.	( )	( )	( )
૯૯. મને અંવવંજવંનં યેંગ્ય દંધનેંનેં અભંવ હામેશં ખટકે છે.	( )	( )	( )
૧૦૦. હુા મંરં દંથીતંરેં દુધી મંરી લંગણીએં દફળસંપૂર્વક પહેંચંડુ છુા.	( )	( )	( )

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AMS

સૂચના

અહિં કેટલાક વિધાનો આપવામાં આવ્યા છે. લોકો જેનો મોટાભાગે ક્યારેક અનુભવ કરે જ છે એવી મૂશ્કેલીઓ કે અગવડોના સંદર્ભમાં વિધાનો આપેલ છે. જેનો ઉત્તર તમારે ત્રણ વિકલ્પોમાંથી એક વિકલ્પ પસંદ કરીને આપવાનો છે. જો તમે આ વિધાનોના ઉત્તર સ્પષ્ટ અને સાચા આપશો તો તમે તમારી જાતને વધારે સારી રીતે સમજવામાં મદદરૂપ થશે.

દરેક વિધાનોની નીચે ત્રણ વિકલ્પો આપવામાં આવ્યા છે. તમારે ત્રણેય વિકલ્પમાંથી એક ઉત્તર પસંદ કરી ખાનામાં (√) નિશાની કરવાની છે. પુસ્તિકામાં આપેલ તમામ વિગતો અને વિધાનોના ઉત્તર બને તેટલા ઝડપથી આપશો. આ માહિતીનો હેતુ માત્ર અભ્યાસનો જ છે, તમે આપેલી તમામ માહિતી સંપૂર્ણપણે ખાનગી રાખવામાં આવશે.

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(૧) લેંકેં અને મનેંરાજનનં દંધનેંમાં મંરી રૂચિ ઝડપથી બતલંય છે.

(અ) હં (બ) ક્યંરેક (ક) નં

(૨) લેંકેં મંરં વિશે ખેંટુા વિચંરે સેંપણ હુા શાંસ રહીને કંમ કરી શકુા છુા.

(અ) હં (બ) ક્યંરેક (ક) નં

(૩) મંરેં વિચંર ચર્ચમાં વ્યક્સ કરસાં પહેલાં હુા જે કહેવં માંગુ છુા, સે દંચુા છે એવેં અંત્મવિશ્વંદ થંય સેની રંહ જોઉ છુા.

(અ) હં (બ) ક્યંરેક (ક) નં

(૪) મંરં વર્સન પર ઈર્ષ્નેં પ્રભંવ રહે છે.

(અ) હં (બ) ક્યંરેક (ક) નં

(૫) જો મને જીાતગી ફરીથી જીવવં મળેસેં

(અ) સત્ન જુતી રીસે જીવવંનુા પદાત કરુા. (બ) જેવુા જીવન જીવુા છુા સેવુા જ જીવુા.

(અ) અ (બ) વચ્ચે (ક) બ

(૬) જીવનની બધી જ વિશિષ્ટ બંબસેંમાં હુા મંરં મંસંપિસંને જ મહત્ત્વ અંપુા છુા.

(અ) હં (બ) ક્યંરેક (ક) નં

(૭) હુા જાણસેં હેંઉ કે અં બંબસ અશક્ય છે છસાં મને કેંઈ 'નં' પંડે ત્યંરે હુા મંનસેં નથી.

(અ) હં (બ) ક્યંરેક (ક) નં

(૮) મંરંમાં જરૂર કરસાં વધુ રદ લેનંર વ્યક્સિની વફંતરી કે તંનસ પર મને શાકં જાય છે.

(અ) હં (બ) ક્યંરેક (ક) નં

(૯) મંરં મંસં-પિસં અંજ્ઞનુા પંલન કરવં મંટે,

(અ) હામેશં ઉચિસ કંર્ય કરવંનુા કહે છે. (બ) હામેશં અનુચિસ કંર્ય કરવંનુા કહે છે.

(અ) અ (બ) વચ્ચે (ક) બ

(૧૦) મંરં મિંત્રંને મંરી જરૂર છે સેનં કરસંા વધુ મંરે સેમની જરૂર છે.

(અ) ખૂબ (બ) ક્યંરેક (ક) ખૂબ ઔંછી

(૧૧) મને વિશ્વંદ છે કે હુા કેંઈપણ દાર્ઘર્ષ્નેં દંમનેં કરી શકીશ.

(અ) હામેશં (બ) ક્યંરેક (ક) ખૂબ ઔંછુા

(૧૨) નંનપણમંા મને આધંરંનેં ડર લંગસેં હસેં.

(અ) હામેશં (બ) ક્યંરેક (ક) ક્યંરેય નહિ

(૧૩) ક્યંરેક મંરી બેંલચંલ અને વર્સનમંા મંરેં ગુસ્દેં સ્પષ્ટ જણંઈ અંવે છે.

(અ) હં (બ) અનિશ્ચિસ (ક) નં

(૧૪) મંરી તેંસ્સીનેં કેંઈ ફંયતેં ઉઠંવે સેં હુા,

(અ) મંફ કરીને ભૂલી જાઉ છુા (બ) નંરંજ થંઈ સેનં પર ગુસ્દે થંઉ છુા

(અ) અ (બ) વચ્ચે (ક) બ

(૧૫) જ્યંરે લેંકેં મંરી અંલેંચનં કરે છે ત્યંરે સેનેં લંભ લેવંને બતલે ગભરંઈ જાઉ છુા.

(અ) હામેશં (બ) ક્યંરેક (ક) ક્યંરેય નહિ

(૧૬) મને લેંકેં પર ઝડપથી ગુસ્દેં અંવી જાય છે.

(અ) હં (બ) ક્યંરેક (ક) નં

(૧૭) મને કશંકની જરૂર છે પણ શેની જરૂર છે સે ખબર નથી.

(અ) હં (બ) ક્યંરેક (ક) નં

(૧૮) મને એવી શાકં થંય છે કે જે લેંકેં દેંથે હુા વંસેં કરી રહેં છુા સેમને ખરેખર મંરી વંસેંમંા રદ છે.

(અ) હં (બ) ક્યંરેક (ક) નં

(૧૯)મંરં મનમંા એવેં જરંપણ શક નથી કે મને પેટની ગડબડ, હૃતયનં ધબકંરં વિગેરે જેવી બિમંરી છે.

(અ) હં (બ) અનિશ્ચિસ (ક) નં

(૨૦) હુા ચર્ચ કરસી વખસે એટલેં ઉગ્ર બની જાઉ છુા કે મંરં મેં માંથી અવંજ નીકળવેં પણ મૂશ્કેલ બની જાય છે.

(અ) ક્યંરેક (બ) ખૂબઔંછુ (ક) નં

(૨૧) લેંકેં કેંઈ કંર્ય પૂર્ણ કરવંમંા જેટલી શક્તિ વંપરે છે સેથી વધુ શક્તિ હુા મંનદિક સનંવને કંરણે વંપરી નંખુા છુા.

(અ) હં (બ) અનિશ્ચિસ (ક) નં

(૨૨) હામેશં દંવધ રહુા અને નંની વંસ પણ ન ભૂલુા એ બંબસને હુા જરૂરી મંનુા છુા.

(અ) હં (બ) અનિશ્ચિસ (ક) નં

(૨૩) ગમે સેટલી મૂશ્કેલી અને તુઃખમાં પણ હુા મંરં નિર્ણયેંને વળગી રહુા છુા.

(અ) હં (બ) અનિશ્ચિસ (ક) નં

(૨૪) મૂશ્કેલ પરિસ્થિસિમાં હુા ખૂબ જ ઉત્તેંજિસ અને ગુસ્દે થંઈ જાઉં છુા.

(અ) હં (બ) અનિશ્ચિસ (ક) નં

(૨૫) મને ક્યંરેક સ્વપ્ન અંવે છે કેમંરી ઊાઘ ઊડી જાય છે.

(અ) હં (બ) અનિશ્ચિસ (ક) નં

(૨૬) મંરંમાં મૂશ્કેલીએંનેં દંમનેં કરવંની શક્સિ છે.

(અ) હં (બ) અનિશ્ચિસ (ક) નં

(૨૭) કેંઈપણ કંરણ વગર હુા વસ્સુએં ગણુા છુા.

(અ) હં (બ) અનિશ્ચિસ (ક) નં

(૨૮) મેંટંભંગનં લેંકેં કેંઈ ને કેંઈ મંનદિક વિક્ષેંપથી પિડંસં હેંય છે, પરાસુ સેએં સેને સ્વીકંરસં નથી.

(અ) હં (બ) અનિશ્ચિસ (ક) નં

(૨૯) હુા કેંઈ ખરંબ દંમંજિક ભૂલ કરુા સેં સેને જલતી ભૂલી જાઉ છુા.

(અ) હં (બ) અનિશ્ચિસ (ક) નં

(૩૦) હુા ખૂબ ગુસ્દે થંઈ જાઉ ત્યંરે કેંઈને મળસેં નથી, (અ) ક્યંરેક (બ) ઘણીવંર

(અ) અ (બ) અનિશ્ચિસ (ક) બ

(૩૧) મંરુા કંમ બગડી જાય સેં હુા રડી પડુા છુા.

(અ) નં (બ) ક્યંરેક (ક) ખૂબ એંછુા

(૩૨) લેંકેં વચ્ચે હેંવં છસાં હુા ક્યંરેક એકલસં અને નકંમંપણંની લંગણી અનુભવુા છુા.

(અ) હં (બ) અનિશ્ચિસ (ક) નં

(૩૩) હુા રંત્રે જાગી જાઉ છુા અને ચિંસંને લીધે ફરી ઊાઘવંમાં મૂશ્કેલી પડે છે.

(અ) હં (બ) ક્યંરેક (ક) નં

(૩૪) મને સકલીફ પડે સેં પણ અંત્મવિશ્વંદ રંખુા છુા.

(અ) હં (બ) અનિશ્ચિસ (ક) નં

(૩૫) નંની વંસમાં પણ હુા મંરી જાસને તુઃખી અને તેંષ્સિ મંનુા છુા.

(અ) હં (બ) અનિશ્ચિસ (ક) નં

(૩૬) હુા એટલેં ઉંત્તેજીસ અને પરેશંન થેંઈ જાઉ છુા કે તરવંજાનેં કિચૂડ કિચૂડ જેવં દંમંન્ય અવંજ પણ દહન કરી શકસેં નથી.

(અ) હં (બ) ક્યંરેક (ક) નં

(૩૭) કેંઈ કંરણદર હુા ગભરંઈ જાઉં સેં ઝડપથી શાંસ થેંઈ જાઉં છુા.

(અ) હં (બ) અનિશ્ચિસ (ક) નં

(૩૮) ભવિષ્યમાં અંવનંર મૂશ્કેલ કંર્ય વિશે વિચંરસાં જ ડરથી ધ્રુજા છુા અથ્વં પરદેવેં થેંઈ જાય છે.

(અ) હં (બ) અનિશ્ચિસ (ક) નં

(૩૯) મેંટેભંગે હુા પથંરીમાં દૂઈ જાઉ એટલે મને ગંઢ ઊાધ અંવી જાય છે.

(અ) હં (બ) અનિશ્ચિસ (ક) નં

(૪૦) અંજકંલ જયંરે હુા મંરં વ્યવદંય કે હિસ આગે વિચંરૂ છુ ત્યંરે સનંવ કે બેચેની અનુભવુા છુા.

(અ) હં (બ) અનિશ્ચિસ (ક) નં

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BSQ

(સૂચના)

તમે તમારા દેખાવ વિષે કેવી લાગણી અનુભવો છો તે સંદર્ભે નીચે કેટલાંક વિધાનો આપેલ છે. દરેક વિધાન સામે ક્યારેય નહીં, ભાગ્યેજ, ક્યારેક, વારંવાર, ઘણીવાર, હંમેશા એવા છ વિકલ્પો આપ્યા છે. તમને જે વિકલ્પો લાગુ પડતો હોય તે વિકલ્પની નીચે આપેલ કૌંશમાં (√) નિશાની કરશો.

	ક્યારેય નહીં	**ભાગ્યેજ**	**ક્યારેક**	**વારંવાર**	**ઘણીવાર**	**હંમેશા**
૧. તમને તમારા શરીરની આકૃતિ (Figure)વિષે કંટાળાજનક લાગણી થયેલી છે ?	( )	( )	( )	( )	( )	( )
૨. તમને તમારા શરીરના આકાર (Shape) વિષે અવી ચિંતા થયેલી છે કે જેથી તમને લાગે કે તમારે ડાયેટીંગ કરવું જોઇએ ?	( )	( )	( )	( )	( )	( )
૩. તમને એવું લાગ્યું છે કે તમારા સાથળ, નિતંબ શરીરના અન્ય ભાગો કરતાં વિશાળ છે ?	( )	( )	( )	( )	( )	( )
૪. તમને એવી બીક લાગે છે કે તમે જાડા કે વધારે જાડા થઇ જશો ?	( )	( )	( )	( )	( )	( )
૫. તમને એવી ચિંતા થઇ છે કે તમારું શરીર પૂરતું મજબુત નથી ?	( )	( )	( )	( )	( )	( )
૬. ખૂબ આહાર લીધી પછી તમને એવું લાગે છે કે તમે જાડા થઇ ગયા છો ?	( )	( )	( )	( )	( )	( )
૭. તમને તમારા શરીરના આકાર (Shape)વિષે એટલું ખરાબ લાગ્યું છે કે તમે રડ્યા હો ?	( )	( )	( )	( )	( )	( )
૮. તમારું શરીર ઘસાય જાય એવી લાગણીથી તમે દોડવાથી દૂર રહ્યા છો?	( )	( )	( )	( )	( )	( )
૯. પાતળી સ્ત્રી સાથે તમે તમારા દેખાવ વિષે સભાન બની જવાની લાગણી અનુભવો છો ?	( )	( )	( )	( )	( )	( )
૧૦. નીચે બેસતી વખતે તમારા સાથળ પહોળા થઇ જાય ત્યારે તમને ચિંતા થાય છે ?	( )	( )	( )	( )	( )	( )

૧૧. થોડોક ખોરાક ખાધા પછી તમને જાડા થવાની લાગણી થાય છે?	( )	( )	( )	( )	( )	( )
૧૨. અન્ય સ્ત્રીનો આકાર (Shape) જોયો છે અને તમને એવું થયું છે કે તમારો આકાર તુલનાત્મક રીતે બરાબર નથી?	( )	( )	( )	( )	( )	( )
૧૩. તમારા આકાર (Shape) વિષેના વિચારોથી તમારી એકાગ્રતામાં ભંગ પડ્યો છે ? (દા.ત. ટીવી જોવામાં, વાંચવામાં કે વાતચીતમાં સાંભળવામાં)	( )	( )	( )	( )	( )	( )
૧૪. બાથરૂમમાં નહાતી વખતે નગ્ન અવસ્થામાં તમને એવું લાગ્યું છે કે તમે જાડા છો ?	( )	( )	( )	( )	( )	( )
૧૫. જે કપડા પહેરવાથી તમારા આકાર (Shape) વિષે તમે સભાન બની જતો હો તેવા કપડા પહેરવાથી તમે દૂર રહ્યા છો ?	( )	( )	( )	( )	( )	( )
૧૬. તમને તમારા શરીરના ચરબીયુક્ત ભાગો કાપી નાંખવાની કલ્પનાઓ આવે છે ?	( )	( )	( )	( )	( )	( )
૧૭. મીઠાઈ, કેઈક્સ કે બીજા ઉચ્ચ કૅલેરીવાળા ખોરાક ખાવાથી તમને જાડા થવાની લાગણી થાય છે ?	( )	( )	( )	( )	( )	( )
૧૮. તમારા શરીરનો આકાર (Shape) ખરાબ છે એવી લાગણીથી તમે સામાજિક પ્રસંગો કે પાર્ટીઓમાં જવાનું ટાળ્યું છે ?	( )	( )	( )	( )	( )	( )
૧૯. તમે ખૂબ જાડા અને ગોળ મટોળ છો એવું તમને લાગ્યું છે?	( )	( )	( )	( )	( )	( )
૨૦. તમને તમારા શરીર વિષે શરમ લાગી છે ?	( )	( )	( )	( )	( )	( )
૨૧. તમારા આકાર (Shape) વિષેની ચિંતાને લીધે તમે ડાયેટીંગ કરવા પ્રેરાયા છો ?	( )	( )	( )	( )	( )	( )
૨૨. તમારું પેટ ખાલી હોય ત્યારે તમને તમારા આહાર વિષે અત્યંત સુખની લાગણી થઇ છે. (દા.ત.સવારમાં)	( )	( )	( )	( )	( )	( )
૨૩. સ્વનિયંત્રણના અભાવને લીધે તમને એવું લાગ્યું છે કે તમારો આકાર (Shape) બરાબર છે ?	( )	( )	( )	( )	( )	( )
૨૪. તમારી કમર કે પેટની આજુબાજુ ચરબી છે એવું બીજા કહે ત્યારે તમને ચિંતા થાય છે ?	( )	( )	( )	( )	( )	( )

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૨૫. તમને એવું લાગ્યું છે કે બીજી સ્ત્રીઓ તમારા કરતા પાતળી છે એ બરાબર નથી ?	( )	( )	( )	( )	( )	( )
૨૬. પાતળા દેખાવાની લાગણીમાં તમે ઉલટીઓ કરી છે ?	( )	( )	( )	( )	( )	( )
૨૭. તમે જ્યારે કંપનીમાં હો ત્યારે તમારે વધુ જગ્યાની જરૂર પડશે એવી ચિંતા થઇ છે ?	( )	( )	( )	( )	( )	( )
૨૮. તમારું શરીર નબળું છે એવી ચિંતા તમને થાય છે.	( )	( )	( )	( )	( )	( )
૨૯. અરીસામાં કે 'શોપવીન્ડો'માં તમારું પ્રતિબિંબ જોઇને તમારા આકાર (Shape) વિષે ખરાબ લાગણી થઇ છે ?	( )	( )	( )	( )	( )	( )
૩૦. તમારા શરીરના વિસ્તારોમાં કેટલી ચરબી છે તે તમે આંગળાઓ ભરાવીને જોયું છે ?	( )	( )	( )	( )	( )	( )
૩૧. લોકો તમારું શરીર જુએ તેવી પરિસ્થિતિથી તમે દૂર રહ્યા છો ? (દા.ત.કપડા બદલવાના રૂમ થી કે સ્વીમીંગ રૂમથી)	( )	( )	( )	( )	( )	( )
૩૨. પાતળા દેખાવા માટે તમે રેચક દ્રવ્યો લીધા છે ?	( )	( )	( )	( )	( )	( )
૩૩. બીજા લોકોની કંપનીમાં હો ત્યારે તમે તમારા શરીરથી સભાન બની જાઓ છો ?	( )	( )	( )	( )	( )	( )
૩૪. તમારા આકાર (Shape) વિષેની ચિંતાથી તમને એવું લાગ્યું છે કે તમારે કસરત કરવી જોઇએ ?	( )	( )	( )	( )	( )	( )

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