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Andrews University
School of Education

OBJECT RELATIONS AND IDENTITY DISTURBANCES IN
BULIMIC WOMEN

A Dissertation
Presented in Partial Fulfillment
of the Requirements for the Degree
Doctor of Philosophy

by
Kathy Appledorn
December 1999

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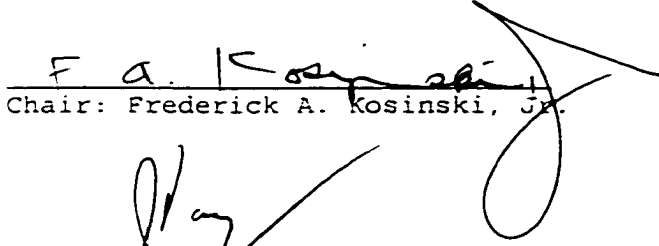
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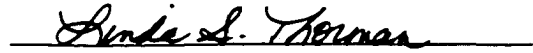
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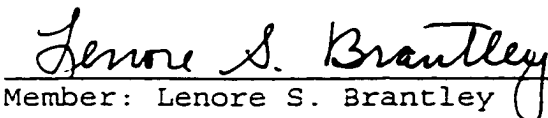
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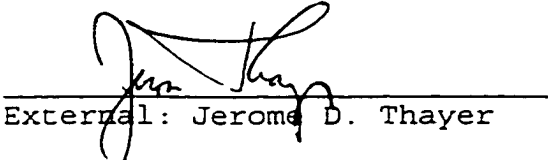

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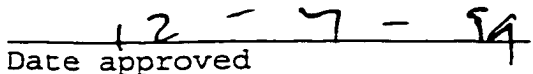

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ABSTRACT

OBJECT RELATIONS AND IDENTITY DISTURBANCES IN
BULIMIC WOMEN

by

Kathy Appledorn

Chair: Frederick A. Kosinski, Jr.

ABSTRACT OF GRADUATE STUDENT RESEARCH

Dissertation

Andrews University

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Title: OBJECT RELATIONS AND IDENTITY DISTURBANCES IN
BULIMIC WOMEN

Name of researcher: Kathy Appledorn

Name and degree of faculty chair: Frederick A. Kosinski,
Jr., Ph.D.

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Problem

Although diagnostic criteria of bulimia center on weight- and food-related issues, eating disorders may be viewed as a response to deficits in self-regulatory functions. The purpose of this study was to investigate the relationship between the severity of bulimia, object relations, and identity. This study tested the hypotheses that women with a more severe eating pathology have high scores on object-relations disturbance as well as identity disturbance. It was postulated that women who have been

assessed as having a more cohesive ego might respond to cognitive behavioral therapy while those who are assessed as having less intact ego resources may require more intensive psychodynamic approaches.

Method

The study involved the administration of three tests by therapists who were treating women diagnosed with bulimia nervosa according to *DSM-IV* criteria. The test instruments included the following: Bulimia Test-Revised, Bell Object Relations Inventory, and the Erwin Identity Scale. An interview was conducted on a selected group of 12 subjects.

Results

There were statistically significant correlations between the severity of bulimia and the severity of object relations and identity disturbance. Specifically, the Alienation subscale of the Bell Object Relations Inventory and the Confidence subscale of the Erwin Identity Scale had the strongest correlation with the BULIT-R. The qualitative results indicated that a number of themes were strongly identified by both "High Bulimics" and "Low Bulimics."

Conclusions

The quantitative analysis indicated there was a relationship between the severity of object relations, identity disturbance, and bulimia. However, the qualitative analysis identified many of the women, in the "Low Bulimic" group, had significant disturbances in their relationships as well as their opinion of their body. It was concluded that both groups exhibited significant object relations and identity disturbances. Therefore, it is suggested that a more psychodynamic approach is useful for understanding the adaptive functions of bulimia.

This is dedicated to Bill, my parents,
and my family

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CHAPTER I

INTRODUCTION

Eating disorders are recognized as a major growing medical and psychiatric problem, affecting millions of women in the United States. Approximately 8 million people in the United States (90% of them women) suffer from eating disorders, according to the National Association of Anorexia Nervosa and Associated Disorders (ANAD, 1995). According to the *DSM-IV* (American Psychiatric Association, 1994), the prevalence of bulimia nervosa among adolescent and young adult females is probably 1 to 3%. According to the National Depressive and Manic-Depressive Association (1998) the typical bulimia patient is a late adolescent or young adult, middle-class Caucasian female who has attempted various diets without much success. Occasional symptoms of bulimia nervosa, such as isolated episodes of binge eating and purging, have been reported in up to 40% of college women.

There is an ever-growing pressure in today's society for women regarding their size, weight, and image. Women are given the message that in order to be successful they must be thin and attractive. They are also socialized to be nurturing and to provide for others. This includes the preparation of food that gives sustenance and nurturance

to oneself as well as to significant relationships. Food is felt to be the route to connection and love as well as physical and emotional well-being. Food is the earliest link between mother and self. The ability to mother, nurture, and respond is symbolized in the provision of food. How a woman wrestles with this conflict and finally resolves it depends on each individual's values and beliefs. How she uses food and what she uses it for, depend on a number of issues.

Eating problems develop under a variety of stressors and situations. There is no clear-cut etiology or resolution to the dynamics of eating disorders. Our culture creates, shapes, and influences psychopathology of all kinds. The influences of social phenomena need to be considered as part of the etiology of eating disorders. However, social pressures are an intensifier not a cause.

Mental health is best viewed as a state or process occurring along a continuum from good or acceptable to bad or unacceptable. This conceptualization suggests that mental health and mental illness are not dichotomous entities but are rather dynamic patterns of change that occur in all individuals throughout the life cycle. Eating disorders actually occur on a spectrum and vary in severity in the general population. Many individuals are concerned about their weight, caloric intake, and figure. Some women may go on crash diets or exercise excessively for periods of time. This is common and even normal among most adolescent

and adult females. The present primacy placed on having a slender rather than a full figure is one etiological factor in bulimia nervosa and anorexia nervosa. Zerbe (1993) stated that obsession with thinness does not single out the patient with an eating disorder. She claimed that 78% of women and 56% of men are dissatisfied with their weight. She estimates that 5-15% of college women have subclinical eating disorders. These statistics indicate that eating disorders are not nearly as common as affective or anxiety disorders; however, they fail to take into account the diagnostic continuum of eating pathologies. Moreover, sociological studies have suggested that a range of eating problems may go unstudied and untreated because of the secretive nature of the problem.

Significance of the Study

Bulimia nervosa is highly refractory to current regimes. The psychiatric literature increasingly illustrates that formally diagnosed patients find it very difficult to fully recover with brief and superficial treatment interventions. Psychoeducational, cognitive, behavioral, and psychopharmacologic treatments form the basis of most treatment plans and are of great help to 40%-50% of all diagnosed patients (Zerbe, 1993). On the other hand, these treatment efforts fall short for a large subgroup of patients with significant symptomatology.

Zerbe (1993) at the C. F. Menninger Memorial Hospital

found that from one-third to one-half of those treated for bulimia are still ill at long-term follow up. In two other reports (Mitchell, Hoberman, & Pyle, 1989; Mitchell, Soll, & Eckert, 1989), it was found that one in every four bulimic patients was a treatment failure. The authors concluded that the success rate might be even worse, because at least one person in the group committed suicide and several others refused to respond to the questionnaire, possibly indicating a worsening pattern of symptomatology.

The eating disorders may improve with treatment for a short period, but relapse is very high over the long run. According to a pilot study at Massachusetts Hospital in which 30 bulimic subjects were followed up at 35-42 months, the probability of relapse was 63% (Zerbe, 1993).

Theorists have cited various possible causes, such as separating from the mother, insufficient nurturing, as well as sociocultural factors. Eating disorders are complicated, complex disorders that require the therapist's patience and willingness to explore possible dynamics before the patients can even begin to respond to therapy. Understanding the importance of symptoms in the maintenance of self-esteem and self-cohesion can help the therapist to have patience with complex and resistant symptoms.

The rationale for examining the relationships between severity of bulimia, object relations, and body identity scores is to identify characteristic patterns of bulimics. Differing patterns may necessitate different approaches. It

may be that subjects with higher object-relations disturbance scores and identity disturbance scores will benefit from an approach that is more psychodynamic while those with lower disturbance and lower object-relations scores will benefit from an approach that is more cognitive behavioral. Because of the high relapse rate associated with current regimes, it is proposed that therapists who gain more knowledge about an individual's ego integrity as well as their body identity may be able to choose more specific and effective therapeutic interventions or treatment strategies.

Theoretical Framework

A pattern of bingeing and purging arises due to a core identity deficit. Food is used metaphorically as a means of emotional regulation. Food may be seen as the first tie with one's mother. The intake of food is frequently associated with emotional sustenance and nurturance. Bulimics derive a greater amount of their nurturance from food. Bulimics use food as a means of self-soothing intense and negative emotions. Bulimics report a restored sense of control, adequacy, alertness, and decreased anger following purging (Johnson & Connors, 1987).

An implication of regulating food intake as a means of regulating self is that the collapse of such regulation might be experienced as a collapse of self-definition. Some authors propose that the establishment of self-regulation is

what the bulimic hopes to establish through the binge (Schupac-Neuberg & Nemeroff, 1993).

Bulimics have experienced their emotions as diffuse and undifferentiated, suggesting a lack of interoceptive awareness, an inability to organize their affective experiences in meaningful ways, and difficulty in soothing their painful feelings so as to limit their intensity.

Weinberg, Norman, and Herzog (1987) described the bulimic's feeling experience as follows:

When they do emerge the bulimic's feelings are often diffuse and undifferentiated. They are likely to be felt as overwhelming dysphoric that results in an experience of helplessness. . . . Her "all or nothing" experience of emotion makes it difficult for her to be involved with others yet feel modulated and in control. (p. 627)

This experience of being overwhelmed by undifferentiated feelings, which can be neither understood nor controlled, is a theme that runs through much of the literature on eating disorders, although the experience is more often labeled "affective in-stability" or "low anxiety and frustration tolerance." The limited interoceptive awareness of these patients is also well documented (Garner, Olmsted, & Polivy, 1983; Gross, Rosen, Leitenberg, & Willmuth, 1986). This lack of interoceptive awareness is characterized by an inability to accurately identify and differentiate among various feelings, and by an inability to identify internal physical sensations such as hunger and fullness. The concept seems to be akin to that of

alexithymia, and appears to be related to the experience of being overwhelmed by and out of control of one's feelings (the inability to self-regulate by calming oneself). There is little evidence to suggest differences in interoceptive awareness among subtypes of eating disorders, although Garner et al. (1983) have found that restricting anorexics has shown less disturbance in interoceptive awareness than either of two groups of bulimics. Wilmuth, Leitenberg, Rosen, and Cado (1988) have found that non-purging bulimics have shown fewer disturbances in interoceptive awareness than purging bulimics.

Thus, research tends to support the clinician's observations that eating-disordered patients have difficulty recognizing, tolerating, and regulating affect and inner tension states. There is also some research that attempts to link these deficits in affect-regulation to bulimic eating patterns. The thesis of most of these investigations is that bingeing and/or vomiting serve a self-soothing function, reducing anxiety, tension, and other dysphoric states. Bingeing and/or vomiting reestablish a sense of emotional equilibrium for the bulimic that engages in these behaviors.

Body Image Disturbances in Eating Disorders

Body image difficulties continue to play a prominent role in the symptomatology of people with eating disorders. Zerbe (1993) pointed out that these difficulties stem from

the earliest times of life. They often reflect failures in the individual process of separating from the family of origin in an age-appropriate way and thereby attaining autonomous functioning. Because these separation problems occur so early, individuals are thought to lack the ability and words to express their feelings. The lack of language keeps the individual from being able to talk about feelings in words but instead forces her to express them somatically or physically. These feelings become concretely expressed through the body. Research has shown that more than 50% of eating-disorder patients struggle with alexithymia (defined as difficulty in putting feelings and fantasies into words). The eating disorder is a failed solution to correct early deficits in self-esteem and strivings for independent functioning. These patients must learn to master rather than avoid the problems that have led them to the eating disorder. They must learn to define the body boundaries in less destructive ways.

The struggle with body image faced by patients with eating disorders can be explained by the concept of denying one's emotional life while attempting to save the autonomous self by focusing totally on one's body. These patients are thought to have not been provided the affirmation that helps one believe in oneself. They seek affirmation in their body self. Their emotional life is completely cut off by the preoccupation with their body.

Teusch (1988) found that most of the factors identified as important in the development of bulimia were interpersonal in nature. Factors identified were parental emotional absence, inexpressiveness or dominance, sibling rivalry, and general family stresses. When parental preoccupations with weight, food, or alcohol were cited, it was the lack of interpersonal nurturance and connection, resulting from the dysfunctional parental behavior, which had been problematic for the bulimic. Bulimics noted a high rate of weight- and diet-related reasons for their behavior. These behaviors were precipitated by "never having felt good enough," "difficulties of feeling calm when alone," and "an absence of close friendships." Feelings of emotional isolation and disconnection were clearly revealed in the interpersonal beliefs that "parents/others don't care about me," "don't know what I am like inside," "expect a lot of me." There was a high occurrence of negative interpersonal experiences that were replete with empathic failures, rejections, and abuse.

Modern psychodynamic models of eating-disorder development emphasize disturbances in "object-relations" (Steiger & Houle, 1991). This theory states that developmental deficits block a child's "separation-individuation" and her capacity to derive satisfaction and comfort through interacting with others. The result is believed to be a narcissistic bodily fixation, which to some extent "replaces" healthy interaction with external

"objects." Failures in parenting prevent the child from internalizing mental functions properly that are necessary for both a stable sense of "self" and "others," and the independent regulation of tension and self-esteem. The child has difficulties in establishing satisfying interpersonal relationships and in deriving need gratification through them. Therefore, the child uses control of her body and eating to derive a sense of personal adequacy and to regulate her affect.

Thus, the struggle with body image faced by patients with eating disorders is due to their difficulty with expressing feelings. They have difficulty expressing themselves as an autonomous individual in relationship with others. Body image problems are often noted clinically, and the concept is useful for developing an understanding of these patients.

Statement of the Problem

The primary features of bulimia nervosa are binge eating and inappropriate compensatory methods to prevent weight gain. In addition, the self-evaluation of individuals with bulimia nervosa is excessively influenced by body shape and weight.

There are two subtypes of bulimia: the purging type and the nonpurging type. The purging-type individual regularly engages in self-induced vomiting or misuses laxatives, diuretics, or enemas. The nonpurging type uses

other inappropriate compensatory behaviors, such as fasting or excessive exercise, but has not regularly engaged in self-induced vomiting or the misuse of laxatives, diuretics, or enemas.

Although diagnostic criteria of bulimia center on weight- and food-related issues, problems associated with the disorder extend further to include personality deficits, decreased personal effectiveness, and difficulties with sexual and social relationships. Eating disorders may be viewed as a response to deficits in self-regulatory functions. The symptoms of eating disorders represent attempts to reestablish a more cohesive self.

There have been a number of studies indicating women with higher levels of eating disorders show higher levels of object-relations disturbances (Becker, Bell, & Billington, 1987; Friedlander & Siegel, 1990; Heesacker & Neimeyer, 1990). Vipond (1992) found statistically significant relationships between self-regulatory deficits and levels of object relations. Statistically significant relationships were also found between self-regulatory deficits and relational experiences, and severity of some symptoms in bulimic groups.

Among college women, feelings of esteem diminish as severity of eating disturbance increases. Scarano and Kalodner-Martin (1994) reported that scores on the Rosenberg Self-Esteem Scale distinguished groups on a continuum. Bulimics had the lowest score, which differed

significantly from subthreshold bulimics, purgers, bingers, chronic dieters, and normal eaters.

The eating disorder is often the tip of the iceberg, the visible manifestation of other interconnected psychiatric and relational issues. The mere management of symptoms cannot be equated with definitive treatment. This study investigated the hypotheses that disturbances in object relations characterize the more severe bulimic syndrome. A number of functional descriptions of bulimia are reviewed. These perspectives all share not only a common view of the symptomatic profile of the syndrome, but also the notion that bulimic women experience some developmental delays. It has been postulated that women who have a more cohesive ego may respond to cognitive behavioral therapy while those who have less intact ego resources require more intensive psychodynamic approaches. It is likely that cognitive-behavioral approaches do not address the developmental issues of women with eating disorders.

Current treatment regimes for this growing population and complicated group of women are associated with a high degree of relapse. It is the theoretical base of this study that object relations and body identity dissatisfaction are closely tied and contribute to the development and maintenance of bulimia nervosa. While body identity dissatisfaction is a pivotal treatment issue in bulimia, it is a part of a larger complex set of issues that also must be addressed. This study has tested the hypotheses that

women with a more severe eating pathology have high scores on object-relations disturbance as well as identity disturbance.

Purpose of the Study

The purpose of this study was to investigate the relationship between the severity of bulimia, object relations, and identity. This study provides empirical information regarding the nature of bulimia. The qualitative aspect of this study provides an understanding of the symptom from the patient's point of view without relying solely on theoretical ideology. By assessing the severity of subjects' eating disorder, their capacity for object relations, and their body identity disturbance, as well as assessing their own individual, internalized meanings, it is hoped that some light may be shed on the complex problem of bulimia.

Hypotheses

Hypothesis 1. There will be a positive correlation between the severity of bulimic symptoms, as assessed by the Bulimia Test-Revised, and the severity of impairment in object relationships, as assessed by the Bell Object Relations Inventory.

Hypothesis 2. There will be a positive correlation between severity of bulimic symptoms, as assessed by the Bulimia Test-Revised, and the severity of identity impairment, as assessed by the Erwin Identity Scale.

Hypothesis 3. There will be a positive correlation between the severity of object relations, as assessed by the Bell Object Relations Inventory, and the severity of identity impairment, as assessed by the Erwin Identity Scale.

Definition of Terms

The following terms are defined as used in this study.

Bulimia Nervosa: Includes recurrent episodes of binge eating. An episode of binge eating characterized by both of the following: eating, in a 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; a sense of lack of control over eating during the episode (a feeling that one cannot stop eating or control what or how much one is eating). It also includes recurrent inappropriate compensatory behavior in order to prevent weight gain, such as self-induced vomiting, misuse of laxatives, diuretics, enemas, or other medications; fasting; or excessive exercise. The binge eating and inappropriate compensatory behaviors both occur, on average, at least twice a week for 3 months. Self-evaluation is unduly influenced by body shape and weight. The disturbance does not occur exclusively during episodes of anorexia nervosa (*DSM-IV*, 1994, p. 547).

Object-Relations Theory: Contemporary object-relations theory concerns the internalization of experienced early child-caretaker interactions and the unconscious construction of the self. The self (self-image, self-structure) is thought to evolve out of an interpersonal matrix, as representations of "good" (gratifying) and "bad" (frustrating) aspects of caretakers. These experiences with caretakers are gradually internalized and organized into complex patterns or schemas of self. Thus, a basic sense of self-in-relationship develops from early interpersonal experiences. These become structured into intrapsychic representations of self, other (object), and the dynamic interplay between them.

The opportunity to internalize and integrate consistent, complementary, self-other relational schemas results in a fundamental sense of self-identity. This involves a basic capacity to identify one's own needs and to take action to gratify them. There is a general trust both in one's feelings and in the receptivity of others. Such a self is capable of understanding and participating in the development of others without being threatened by the loss of one's self in the relationship.

Delimitations of the Study

The population for the study included only females in the Southwest Michigan and Northern Indiana area who have been in therapy and were willing to participate in the

study. Only three tests were used in the investigation. The sample for the study was delimited to 30 women undergoing therapy. The probability of finding subjects for the study was expected to be difficult due to the secrecy and stigma associated with the diagnosis of bulimia nervosa.

Limitations of the Study

Only a few therapists were willing to allow their clients to participate due to confidentiality issues, client's readiness to disclose, the well-being of the client, or even convenience issues. The therapist's choice of suitable clients may be based on very individual and idiosyncratic reasons that could influence the study. In addition, clients in therapy and willing to participate in the study may be more autonomous, be more open regarding their illness, and be willing to share as well as learn about their illness. Many bulimic women are simply not amenable to sharing a very personal aspect of themselves. It is possible that women who are willing to become involved may be more psychologically mature.

Another limitation of the study has to do with the psychological effects of food deprivation. It may be that in malnourished or even starving individuals one's sense of self and psychological integrity is disturbed. Although the influence of proper nutrition on the well-being of bulimic women must be considered, there is evidence to suggest that

a deeper, characterological problem exists that is not alleviated with improved diet.

CHAPTER II

REVIEW OF THE LITERATURE

The literature for this study was drawn from three major areas: bulimia, object relations, and body identity. Bulimia was discussed as it relates to object-relations theory. Object relations theory was concerned with the internalized meanings the child has developed and the impact this has on her current interpersonal and intrapersonal relationships. Body identity was explored from a developmental perspective.

Functional Aspects of Bulimia

Bulimia has been conceptualized in a number of ways. It is important to review briefly the most prevalent notions of bulimia. In behavioral terms, a common belief is that bulimia allows individuals to ingest high-calorie foods without weight gain (Bruch, 1985). Concern with weight and dieting has been identified by a number of investigators as a common antecedent of bulimia (Becker et al., 1987; Zerbe, 1993).

Bulimia is conceptualized as a response to specific triggers as well. Binge-purge patterns have been discerned

in association with stressful events, such as interpersonal conflict, guilt around snacking, or life changes. Many bulimics describe binges as a separate, mysterious entity or part of self that is seemingly without cause or correlate (Gans, 1985). Both the tendency to block out affect during a binge and the development of the syndrome into an automatic behavioral sequence have made it difficult to discern specific triggers of the bingeing and purging. Research suggests that bulimia may function as a relaxant or a tension reducer, aiding bulimic women with the task of regulating affect (Johnson & Larson, 1982; Orbach, 1978). This is based on the aforementioned findings that stressful events precipitate trigger binges. Research also suggests that bulimic women harbor significant anger that they are unable to express comfortably. This is due to either impulsive tendencies, which may result in rageful explosions, or protective wishes and guilt, which prevent the release of affect (Gans, 1985). Bulimic behavior may numb the affect to the extent that whatever is behind the binge is completely blocked out. There is some literature that suggests bulimic women are unable to accurately identify and articulate their inner states. Some theorists propose that there is a progression towards health as the bulimic woman is better able to identify and articulate her feelings and thoughts (Bloom, Gitter, Gutwill, Kogel, & Zaphiropoulos, 1994; Friedlander & Siegel, 1990; Heesacker & Neimeyer, 1990; Teusch, 1988).

Zerbe (1993) has discussed the attempt at self-protection in which all attention is focused on the bulimic cycle as opposed to investing in relationships and commitments. Particularly for victims of rape and sexual abuse, it may be safer to remain at home, negotiating closeness with food, than to risk intimacy that could lead to violence or even violation. As these women reach adulthood, a time at which they might gain the power to assert and to protect themselves, they still experience themselves as small and vulnerable. Thus, continuing to feel frightened as a result of early experiences, these women tend to avoid situations in which sexual feelings are mobilized. This consequently delays a normal developmental progression towards relationships and intimacy.

Orbach (1978) stressed that the act of compulsive eating creates a defensive barrier between a woman and others. Being overweight offers an explanation for any failures that might arise ("I'm unattractive, repulsive, have no control"). This is also a distraction from difficult decision-making around competitive and sexual activity. Binge-eating may be a source of comfort and companionship for those lacking a close, trusting relationship. Bulimia may be seen as an avoidance of intimacy and the pressures of the outside world.

Bulimic symptomatology, though self-sacrificing, may be experienced as a form of loyalty and protection. As opposed to disclosing secrets that could result in marital break-up,

familial dissolution, or punishment of an abuser, women hide any painful information. They attempt to maintain control over potentially hurtful feelings or family secrets by bingeing and purging. "Stuffing" food is associated with stuffing feelings, while purging provides a safe pathway for emotional release.

In gaining an understanding of the bulimic syndrome, the component of secrecy must be highlighted. While bulimic women often maintain an outward appearance of normalcy (i.e., normal body weight, job, friends, dress), secrecy is always preserved by private bingeing (Herzog, 1982; Pyle, Mitchell, & Eckert, 1981). This secrecy is associated with shame around eating behavior, loss of control, and body image.

These women may also secretly struggle with guilt linked to desire for food in the context of society's mandates for slimness and abstinence, and of fear of being "found out." Secrecy around eating may serve as a metaphor for larger emotional and psychological secrets and associated hidden feelings such as familial discord or incest (Chernin, 1981; Orbach, 1978).

Bulimia is a symptom that conveys the individual's conflictual relationship with food. The disturbed relationship to food may be an enactment of one's relationship to significant others. The very act of eating a tremendous amount in a brief sitting may be symbolic of the desire to merge with the early relationships that the

food comes to actually represent. Subsequently, the vomiting, starving, or aggressive exercising may come to symbolize the hostile rejection and repudiation of the bad object. Whatever the symbolism, it seems that eating disorders may be interpreted as representing an effort to work through, with the use of food, some ongoing conflict in the individual's relational life.

Medical Complications

While bulimics do not typically risk the fatal symptoms of anorexics, they do endanger a number of major organ systems. Physiological symptoms range from temporary discomfort, such as nausea, abdominal distention, breathlessness, and swelling of the extremities, to more severe electrolyte imbalance, low blood pressure, kidney damage, and cardiac arrhythmias (Mitchell & Pyle, 1982; Zerbe, 1993). While a detailed description of the potential medical complications of bulimia is outside of the scope of this review, the typical result of bulimic behavior deserves much attention. Despite the potential severity of these complications, bulimic women may go years without medical treatment. Both their secrecy and their willingness to risk their own health appear to parallel the psychological self-sacrifice and suppression of affect that characterize bulimic women.

Eating Disorder as a Developmental Disturbance

An eating disorder is not a disturbance of the eating function. The deeper psychological disorder is related to underlying disturbances in the development of the personality, with deficits in the sense of self, identity, and autonomy. Underneath the self-assertive facade of the eating disordered behavior, a woman with anorexia or bulimia experiences herself as acting only in response to demands coming from others and not doing anything because of her desires (Bruch, 1973). Deficient in self-regulatory structure, she feels helpless, ineffective, overwhelmed, unreal, and empty without external support (Goodsitt, 1985). This displayed defiance is not an expression of strength and independence, but a defense against the feeling of not having a core personality of her own, of being powerless and ineffective if she gives in (Bruch, 1985).

During infancy, the mother, in families where eating disorders occur, derives no pleasure from nursing her child. The ritual aspect of feeding takes precedence over the emotional relationship with the child. Parental needs and desires stifle any of the child's own initiatives. During childhood and the latency period, an insensitive parent constantly interferes, criticizes, suggests, takes over vital experiences, and prevents the child from developing feelings of her own. Projective identification plays an important role in the intrapersonal and interpersonal dynamics of members of these families (Humphrey, 1986).

The child is needed to fulfill a critical function for one or both parents. Parents project the unwanted, uncomfortable aspects of themselves onto the child. They may perceive their daughter as greedy, demanding, incompetent, selfish, weak, dishonest, lazy, and promiscuous. The daughter accepts or identifies with these projections because she fears abandonment or rejection. Because of her need to maintain emotional and physical connection she will accept her parent's "definition" of her.

Bruch (1973) has observed that individuals with eating disorders experience not being in control of their behavior, needs and impulses, not owning their own bodies, and not having a center of gravity within themselves. Instead, they feel overwhelmed by other people's influences and actions. Bruch has noted from numerous detailed reconstructions of their developmental histories that they had distorting experiences. These experiences involved an absence or paucity of appropriate and confirming responses to signals that indicated their needs and other forms of self-expression. Her view of development is very similar to object-relations theory. The more appropriate responses to the various expressions of a child's needs and impulses, the more differentiated the child will become in identifying her bodily experiences. Her bodily experiences, sensations, thoughts, and feelings will be felt as arising within her, and as distinct from the environment. She will grow into a person, who regardless of the difficulties in living, feels

essentially self-directed in her experiences. The failure of regular and persistent appropriate responses to her needs deprives the developing child of the essential groundwork of acquiring her own self-identity. The child, whose needs and perceptions have not been consistently acknowledged or validated, will have difficulty with discriminating perceptual and conceptual awareness of her own function.

A child growing up this way may acquire the facade of adequate functioning by robot-like submission to her environmental demands. The defect in self-initiative and active self-experience will become manifest when she is confronted with new situations for which the distorted routines of her past background have left her unprepared. Puberty is frequently the time when this confrontation takes place. Rather than knowing and listening to what her body is indicating, she is likely to rely on the environment for instruction.

In this theoretical model of child-mother interaction, the emphasis has been on what fails to go right, and not on any particular traumatic event. Awareness of herself as a separate individual evolves only through experiences and continuous interaction with the environment. The sense of adequacy and competence she achieves in her development is related to the appropriateness with which her needs are met. It is important whether they are fulfilled in a way that is attuned to her own expression, or whether they are

disregarded, either completely neglected or fulfilled in a mechanical way.

Sociocultural Factors

In our culture, where thinness is applauded, obesity results in social discrimination and isolation. Wooley (1991) reviewed numerous studies documenting the stigma surrounding obesity and the hatred directed towards obese children and adolescents. She concluded that anti-fat attitudes learned in childhood become the basis for self-hatred among those who become overweight at later ages. It develops into a source of anxiety and self-doubt for anyone fearful of becoming overweight. She documented the hostility directed toward the obese, and confirmed and explored how females are more affected than males by this anti-fat prejudice. Due to conflicting and excessive cultural expectations, young women may engage in the pursuit of thinness to obtain social approval and increased acceptance.

For anxiously attached individuals, weight loss and maintenance may be viewed as a means of assuring love and success. It may also serve as a means of establishing and controlling the availability of engendering interpersonal attachments. An argument can be made that the likelihood of a woman's betraying her body by any means increases when she finds it difficult to be true to herself. She has not had the resources to develop a sense of self. She attempts to

form a self that meets the multiple demands of society, loved ones, and her own ideals.

Although there are other important reasons for the occurrence of eating disorders, society's emphasis on superficiality in relationships and its idealization of a beautiful body promote self-esteem regulation by superficial modalities. The realities of one's inner emotions as well as illness, aging, and the finiteness of life must be dealt with. To prepare for this confrontation with life's vicissitudes, one must know meaning and purpose that transcend the acquisition of thinness and beauty.

Object Relations

Because there are many schools of thought on object-relations theory, in this paper the work of Donald Winnicott is explored. As a pediatrician, who later became a psychoanalyst, he published new conceptual ideas that extended the scope of classical psychoanalytical framework in the 1950s. D. W. Winnicott (1965) viewed the mother-child relationship as central to infant psychological development. The mother served the task of being optimally available so that the infant could gradually begin to internalize his image of her. In the capacity of "object-relating," the self (infant) is isolated, and the object (mother) is only seen in relation to the self's needs. In "object-usage," a maturational achievement, the infant recognizes the object as a separate being, with her own

feelings and needs but also shares her experience of reality. Moving from the first state to the second is the developmental task for the infant.

Winnicott's main focus of concern is the struggle of the self to be both individualized and connected with others. In his view, self-development is possible only in the context of interactions between a child and significant others. Significant others may be thought of as those who care for the child on a regular basis. They organize the child's experience and thereby provide for the development of integrated self-experience. The concept of the self and its development into either an integrated self-experience or a false self-organization is central. Man can find himself or continue to grow and develop only in relationship with others. There is independence gained through acknowledgment of the need for human connection. Winnicott has provided a subtle account of the development of the self out of a relational matrix. The development of the self was felt to be not driven by pleasure, as Freud proposed, but for acknowledgment, fulfillment, and development of one's authentic and genuine feelings and needs in one's relationships. Man strives to be a spontaneous and genuine being in his relationships with significant others.

Winnicott's approach to psychopathology and treatment reflects relational premises. Mental health is constituted by the relative integrity and spontaneity of the self. Psychopathology involves a constriction in the movement and

expression of the self. The necessary and sufficient factor responsible for mental health is appropriate parental provisions or "good-enough mothering." All psychopathology involves impairment in the functioning of the self, and is thus, by definition, a product of parental deficiency. The relationship between mother and infant has consisted of complex and mutual emotional needs and was not essentially physical. The differentiation and structuralization of the self was based on the interactions and emotional nature of the early relationship between the infant and mother. Mothers in one way or another identify themselves with the baby that is growing within, and in this way they achieve a very powerful sense of what the baby needs. This identification was termed by Winnicott as "Primary Maternal Preoccupation." The identification with the baby lasts for a certain length of time after parturition, and gradually loses significance. The mother through identification of herself with her infant knows what the infant feels like. She is able to provide almost exactly what the infant needs in the way of holding and in the provision of an environment generally. Without such identification she is not able to provide what the infant needs at the beginning which is a "live adaptation to the infant's needs" (p. 54).

The establishment of a relationship between psyche and soma develops through the natural coordination of the infant's needs and maternal care. The infant's organization of his own experience is preceded by and draws upon the

mother's organized perceptions of him. The mother provides a "holding environment" within which the infant is contained and experienced. The natural tendency to integrate is made possible by the mother's care in which the infant is kept warm, handled and bathed, and rocked and named, and also by acute instinctual experiences that tend to gather the personality together from within.

It is the instinctual experience of the mother and the repeated quiet experiences of body care that gradually build up one's personality. There is a dawning sense of being a specific person whose particularity is rooted in his body and which will be developed into the conviction of being who one happens to be. This involves, at a very early stage, being able, with increasing competence, to orient oneself in time and space. The infant who has not had one specific person to gather his bits together starts with a handicap in his own self-integrating task (Phillips, 1988).

When the baby looks into the mother's face, he sees himself. If the mother is empathically aligned with the baby, this is the baby's first experience of effectiveness; his affect produces a mirrored response in the mother. Mutually and reciprocally, the infant's internal state is also given form and definition by the accuracy of this empathic attunement. Healthy development requires a brief but perfect environment. By perfect, Winnicott means a mother whose maternal preoccupation makes possible a very close and accurate sensitivity to her infant's needs and

gestures. Despite their fragmented and formless qualities the mother provides the infant with a precise reflection of his own experience and gestures. These empathic and timely responses are viewed as the precursors to the developing inner psychic structures of the self. Imperfections in mirroring inhibit the child's capacity for self-experience and integration and interfere with the process of "personalization." When the mother is able to resonate with the baby's wants and needs, the latter becomes attuned to his own bodily functions and impulses, which become the basis for his slowly evolving sense of self. The failure of the mother to actualize the child's gestures and needs undermines his belief in his own powers and prevents the development of a connection between psyche and soma.

Empathic mirroring molds body sensations both internal and body surface into distinctions of the self. By distinguishing these sensations there is a development of body boundaries while a parallel reality of internal body functions and needs independent of others is developed. The individual begins to identify limits of the body self, where one's body ends and the rest of the world begins.

Thus, the mirroring experience begins the infant's perceptual existence, and from it he develops schemas of the human face, voice, and touch, which subsequently become the matrix for an internal composite experience of the caretaker. At a few months of age, an initial representation of the mother develops from consistent

experiences. Within time, the representation can be internally evoked without the other's presence. Each consistent experience contributes itself to a more durable internal representation. These consistent, empathic interactions lead to a cohesive internalized body image. As the child's body image is internalized, she develops the ability to look at her image objectively. This ability to think objectively allows the child to think and perceive in more complex ways.

True Self/False Self

Winnicott (1965) has suggested that deficiencies in maternal care, or the failure to provide a perfect environment and its graduated withdrawal, have a debilitating impact on the emotional development of the child. Maternal failures are of two kinds: inability to actualize the hallucinatory creations and needs of the infant when she is in excited states; and interference with the infant's formlessness and unintegration when she is in quiescent states. Ideally, the mother is the medium for formlessness and the instrument of omnipotence. Any interference with these functions is experienced by the infant as an "impingement." Something from the outside is making claims on her demanding a response.

He has envisioned the infant as born with the potential for unique individuality of personality, which he termed a True Self personality organization. The True Self can

develop in the context of a responsive holding environment provided by a good-enough mother. The good-enough mother meets the omnipotence of the infant and to some extent makes sense of it. She does this repeatedly. A True Self begins to have life, through the strength given to the weak ego by the mother's implementation of the infant's omnipotent expressions. When a person is able to express herself both outwardly and inwardly without tailoring her expression in a defensive way to the expectations or demands of others, she is able to pursue her own genuine interests and aspirations; she can express her real self.

For Winnicott, a capacity to be spontaneous can only come out of an early experience of reliability. However, when a mother substitutes something of herself for the infant's spontaneous gesture, the infant experiences a traumatic disruption of his developing sense of self. When such "impingements" are a central feature of the early mother-child relationship, the infant will attempt to defend himself by developing a second (reactive) personality organization (the False Self organization). This False Self vigilantly monitors and adapts to the conscious and unconscious needs of the mother and in so doing provides a protective exterior behind which the True Self is afforded the privacy that it requires to maintain its integrity.

Through this False Self, the infant builds up a false set of relationships, and by means of introjection (incorporating others' attributes within one's self) even

attains a show of being real, so that the child may grow to be just like mother, nurse, aunt, brother, or whomever dominates the scene. The False Self has one positive and very important function: to hide the True Self, which it does by compliance with environmental demands.

To avoid annihilation or disruption in one's relationship, to maintain a vital connection, the False Self manages life and protects one's true feelings. Functioning in this mode can frequently lead to academic, vocational, and social success, but over time the person increasingly experiences herself as a bore, "going through the motions," detached, mechanical, and lacking spontaneity. This makes it difficult for a person to relinquish her reliance on this False Self mode of functioning despite an awareness of the emptiness of life that evolves from such functioning.

At the other end of the scale (in health), there is a compliant aspect to the True Self . . . an ability of the infant to comply and not to be exposed. The ability to compromise is an achievement. The equivalent of the False Self in normal development is that which can develop in the child into a social manner, something which is adaptable. In health this social manner represents a compromise. At the same time, in health, this compromise ceases to become allowable when the issues become crucial. When this happens the True Self is able to override the compliant self. (Davis & Wallbridge, 1981, p. 51)

Transitional Objects

An infant's imaging capacity begins at 8-13 months, at which time the image and its properties seem to exist independently of the object or person experienced. As the

capacity to make images and internal representations develops, people or objects can exist apart from the infant's sensory perception of them. This imaging capacity is initially primitive and is limited to identification of symbols or transitional objects to take the mother's place; a thumb to suck rather than a breast; a blanket to rub rather than the mother's skin. The first transitional objects are those representing the body of the mother.

Winnicott (1965) demonstrated the developmental importance of the solacing transitional objects. The comforting experiences, if they occur consistently and adequately, are internalized gradually so that the experience becomes an internal function. When the comforting internalization is incomplete, the person continues to seek and, to a limited degree, experiences solace but fail to develop an independence from the external source. An attempt to create a transitional object may itself become a symptom if the object is a substance (disguised to soothe) such as alcohol, food, or drugs. A true transitional object is one that symbolizes a healthy relationship with the primary nurturing figure. The most important dimension of transitional phenomena is not the objects themselves, but the nature of the relationship to the objects, representing a developmental way station between hallucinatory omnipotence and the recognition of objective reality.

The experience of internal solace and the ability to develop nurturing relationships represent a lifelong developmental process. Maternal soothing, subsequent ego function, and the ability to console are all related. Infants reared without consistent, reliable comforting do not develop transitional object attachments.

Object Relations and Eating Disorders

Object relational conceptualizations of bulimia stress disturbances in early child-caregiver interactions. Environmental failures such as parental inconsistency, emotional unavailability, or deficits in empathic attunement to the needs of the developing child are thought to prevent the internalization of mental structures and functions. These functions are necessary both for the self-regulation of tension and self-esteem and for a stable sense of self and others. The result is thought to be an inability to obtain satisfaction and comfort through interpersonal relations. Bulimic behaviors are thought both to compensate for these interpersonal and intrapsychic deficits (Humphrey, 1986; Sands, 1991) and to reflect dysfunctional object relations (Barth, 1988; Becker et al., 1987; Friedman, 1985).

Chronic failures on the part of the caretaker(s) to decode and respond consistently and accurately to the developing child's self-initiated cues (e.g., for feeding versus the alleviation of other tensions or emotional needs)

and to "mirror" or empathically affirm the child's unique feelings, sensations, and spontaneous gestures are thought to result in such later body/self deficits as difficulty identifying and distinguishing bodily and emotional states, perceived personal ineffectiveness, and disturbed or distorted body image. The perceived absence of a consistently available, soothing, and comforting external other to relieve, modulate, and organize strong affective states is thought to result in chronic deficits in later self-esteem and tension regulation. One who has not fully internalized these caretaking functions will later tend to lack, both somatically and psychologically, an independent center of initiative and reference (Bruch, 1973; Krueger, 1989).

The bulimic binge-purge cycle, like other addictive behaviors, represents a healthy, albeit misguided, attempt at self-restitution. Gorging oneself with food may be the first medium for the transmission of soothing and comfort. It is thought to express and temporarily meet primitive needs for emotional nurturance and connection. Purging expresses needs for self-definition and separation. This new restitutive system works temporarily, in that it regulates or dampens dysphoric affects such as depression and anger, and creates a temporary feeling of well-being or euphoria. By detouring basic relational needs into eating pathology, however, it also removes the individual from

human responsiveness and the emotional nurturance she needs to complete her self-development.

Bulimia may be organized by Winnicott's (1965) concept of the mother-infant "holding environment." Nugent and Constantine (1988) have proposed that in bulimic families all members have experienced various failures in their early parental holding environment, and that these failures are carried through the generations. The primary failures in bulimic families involve: (1) nurturance, (2) soothing and tension regulation, and (3) empathy and affirmation of separate identities. The authors have maintained that these failures in the family's holding environment lead to transgenerational developmental adaptations. These maladaptations involve reliance on others and the use of defenses that require others to complete the self, including splitting, idealization, and projective identification. Such deficits and adaptations determine the level and quality of intrapsychic experience within individual family members, their interpersonal relationships, and the dynamic functioning of the family as a whole.

Bruch (1973) has identified failures in this aspect of the holding environment as the major cause of eating disorders, both bulimia and anorexia nervosa (Johnson & Connors, 1987; Masterson, 1977; Minuchin, Roseman, & Baker, 1978). Whereas, in anorexia nervosa, the child's developing self is enfeebled by negative responses to separation

coupled with more positive responses to dependent and regressive behavior (Masterson, 1977) in bulimic families there is a paucity of positive responses to any behavior; instead, the child's separate self is criticized, ignored, or enlisted in meeting the parents' needs. The spontaneous gesture is met with invalidating responses, ranging from parental self-preoccupation to hostile rejection. The child's age-appropriate attempts to separate are negatively acknowledged, and are met with some form of abandonment or punishment. The developmental shifts between independence and interdependence are undermined by the parents' support being made contingent on the child's compliance with their needs and expectations (Humphrey & Stern, 1988).

Several empirical studies support object-relations formulations of eating disorders. Humphrey (1986), using Benjamin's Structured Assessment of Social Behavior, has demonstrated that anorexic and bulimic patients display hostile and neglectful attitudes toward themselves that compare to the attitudes which they (as children) had experienced through their parents. The compulsion to binge-eat almost always belies a profound emotional hunger that is based in life-long feelings of deprivation and emptiness. According to Humphrey, all family members feel deprived of emotional supplies to one degree or another, and feel correspondingly "hungry" emotionally.

Villejo, Humphrey, and Kirschenbaum (1997) have examined the impact of activating internalized family images

of affective states and behavioral self-regulation with 64 female binge eaters. The family induction had a differentially negative impact on binge eaters. When their family images were activated, binge eaters felt more negatively about the experiment, more hostile, experienced greater sensations of hunger, and were more preoccupied with their family images than their counterparts in the other groups. Behaviorally, they also required a relatively greater amount of time to complete a visual-motor task, with a degree of accuracy comparable to that of other subjects.

Becker et al. (1987) were interested in determining whether object-relations disturbances would be related to levels of disordered eating. Over 540 college women responded to the Bell Object Relations Inventory (BORI; Becker et al., 1987) and an inventory assessing bulimia. To assess differences in subjects' object-relations functioning, the authors divided the sample into bulimics and nonbulimics and compared the scores of the two groups. Results indicated that, when compared to a sample of nonbulimic women, bulimic patients exhibited more than twice the percentage of object-relations disturbance in the area of insecure attachment. This is consistent with the widely held belief that early developmental deficits in the self contribute significantly to the etiology and maintenance of disturbed eating.

Friedlander and Siegal (1990) found through the results of their study of eating disorders and family relationships

that a failure to achieve a separate sense of identity, if not a predisposing factor, at least plays a role in maintaining the client's maladaptive patterns. Their findings indicated that dependency conflicts and poor self-other differentiation were predictive of bulimia, as well as the pursuit of thinness, an inability to discriminate feelings and sensations, distrust of others, immaturity, and beliefs about personal inadequacy. Their findings showed a strong support for theoretical assertions regarding intrapsychic and familial factors contributing to the etiology and maintenance of eating disorders.

Guidano and Liotti (1983) argued that early object relationships are central to the development of self-structures.

In their words, "parents, as a mirror, provide children with a self image . . . [that] orients and coordinates children's self-perception until they are able to perceive themselves in keeping with the image that is supplied to them" (p. 103). If these images are vague, unstable, and shifting, however, then these "distorted self-conceptions regarding fundamental aspects of identity (lovableness, personal value, etc.) not only will determine a particular attitude toward reality, but also will notably influence the cognitive and emotional process in course, resulting in a rather rigid and defensive attitude toward oneself." (p. 105)

Steiger and Houle (1991) explored defense styles and object-relations disturbances among university women with eating disorders. Their findings support the notion that eating-disordered women have more object-relation problems and were more reliant on maladaptive defenses. Other

studies have identified pathology in eating disorders that is congruent with object-relations views, on dimensions pertaining to the capacity to achieve an adequate sense of recognition from others and to function independently from others (Steiger, Vander Feen, Goldstein, & Leichner, 1989).

Galín (1993) explored the following factors in bulimic women: lack of autonomy, feelings of ineffectiveness, maturity, and secure attachments. She predicted that attitudes towards women's roles could predict who would be vulnerable for developing eating disorders. Her research indicated that subjects who were at risk for eating disorders were less autonomous, felt control was externally located, felt less close with their parents, were less likely to be securely attached, and reported that they valued beauty, independence, and career-oriented achievement.

Body Identity in Eating-Disordered Women

The expression "body identity" is a vague concept that is widely used in psychological evaluation. Bruch (1973) has defined the concept of body identity as

the correctness or error in cognitive awareness of the bodily self, the accuracy in recognizing stimuli coming from without or within, the sense of control over one's bodily functions, the affective reaction to the reality of the body configuration, and one's rating of the desirability of one's body by others.
(p. 89)

She has noted how the obsession of the Western world with slimness, and the condemnation of any degree of overweight as undesirable and ugly, may well be considered a distortion of the social body concept.

Bruch has described patients with weights as low as 67 pounds who, despite their condition, persist in conceiving themselves as fat. She has stated that a realistic body-image concept is a precondition for recovery. There is no real or lasting cure achieved without correction of the body image misperception.

Lichtenberg (1985) described the concept of the body self as a combination of the psychic experience of body sensation, functioning, and image. He hypothesized that reality testing occurs in a definite developmental sequence of increasing awareness and integration of body self. Body image dissatisfaction has been correlated with both the development and maintenance of bulimia.

Ideally there should be no discrepancy between the body structure, body identity, and social acceptance. Obese people live under the pressure of a derogatory social environment. Such a continuous insult to a person's physical personality may result in a discrepancy between body structure and the desired and socially acceptable image. A young person whose constitutional body structure does not conform to the socially acceptable image finds herself under enormous pressure and constant criticism. According to Bruch, even psychosis may result from such

discrepancies. Girls are taught at a very young age by family, peers, school, and the media that being successful or desirable involves being thin. If a young woman perceives that her body is not acceptable as it is and that culture values a body shape she will never have, she may feel unattractive, unlovable, and, therefore, a failure as a woman. If there is a lack of emotional connectedness, whereby the individual craves affection and is overwhelmed with feelings of emotional isolation as well as confusion, a vicious cycle of dieting, bingeing, and purging may ensue. This cycle leads to an enormous degree of self-doubt.

The experience of self-hatred and contempt for being fat is not only determined by social attitudes, it is also closely interwoven with psychological and interpersonal experiences early in life. The child absorbs the attitudes of others toward her body and its parts. She may develop a body concept that is pleasing and satisfying, or she may come to view her body and its parts as unpleasant, dirty, shameful, or disgusting. Bruch has recognized that the attitude of parents is integrated into a child's body concept and those derogatory attitudes have a very strong effect.

Evidence suggests that women with eating disorders and body image disturbance have had personal experiences with social rejection in connection with appearance. From their poll of 33,000 women, Wooley and Kearney-Cooke (1986) have found that women with a negative body image were more likely

to have had mothers who were critical of their appearance. Another large-scale survey of body image attitudes reported that childhood teasing about appearance led to a negative body image and a tendency to develop an eating disorder (Fabian & Thompson, 1989). Numerous studies have shown that a high proportion of bulimic persons were overweight prior to the onset of their disorder, which suggests that they received negative feedback about their appearance as children and adolescents (Ben-Tovim & Walker, 1992; Steiner-Adair, 1991).

Many authors would agree that hateful self-contempt is not really related to the excess weight, but to some deep inner dissatisfaction. Bulimic women want to feel better about themselves. Because they feel that "being too fat" is the cause of their despair, they are determined to correct it. In this struggle for self-respect and respect from others, whatever idealized weight they reach will never be "just right" for giving them their inner reassurance. The downhill spiral continues. Bruch has argued that it is the distorting and undermining interpersonal experiences early in life that result in this self-concept of being monstrous and grotesque.

The bulimic woman's body distortion remains a puzzling concept. A growing body of literature explores the bulimic woman's ego development and ability for conceptualization. This theory proposes that as one has developed a more cohesive, integrated ego structure, one is better able to

accurately identify feeling states as well as physiologic, somatic states. There is a parallel development in terms of her cognitive structure. The bulimic woman who has not developed a solid frame of reference is unable to rely on her own internal states to guide her. Although there may be vague diffuse feelings and confusion she is unable to adequately articulate her distress. She may turn to food or exercise as a means of relieving her inner turmoil without full acknowledgment of the precipitating emotional causes.

According to Krueger (1989), bulimic individuals' developmental arrest includes the cognitive incapacity to internalize the mirroring other. There was no one to validate and reflect on one's feeling states and, therefore, it is difficult for the child to identify one's emotional and feeling states. The self and the mirroring-other distinction are incomplete, so symbolization of the mirroring other is incomplete. The affected individuals are not able to look at themselves in a valid way and so they are unable to recognize their feelings and sensations. They cannot see themselves objectively and symbolically.

With the failure of development of a cohesive body and psychological self, self-reflection and self-observation are difficult. They are unable to make sense of, or even acknowledge or express, feelings. This mode of thinking is characteristic of earlier development and attests to cognitive and emotional developmental arrest. Components of this cognitive developmental arrest include the "all or

nothing" experience of emotion, as well as the assumption that others are an extension of one's self, automatically understanding and sharing one's thoughts and feelings without their being verbalized. An individual developmentally arrested is unable to consider an alternative to her views. In her thinking the part represents the whole. The bulimic woman looks at herself in the mirror, and focuses on one part of her anatomy, concluding when she sees some curvature that she is fat all over.

The eating-disordered patient's personal experience is one of feeling lost, empty, and without boundaries. The mirroring other (self-other) had been functioning, prior to the narcissistic injury, as a referral base and regulator to maintain formation and boundary functions. With the withdrawal or unavailability of the soothing other, the individual must precipitously rely only on her vague or conformed boundaries and internal regulation. These incomplete and indistinct body boundaries do not provide an adequate foundation for a solid, cohesive, consistent sense of self.

Persons with a vulnerable self-organization, who experience the threatened loss of the integrity of the self, will attempt to bolster their sense of self. What object-relations therapists refer to as "transitional objects," Atwood and Stolorow (1984) have called "concretization." Concretization serves the function of strengthening their

sense of self. They define concretization as "the encapsulation of structures of experience by concrete, sensorimotor symbols" (p. 85). These symbols may involve either motor activity or perceptual imagery. Motor activity includes various behavioral enactments, such as compulsive ritualistic behavior, perversions, addictions, or other kinds of "acting out." Perceptual imagery includes symbols, dreams, and hallucinations. There develops an obsessive-compulsive behavior pattern designed to restore a damaged self.

Thus, the concept of concretization portrays the basic function of bolstering and maintaining the cohesive and stable organization of the person's self. For patients faced with the threatened loss of the integrity of the self, "concretization may serve to recover a disorienting sense of unreality by restoring a sense of the real. Adhering to the concrete attitude is then a means of maintaining . . . their sense of reality, of possessing an ordered and orderly existence" (Josephs, 1989, p. 492).

The symptoms exhibited by eating-disordered patients primarily serve to concretize self-experience, thereby reducing the risk of more severe loss of cohesion and stability of the self. How the bulimic person feels about her self is experienced concretely in terms of how she views her body. In seeing herself as "fat," the young woman is concretizing her self-image of being "out of control" and imperfect.

In the treatment of over 300 eating-disorder patients both in inpatient and outpatient settings, two findings were consistent (Krueger, 1989). First, the body image of each patient was developmentally disrupted-blurred, distorted, indistinct, or incomplete. It has been well demonstrated that patients with eating disorders have a sense of estrangement from their bodies, insensitivity to body sensations, and blurred body boundaries. Second, they had an early preoedipal and even preverbal developmental arrest that includes a lack of internal body boundaries, distinct body image, and cohesive sense of self. Additionally, each individual began definitive developmental improvement (i.e., more than just symptomatic improvement) when aspects of body self (including body image) were addressed and integrated in treatment along with aspects of the psychological self (Krueger, 1989).

Research has indicated that the highest and earliest relapse rate in eating-disorder patients occurs in individuals with the most distorted body image (Bruch, 1973). Sugarman and Kurash (1982) have postulated that an arrest occurs at the earliest stage of transitional object development in that there is a failure to adequately separate physically and cognitively from the maternal object.

The association between body image distortion, specifically overestimation of body image, and anxiety, depression, physical anhedonia, and a sense of pervasive

ineffectiveness has been demonstrated by other investigators (Scarano & Kalodner-Martin, 1994). The severity of this distortion has been correlated with the poorest prognosis.

Zakin (1989) explored differences between bulimic and nonbulimic adolescent women on body satisfaction, body boundary definiteness, and body awareness. Bulimic women have shown greater disturbance on all body image dimensions employed. They were found to be less satisfied with their bodies and appearance than non-bulimic women, and they were also found to experience their bodies as less definite and more easily penetrated than non-bulimic women. In addition, they have shown greater distortions concerning their bodies and body processes. Bulimic women were more dependent on their mothers, experienced their mothers as more overinvolved with their bodies, and have shown more anger than nonbulimic women.

Neimeyer and Khouzam (1985) argued that the level of one's construct system differentiation should predict eating-disordered behavior. Differentiation is understood as the relative number of different dimensions of judgment used by a person. More highly differentiated individuals are regarded as more cognitively complex insofar as they bring to bear a greater number of alternative perceptions in processing relevant information. They found that higher levels of eating disorder were related to lower levels of cognitive differentiation. They have hypothesized that this might reflect a relative ineffectiveness of the individual

in distinguishing among important aspects of the interpersonal field.

Button (1983, 1987) found evidence that anorexic and bulimic women have more tightly organized construct schemas than do normal eaters. He has found that the more tightly organized one's thinking, or the more constricted and inflexible the individual was in her thinking, the more resistant the individual was to change.

Heesacker and Neimeyer (1990) explored the relation between eating disorder and disturbances in object relations and cognitive structure. Results indicated that the eating disorder was predicted by measures of object-relations disturbance and cognitive structure. Women with higher levels of eating disorder have shown higher levels of object-relations disturbances along two of the four subscales (Insecure Attachment and Social Incompetence), and more simplistic and rigid social cognitive schemata. Their findings have indicated cognitive construct systems that were highly integrated but poorly differentiated. The authors proposed that maladaptive eating behavior may be due, in part, to a rigid and overly constricted cognitive structure that results in a unidimensional framework for construing self and others.

Teusch (1988) investigated whether level of ego development as explained by Loevinger is predictive of bulimics' conceptualizations of their disorder. Ego levels correspond to an increasing ability to reflect on oneself,

to think with greater complexity, and to become aware of feelings and motives for one's behavior. Ego development is defined as the "overall frame of reference" through which an individual organizes his/her experience. It represents the individual's movement towards increasing differentiation and integration. There are, according to the author, broad categories of ego development: Preconformists, Conformists, and Postconformists. These categories differ from each other along the dimensions of impulse control, motivational orientation, conscious concerns, and interpersonal and cognitive style. Regarding the maintenance of bulimia, it was predicted that Postconformist bulimics would show a clearer awareness of their motivations for binge-purge behaviors and exhibit an increased ability to articulate both the concrete and symbolic meanings of gorge-purging. The results have demonstrated a significant variation with regard to verbalizing affect and taking responsibility for their behavior. Postconformists tended to locate the reasons for their bulimia within themselves (i.e., their own self-restraint, lack of assertiveness, inability to ask for emotional support). In addition, they have perceived external factors such as lack of approval and affection from others. The Postconformists tendency to associate the development of bulimia with negative interpersonal beliefs have revealed their high level of self-awareness and sensitivity to interpersonal dynamics. Although the bulimics have differed with regard to depth and complexity

of insight into their illness, they were similar in that they have consistently connected experiences of emotional isolation with the development of bulimia and have defined their binge-purge behavior as a coping mechanism for their feelings.

Sparks (1994) hypothesized that the onset of eating disorders is related to the late-adolescent developmental task of identity development. In line with expectations, eating-disordered subjects have scored higher on ideological diffusion but lower on ideological achievement. They have scored higher on interpersonal diffusion and lower on interpersonal achievement. In addition, there were significant correlations between ideological diffusion and measures of depression and anxiety. There were also significant correlations between ideological moratorium and measures of depression, anxiety, social alienation, family discord, and borderline personality symptomatology.

Schupac-Neuberg and Nemeroff (1993) proposed that bulimics lack a clearly defined self, and subsequently utilize their physical bodies as a means of self-definition and regulation. Three major aspects of this perspective were assessed: identity disturbance, use of the binge and purge as means of emotional regulation, and sensitivity to interpersonal contact. Bulimics were found to have reported greater amounts of identity confusion, enmeshment, and overall instability in self-concept than normal controls and binge eaters. They have found that the binge leads to an

escape from self-awareness for bulimics, and the purge has served to manage the negative affect.

Eating Disorders and Affect Regulation

Mahler, Pine, and Bergman (1975) have offered an explanation for depression as an autonomy deficit. They have suggested that depressive affect is first mobilized in infants during the separation-individuation phase of development. During this time the infant is striving both for an increased sense of separateness from mother and for individuality. Healthy negotiation of this issue would incorporate a feeling of being connected while still being one's own self. If the growing child feels supported while venturing out and practicing independence, he will feel supported in being more autonomous. If this "practicing phase" is not negotiated properly, the child may experience a loss of her connection. It is the giving up of this gratifying, merged state that Mahler et al. (1975) believed first creates depressive affect and serves as a prototype for later depressive feelings. Accordingly, a depression-prone individual might seek to maintain or recapture a symbiotic-like state as a way of eliminating or reducing depressive affect, and she will sacrifice strivings for autonomy toward that end.

Women with bulimia generally have relationships with their mothers characterized by over-identification. There is a sense shared by mother and daughter of enmeshment, and

a style of relating based not on genuine recognition of the child as a separate person, but rather on the sense that mother and daughter are in some way the same person. The daughter, in such a relationship, suffers from insufficient acknowledgment as an individual with her own unique sensations, feelings, and needs (Beattie, 1988).

Food may be the most concrete symbol of the maternal object. Through a woman's relationship and control of food intake and body shape a woman can act out almost every aspect of the ambivalent struggle with the actual and the internalized mothering-other. Through food, a young woman can demand and reject nurturance. She can deny her dependent cravings and defy the mother through being in absolute control of her own body. Through a woman's relationship with food she can soothe, tranquilize, and alleviate unacknowledged and troublesome feelings of inner rage and tension, depression, and loss. Giving into regressive wishes is then negated and punished through purging, which it can give vent to aggression and provide emotional release.

The bingeing behavior is complex. The impulse to binge may itself represent an urge or feeling which the woman feels is unacceptable. Bingeing may also occur secondarily as a defense against a feeling. Bulimic women usually lack the ability to soothe themselves and also have a limited ability to tolerate painful or powerful feelings.

The process of becoming bulimic has its roots in suppressing the individual's natural spontaneity. The natural, living self cannot be allowed to emerge since its emergence is expected to provoke an attack or abandonment. This fear of abandonment necessitates repression of the woman's genuine feelings and instincts.

The symptoms of bulimia are both a recapitulation of the situation with the mother and a defense against it. In a compulsive, repetitive fashion, the daughter keeps taking in maternal nourishment and rejecting it. Only in secret can she feed the natural self. Her rejection of this nourishment may reflect her anger that her real self is hidden and it is only her false self that can be seen (Jones, 1985).

According to Bruch (1985), "the basic illness is not a disturbance of the eating function . . . [but is due] to underlying disturbances in the development of the personality" (p. 9). She has stated that patients feel helpless and ineffective: "The severe discipline over their bodies represents a desperate effort to ward off panic about being completely powerless . . . of not having a core personality of their own, of being powerless and ineffective when they 'give in'" (p. 10).

The ability to regulate internal tension states and to modulate affect is an important function performed by a cohesive self. Masterson (1985) has identified two manifestations of this self-regulatory function:

(1) spontaneity and aliveness of affect, and (2) the capacity to minimize and soothe painful affect.

Barth (1988) has stated that it is human nature to strive for self-esteem and for a cohesive, stable sense of self over time and across stressful situations. Many individuals with bulimia have neither a stable sense of self nor a sense of self-esteem. The bulimic symptoms help to alleviate feelings of fragmentation, disorganization, confusion, and self-hatred, while at the same time confirming a stable, if negative, sense of self. It is felt that the negative self-perception is all they know. Without it they would have no self-perception. The symptoms are part of an effort to organize the self and/or maintain self-esteem. Bulimic symptoms may be used to sooth painful and unacceptable feelings or to adapt to an environment in which the self is constantly subjected to painful, damaging experiences. Barth believes that symptoms are not simply evidence of psychopathology but are often evidence of an adaptive response to a maladaptive environment. While bulimic behavior may seem maladaptive to an outside observer and may cause the individual pain, it is also a highly successful method for protecting a damaged self in a frightening world. For many people with bulimia, unable to soothe themselves in other ways, and unable to trust others to provide nurturing functions, the bulimic behavior, rather than another person, fulfills some of these functions.

It is possible to translate the findings on depression into the language of object relations. One might postulate that the emptier or more conflict-ridden the inner object world of the individual, the greater the likelihood that severe eating pathology has arisen as a form of compensation.

Ulrich (1992) has explored the relationship between the severity of the subjects' symptoms of bulimia nervosa, and the presence of object relations and depression in these individuals. The results of her study have indicated that there were moderate correlations between aspects of object relations and severity of eating disorder. Eating-disorder and noneating-disordered groups have differed significantly on levels of depression, with the bulimic group reporting moderate levels of depression. Additional differences among groups were found on measures of body dissatisfaction, ineffectiveness, and interoceptive awareness.

Billig (1987) explored the relationship between level of ego development, depression, locus-of-control, assertiveness, and severity of bulimia. He found that bulimics were generally unassertive. The level of assertiveness was found to be associated with an internal locus of control and inversely with depression. Depression was associated with measures of external locus of control and severity of binge eating. The presence of purging was associated positively with both measures of external locus of control and severe binge eating, and inversely with age.

Bulimic women have more difficulty regulating dysphoric affects and self-esteem, are more vulnerable to fragmentation experiences, and have reported more primitive relations and self-object experiences than either normal individuals or overweight dieters (Vipond, 1992). Statistically significant relationships were found between self-regulatory deficits and levels of object relations across groups of bulimic women, overweight women, and controls.

Attempts to measure affect prior to binge or binge-purge episodes strongly support the thesis that these episodes are often precipitated by negative emotions. Bruch (1973) has noted that individuals with compulsive eating patterns often eat in response to unpleasant emotional states--particularly anxiety and depression. Binge eaters, according to Bruch, have reported that eating reduced tension and made them feel better.

Bulimic patients have reported overeating to relieve distressing emotions such as anxiety, depression, and guilt (Bruch, 1973; Casper, Eckert, Halmi, Goldberg, & Davis, 1980). In addition, these patients have reported that feelings of frustration, tension, emptiness, and boredom induced cravings for certain foods; and that the activities associated with eating these foods had an emotionally soothing effect on them. In a number of other similar studies, negative mood states were identified as precipitants of bingeing.

McCanne (1985) has examined the relationship of anxiety, assertiveness, and locus of control to bulimia in college students. Those in therapy for bulimia scored lower in assertiveness and greater in anxiety than did controls.

Goodsitt (1983) has described the self-regulatory functions of disordered eating behaviors as follows:

One aspect of the chaotic eating behavior of eating-disordered patients is the terribly deficient capacity to self-regulate that these patients are burdened with. Be it food, impulses, moods, behavior, or relationships, these patients either swing wildly from one extreme to the other, or they find one end of the spectrum and remain frozen there. They are deficient in self-esteem and tension-regulation. They rely on external cues such as obsessively counting calories to determine how much to eat. When they are unable to do this, they vomit to control their food intake. Internal psychic mechanisms of self-regulation are not reliable. If this disorder is anything, it is a disorder of deficient self-regulation. (pp. 53-54)

Goodsitt views other symptoms as attempts to regulate internal tension states and self-esteem. Compulsive activity, in his view, is a kind of self-stimulation that alleviates feelings of deadness, and allows the eating-disordered patient to experience herself intensely. The "frantic business" of these compulsively active women substitutes for a coherently organized set of goals and values, and gives the bulimic's life a sense of organization, direction, and meaning. These activities are "the outward manifestation of a disrupted and over-stimulated self-organization" (p. 55).

Goodsitt (1985) has suggested that the binge-vomit sequence serve an organizing function, as does

self-starvation. The disturbing but vague feelings that often precipitate a binge are replaced by intensely felt affects that are made comprehensible by attributing them to the binge. Self-starvation and the thought, planning, and organization that go into the activities surrounding eating and weight loss become the central goals and ambitions in the eating-disordered woman's life. They maintain a fragile self-esteem and overcome a paralyzing sense of ineffectiveness. Thus, in all types of eating disorders the illness itself becomes the central organizing event in the patient's life.

Although these symptoms provide temporary restitution to a state of greater self-cohesion, they are nevertheless unhealthy substitutes for a developmental process that has not yet been completed. The symptoms are dysfunctional in that they do not pave the way for further development; on the contrary they inhibit such development. In her desperate attempts to organize herself around her eating and weight, the eating-disordered woman often finds herself caught in a descending spiral in which she becomes increasingly isolated from potential self-soothing experiences that could ultimately assist her in building internal structures. As she becomes more isolated from other sources of self-esteem, self-organization, and tension-regulation, she becomes more vulnerable to fragmentation, and her symptoms are likely to escalate, isolating her still further.

Markosian (1997) explored the relationships among separation-individuation, bulimia, social characteristics, and perceived parenting style in bulimic and non-bulimic college females. The author found that bulimics are underseparated from their parents when compared to non-bulimic subjects. The bulimic women exhibited a distinctly different pattern of social qualities characterized by higher levels of depression, lower self-esteem, higher private and public self-consciousness, and higher social anxiety than the non-bulimic subjects. There were strong relationships between type of parenting style received and level of independence; the warm and flexible authoritative parenting style was most closely linked to a supportive relationship between the parent and child that was free from the undercurrents of anger and resentment.

Several studies in the literature have investigated the following factors: the relationship between the severity of bulimia and object relation impairment, as well as the relationship between severity of bulimia and identity. No studies have been found that explored the relationship between all three factors: severity of bulimia, object relations, and identity. By assessing the severity of subjects' bulimia, the nature of their body image disturbance, and their capacity for object relations, it is hoped some light may be shed on the developmental aspects of eating disorder.

CHAPTER III

METHODOLOGY

The primary purpose of this descriptive study was to examine the relationship between the severity of bulimia, the severity of object relations, and identity disturbance. It was expected that the greater the severity of an eating disordered client's internalized object relations, the higher the scores would be on self-identity disturbance. It was believed that there was a correlation between the severity of object relations (or ego integrity) and symptoms of bulimia, and body identity.

Design

This study was a descriptive study examining the relationships between bulimia, object relations, and body identity. The study involved the administration of tests by therapists who were treating women diagnosed with bulimia nervosa according to *DSM-IV* criteria. The test instruments included the following: Bulimia Test-Revised, Bell Object Relations Inventory, and the Erwin Identity Scale. A follow-up interview was conducted on a selected group of subjects.

Sampling

Thirty subjects were recruited through recommendations from therapists in the Southwestern area of Michigan and Northern Indiana. These women were diagnosed with bulimia nervosa according to *DSM-IV* criteria. Subjects were at various stages of therapy. Subjects ranged in age from 18 to 65 years. Of the 30 subjects a subgroup of 12 individuals was used for the qualitative interview. The criteria used for choosing the twelve subjects for the qualitative interviews were based on the scores of the Bulimia Test-Revised. The qualitative interviews were based on the Bulimia Test-Revised scores and the subject's willingness to participate in the study.

Procedures

Women were recruited through contact with local therapists. Therapists included limited licensed psychologists, social workers, and fully licensed psychologists. Therapists in the Southwestern Michigan and Northern Indiana area were contacted by telephone. There were very few therapists and organizations willing to participate. However, each therapist who indicated a willingness to participate was met with individually by the researcher. The therapist was given a packet containing a brief statement explaining the purpose of the study and the specifications of the research project. It was hoped that

the therapist would then identify potential candidates for the study.

Each prospective candidate received a research packet that included three tests, a consent form, and a cover letter. Subjects were asked to fill out questionnaires in privacy, further ensuring confidentiality, and then they were asked to return the questionnaires to the therapist. A small subsample (12) of subjects was chosen for qualitative interviews based on their bulimia scores. These interviews included several qualitative questions and were conducted by the investigator.

Instrumentation

Bulimia Test-Revised Scale (BULIT-R Scale)

The Bulimia Test-Revised scale (BULIT-R scale; Thelen, Farmer, Wonderlich, & Smith, 1991) is a revision of the earlier BULIT Scale (Smith & Thelen, 1984). The scale is designed to investigate a range of attitudes and behaviors associated with bulimia in both clinical and nonclinical populations, categorizing subjects into bulimic and normal eaters consistent with *DSM-III-R* criteria. It is a 36-item scale with a 5-point forced-choice, Likert format. It has been shown to diagnose approximately 3% of the female college population as bulimic. Predictive ability is high, identifying significant differences between bulimic eaters ($M = 104.54$) and normal eaters ($M = 60.71$), $t(100) = 13.02$, $p < .0001$. Test-retest reliability was found to be .95

($p < .0001$) using the Pearson product-moment correlation. An overall validity coefficient was obtained by correlating total BULIT-R scores with group membership based on rater judgment ($r = .74, p < .0001$). Furthermore, the scale correlates highly with another measure of bingeing behavior, the Binge Scale ($r = .85, p < .0001$), indicating a high level of concurrent validity.

Bell Object Relations Inventory (BORI)

The Bell Object Relations Inventory (BORI; Becker et al., 1987) is a 45-item, self-report test. In its original form, the Bell Object Relations Reality Testing Inventory was a 90-item inventory, with 45 items designed to assess object relations and 45 items designed to assess reality testing. The directions of the test ask the subject to respond true or false to statements according to their most recent experience. The essential purpose of this measure is to assess a subject's object relations by determining how the individual experiences him or herself in relation to others and to the world. This conceptualization of object relations follows the definition of object relations as an ego function, which enables the individual to establish and maintain healthy interpersonal relationships.

The inventory is comprised of four subscales, derived from factor analysis using an oblique rotation, which the authors of the study determined to be the most clinically relevant. The scales correlate moderately with each other;

however, each subscale bears a unique relation to described variations in psychopathology. These subscales are labeled Alienation (ALN), Insecure Attachment (IA), Egocentricity (EGC), and Social Incompetence (SI). Internal consistency was in the good-to-excellent range for the four factors: ALN = .90; IA = .82; EGC = .78; SI = .79. Split-half reliability coefficients were in the good-to-excellent range for the four factors: ALN = .90; IA = .81; EGC = .78; SI = .82. The four factors were found to have nonsignificant Pearson correlations with the Marlowe-Crowne Social Desirability Scale.

All derived subscales are defined by Bell in his scoring manual for the Bell Object Relations Inventory. The first derived subscale, Alienation (ALN), is composed of items that assess a basic lack of trust in interpersonal relationships. Individuals who score high on this subscale feel unable to attain closeness with anyone, and are unable to attain a stable and satisfying level of emotional closeness. Social relationships are typically superficial, and the individual feels no real sense of connection or belonging. High scorers are suspicious and guarded, tend to be self-isolative, and to feel that there is no one with whom they can share their inner thoughts.

There are certain developmental issues suggested by this description that may serve to clarify these individuals' object-relations disturbances. High ALN scorers may have experienced difficulties in the mother-

infant bond, leading to an incomplete integration of part objects. Furthermore, there is most likely an ego-boundary disturbance in these individuals, as suggested by an inability to perceive others as distinct and separate from the self.

Insecure Attachment (IA) is the second subscale. It taps into issues related to the painfulness of interpersonal relationships. Individuals who score high on this subscale tend to be highly sensitive to rejection and easily hurt by others. They may seek out interpersonal relationships out of a desperate desire for closeness, and they have a low tolerance for any type of separation, loss, or loneliness. Feelings of worry, guilt, anxiety, and jealousy may lead to maladaptive patterns of sadomasochistic interactions in relationships. These individuals need frequent reassurances from others of their love, all the while remaining vigilant for signs of potential abandonment. Relationships are entered into out of an intensely painful quest for a sense of security. Others are experienced as extensions of the self. High scores have been found in the non-psychiatric samples, and tend to be individuals with avoidant, dependent, or compulsive personality disorders.

The object relations suggested by this subscale are at a somewhat higher level than those of ALN. Although there is a more integrated sense of internalized object representations, there is still an inability to sustain a sense of connectedness to the object in its absence.

Mutuality and autonomy in relationships are avoided, out of fear of relational loss.

Items with a high loading on the Egocentricity (EGC) scale point to three basic attitudes towards relationships: a mistrust of others' motivations, a belief that others exist only in relation to oneself, and a sense that others are to be manipulated for one's own self-centered aims. People who score high on these items tend to be self-protective and exploitative, and are intrusive, coercive, and demanding. They alternate between viewing themselves as omnipotent and on top of the world, or as powerless and under the control of an indomitable force. Elevations on this subscale were found most frequently in those with narcissistic, histrionic, and antisocial personality disorders.

The highest loading of items comprising the Social Incompetence (SI) scale indicates shyness, nervousness, and a sense of uncertainty about how to interact with members of the opposite sex. Additional items portray great difficulty making friends, a sense of social insecurity, an absence of close relationships, and unsatisfactory sexual adjustment. Relationships, particularly with the opposite sex, are bewildering and unpredictable. On the whole, the self is experienced as separated from human society by an unbridgeable gulf of confusion and terror. Elevations on this scale are most frequently found in psychotic populations.

The Erwin Identity Scale (EIS)

The Erwin Identity Scale (EIS; Erwin & Delworth, 1980) was used to assess students' level of identity. The EIS measures three dimensions of a student's self-image. These three dimensions include (1) confidence, (2) sexual identity, and (3) conceptions about body and appearance. Each respectively has Cronbach's alpha reliability estimates of .90, .74, and .81 (Erwin & Schmidt, 1981). The instrument is also reported to have good construct and predictive validity (Erwin, 1977).

The first derived subscale, Confidence, is composed of items that assess one's assuredness in one's self and capabilities. Confidence is described as a conscious self-reliance while recognizing the necessary dependence on outside sources. This recognition is an awareness and faith in one's own capabilities yet a realization that there are limits.

Sexual Identity is the second subscale. The Sexual Identity Scale attempts to measure the clarification, understanding, and acceptance of one's sexual feelings. The person with a high degree of sexual identity recognizes his or her feelings as natural and normal. There is an absence of guilt because of their presence. Sexual identity includes not only a positive acceptance of one's sexual feelings but also a control of one's sexual feelings.

Conceptions about Body and Appearance is the third subscale. Identity is an accurate self-perception and

acceptance of one's body and one's appearance. It is an issue of presentation of self. Increasing acceptance of one's body, particularly in relation to other people, is a necessary component. One's appearance and dress are resolved issues representing a balancing of personal preferences, the desires of others, and situational expectations.

To help establish construct validity the scales of Lack of Anxiety (LA) and Personal Integration (PI) from the Omnibus Personality Inventory (OPI) were administered in conjunction with the EIS. The interscale correlations between the subscales of the EIS and the scales of the OPI ranged from .41 to .81. In longitudinal studies, the EIS was found to be sensitive to changes in awareness and acceptance of one's self.

Null Hypotheses

The following null hypotheses were tested:

Hypothesis 1. There is no correlation between the severity of subject's bulimic symptoms as measured by the Bulimia Test-Revised, and the severity of impairment in a subject's object relations as measured by the Bell Object Relations Inventory.

Hypothesis 2. There is no correlation between the severity of a subject's bulimic symptoms as assessed by the Bulimia Test-Revised and the severity of a subject's identity impairment as assessed by the Erwin Identity Scales.

Hypothesis 3. There is no correlation between the severity of a subject's object relations as assessed by the Bell Object Relations Inventory and the severity of a subject's identity impairment as assessed by the Erwin Identity Scale.

Treatment and Analysis of Data

Each subject's scores for the three instruments were determined. The three tests included: Bulimia Test-Revised, Bell Object Relations Inventory, and Erwin Identity Scale. The score from the Bulimia Test-Revised identified individuals with a severe eating disorder. The scores for the Bell Object Relations Inventory as well as the Erwin Identity Scale were calculated. Then, regression analysis was performed to test the research hypotheses.

Qualitative Analysis

An individual case analysis was performed on twelve cases with varying degrees of bulimia. This study involved investigating themes consisting of multiple variables of potential importance. By investigating the individual experience of each subject it was hoped to enrich the understanding of the dynamics underlying bulimic women. Of particular interest was the bulimic woman's experience of significant relationships.

Procedure

There were a total of eleven questions developed for

the qualitative interview. These questions were developed and reviewed by the writer. They were rewritten and redeveloped and finally cross-examined by an independent reviewer in the field who was experienced with object relations therapy as well as eating disorders. An individual interview was scheduled with each subject within 4 months of the completed tests. The interviews were conducted in the primary therapist's office.

During the interview the following questions were asked verbatim:

1. How do you imagine your life would be if you were very thin?
2. What would it be like to be 50 pounds heavier?
3. How do you cope with strong feelings like loneliness, anger, or sadness?
4. What feelings or events might contribute to a binge? Tell me how you feel after you purge?
5. How would you describe your mother's personality?
6. How would your mother describe your personality?
7. What were mealtimes like in your family?
8. What comments did your family make about your body as you were growing up?
9. What comments did your family make about eating and weight gain as you were growing up?
10. What do you think your parents' expectations were for you?

11. What are you aware of going on emotionally when you are overwhelmed with feeling fat?

The data gathered from the questions were written verbatim during the interview. The interviews were tape-recorded with an audiocassette tape recorder. Communications tools used to gather data were probes, prompts, reflections, paraphrases, and clarifications. No leading questions or interpretations were made. Direct observations regarding nonverbal and emotional presentations were recorded in writing.

Analysis

When the data were collected an inductive analysis was made for each case. The analysis involved a three-step process including: (1) developing domains of topic areas by grouping information and coding the domains, (2) abstracting and summarizing the core ideas of the raw data from each domain, and (3) developing categories to describe consistencies across cases (case analysis). Finally, an analysis was performed on variations within the total sample to assess any variation that resulted from additional perspective-taking training.

The variations in the patterns or categories developed between the groups were integrated into the findings in this study. The patterns identified were compared with the three hypotheses to evaluate whether they provide a better understanding of the results. Other findings that were not related to the hypotheses were also discussed.

Procedures for Qualitative Analysis

This section provides a detailed description of the procedures used in the qualitative analysis. Hill, Thompson, and Williams (1997) and Merriam (1988) provide an excellent discussion of the qualitative methods used in this research. This research was done with the help of a colleague who is a doctoral-level therapist with more than 10 years experience with the general population. After all the data were collected and transcribed word for word, the following procedure was utilized:

Step 1. This step involved organizing all the raw data from the interviews into topic areas or *domains*. Domains are used to cluster information about the area that the researcher wants to explore. Domains were developed by reading the interview several times and making intuitive hunches about the consistencies and inconsistencies in the data. A second way domains were developed is based upon theory and the focus of this research. It should be noted that many domains were changed and reworked because they did not fit the data.

For example, in this research study, a Domain of Identity Disturbance was considered because of the bulimic woman's tendency to consider other people's expectations rather than staying true to her own expectations. The interview data did not support this topic so it was deleted as a domain. New domains were also added to accommodate unexpected data. For example, after reading the data

several times it was noted that there was a tendency for subjects to talk about their need for their father's approval. Therefore, an additional domain was developed to cluster information about the need for paternal approval. As a rule, all of the data from the interviews were placed in a domain. If the data did not fit a domain, they were placed in an "other" domain for further analysis and consideration. During Step 1, both researchers engaged in dialogue to clarify and explore different ideas for domains.

Step 2. Step 2 involved *coding* the data. This involved reading the transcript for each case and assigning each block of data into a domain. A block of data could be a phrase or several sentences. The two researchers independently coded the data. A number was assigned to each domain, and was placed next to the relevant section of the transcript. Once a transcript was coded independently, the researchers came together to review the *coding*. The overall goal was to arrive at a consensus decision about the most appropriate domain for the data. At this point some names of domains were changed to better fit the raw data. For example, a domain labeled "Object Relations" was changed to "Significant Relationships," which was more comprehensive of the raw data. Step 2 ended when a consensus was reached on all coding of the data.

Step 3. Step 3 involved summarizing the content of each domain into core ideas. The core ideas were carefully

summarized into *abstracts*. The abstracts for each domain were first written independently, by the two researchers. Once they were developed independently the researchers came together to develop a consensus among all the abstracts for each domain.

Step 4. Up to this point the researchers examined the data in individual cases only. Now a *cross analysis* of all the cases in both groups was made to determine similarity and differences in the core ideas or abstracts. The researchers took all the core ideas from each domain across cases and copied them onto a new sheet of paper. They were then examined and analyzed independently by each researcher to determine how these core ideas clustered into *categories*. A category described a consistency, or pattern, in the core ideas of each domain. After each researcher had completed this process independently, they came together to discuss the ideas and reach a consensus concerning the categories of each domain. A consensus was also reached for the names of each category.

Step 5. At this point the researchers had spent a significant amount of time developing domains and developing core ideas. There were many changes in domains and categories when the data were analyzed. During this step researchers carefully reviewed the data to ensure that the domains and categories accurately reflected the data.

Step 6. During Step 6 it was determined how frequently the categories applied to all 12 subjects.

A category that applied to over 80% (10-12) of the cases was *general*. If the category applied to 51 to 80% (6-9) of the cases it was considered *typical*, and a category that applied to 25 to 50% (3-5) was considered *variant*. All categories below 25% were deleted because they were not considered descriptive of the samples. Rather than delete categories that did not apply to the total samples, these categories were written down to see if they could be broadened so as not to lose critical data. For example, during the analysis it was noted that many subjects were able to identify behaviors that involved avoiding interaction with others. There were other subjects that utilized isolation behaviors. Both of these behaviors related to defenses used to handle or manage difficult situations. Rather than lose these data, we combined the categories to call it "Utilization of isolation and avoidance strategies" because it was descriptive of avoidant behavior.

Step 7. By this time, all categories had been developed for the 12 subjects and placed in a *general*, *typical*, or *variant* classification. Now the researchers analyzed the Low Bulimic Group and the High Bulimic Group independently to identify if there were any changes in the classification of the categories. The researchers looked at each of the categories developed from the total group samples analysis, and analyzed how they applied to each group independently. For example, during the Total Samples

Analysis, a category was identified called "Utilization of eating as a defense to maintain control." This category, or pattern, was identified in 9 out of 12 cases creating a *typical* classification. When this category was analyzed independently for the High Bulimic Group, there were 5 out of 6 subjects in this category creating a *general* classification. When the Low Bulimic Group was analyzed independently for this category, 4 out of 6 subjects were identified, creating a *typical* classification. Therefore, independent analysis between the High Bulimic Group and the Low Bulimic Group revealed some differences in this category. The High Bulimic Group revealed a stronger pattern of using their eating behaviors to maintain a sense of control (5 out of 6 subjects) as compared to the Low Bulimic Group (4 out of 6 subjects).

CHAPTER IV

PRESENTATION AND ANALYSIS OF DATA

This chapter presents the data and analysis and is divided into three main sections. The first section includes a description of the group sample, providing data on age, educational level, and race. The second section provides the results of testing all three hypotheses. The last section summarizes the research findings.

Description of the Sample

The total population studied was 30 women living in the Southwestern Michigan and Northern Indiana area, currently undergoing therapy for treatment of bulimia. These women were diagnosed with bulimia nervosa according to *DSM-IV* criteria. Subjects were from 18 to 58 years of age. Of the 30 subjects, 27 were White, 2 were Black, and 1 was Hispanic. Of the 30 subjects a subgroup of 12 individuals was used for the qualitative interview. A description of ages and education of the group is provided in Table 1.

Table 1

Group Description for the 30 Subjects

	Age	Education
Mean	32.2	14.4
SD	10.6	2.2
Median	28	14
Range	18-58	12-18

Testing of the Hypotheses

All three hypotheses were tested at a 0.05 level of significance. Each analysis of the three hypotheses is shown separately. First, the group statistics (Table 2) of the scores for all 30 subjects are presented. Then, the correlations between the tests are shown. The *p*-value corresponding to the significance of the independent variables is examined. The first two hypotheses were tested using least-squares linear regression. The influence of the potential outliers is examined. Finally, the third hypothesis was tested using a canonical correlation analysis.

The Pearson correlations between the BULIT-R and the subscales of the Erwin Identity Scale and the Bell Object Relations Inventory are shown in Table 3. As shown, below there was no statistically significant correlation between BULIT-R and either Body and Appearance or Social Incompetence.

Table 2

Group Description of the Test Instruments Results for the 30 Subjects

Test Instrument	Minimum	Maximum	Mean	SD
BULIT-R	61	140	107.40	20.00
Body & Appearance	22	67	43.23	9.66
Confidence	37	97	65.83	18.65
Sexual Identity	27	80	48.33	12.46
Alienation	42	80	63.17	10.39
Egocentricity	30	77	56.20	10.01
Insecure Attachment	39	80	61.23	9.68
Social Incompetence	37	78	59.30	9.31

Table 3

Correlation Between BULIT-R and Bell Object Relations Inventory and Erwin Identity Scale for the 30 Subjects

Test Instrument	Pearson Correlation	p-value
BULIT-R vs. Alienation	0.479	0.007
BULIT-R vs. Egocentricity	0.415	0.023
BULIT-R vs. Insecure Attachment	0.414	0.023
BULIT-R vs. Social Incompetence	0.295	0.113
BULIT-R vs. Confidence	-0.537	0.002
BULIT-R vs. Sexual Identity	-0.454	0.012
BULIT-R vs. Body and Appearance	-0.312	0.093

The intercorrelations between the Erwin Identity Scale and Bell Object Relations Inventory are shown in Table 4.

Table 4

Pearson Correlation Analysis of Subscales of Erwin Identity Scale and Bell Object Relations Inventory

	Alienation	Egocentricity	Insecure Attachment	Social Incompetence
Confidence	-0.814 0.000	-0.620 0.000	-0.696 0.000	-0.679 0.000
Sexual Identity	-0.671 0.000	-0.564 0.001	-0.524 0.003	-0.450 0.013
Body and Appearance	-0.433 0.017	-0.341 0.065	-0.485 0.007	-0.370 0.044

Note. All Pearson Correlation values are shown with their corresponding probabilities (2-tailed).

Hypothesis 1

Hypothesis 1. There is no correlation between the severity of subject's bulimic symptoms as measured by the Bulimia Test-Revised and the severity of impairment in a subject's object relations as measured by the Bell Object Relations Inventory.

The null hypothesis was rejected. A least-squares linear regression, using a stepwise process, is shown in Table 5. Alienation was the only independent variable that was statistically significant ($p = .007$). However, due to the high degree of multicollinearity, it was not possible to separate the effects of the independent variables. The intercorrelations among the four subscales of the Bell

Table 5

Regression Analysis of BULIT-R Versus Alienation for the 30 Subjects

The regression equation was

$$\text{Bulimia} = 48.4 + 0.935 \cdot \text{Alienation}$$

Predictor	Coefficient	SD	T	p
Constant	48.36	20.40	2.37	0.025
Alienation	0.9351	0.3190	2.93	0.007
<i>S</i> = 17.81		R-square = 23.5%		R-square (adj.) = 20.7%

ANOVA

Source	DF	SS	MS	F	p
Regression	1	2724.4	2724.4	8.59	0.007
Residual Error	28	8878.8	317.1		
Total	29	11603.2			

Object Relations Inventory ranged from 0.384 to 0.645.

The relatively low *R*-square (23.5%) was of some concern. The scatter plot and fitted regression for BULIT-R versus Alienation is shown in Figure 1.

Subject 9 (circled point in Figure 1) was noted to have an influence on the least-squares fit. By removing this observation (Cook, 1977), *R*-square increased from 23.5% to 36.4% (Figure 2). To preserve the integrity of this analysis, Subject 9 was not removed from the model. However, the influence on *R*-square and some possible explanations for the outlier tendencies are discussed in chapter 6.

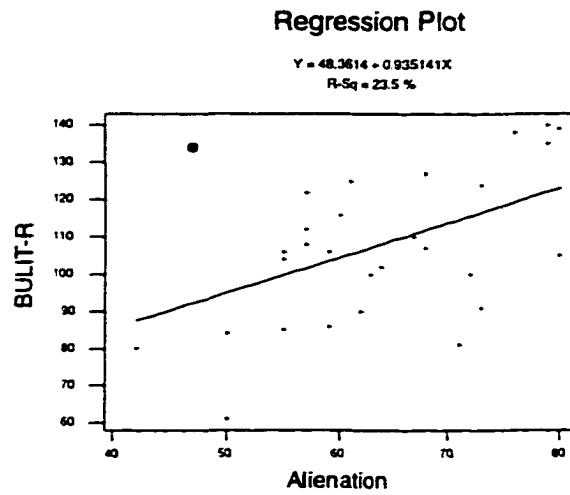


Figure 1. Scatter plot of BULIT-R and Alienation.

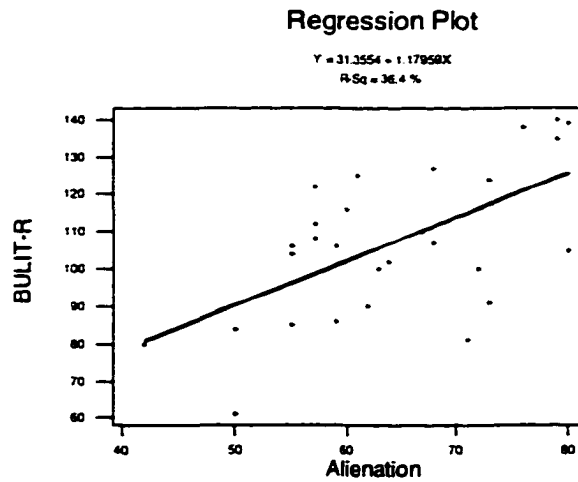


Figure 2. Revised Scatter plot of BULIT-R and Alienation.

The residuals were tested for normality. The results indicated that the residuals were normally distributed.

Hypothesis 2

Hypothesis 2. There is no correlation between the severity of a subject's bulimic symptoms as assessed by the Bulimia Test-Revised and the severity of a subject's identity impairment as assessed by the Erwin Identity Scale.

The null hypothesis was rejected. Least-squares linear regression, using a stepwise selection process, is shown in Table 6. Confidence was the only independent variable that was statistically significant ($p = .002$). However, due to the high degree of multicollinearity, it was not possible to separate the effects of the independent variables. The intercorrelations among the four subscales of the Erwin Identity scale ranged from 0.384 to 0.693.

A scatter plot with a fitted regression line is included for BULIT-R versus Confidence (Figure 3). The R-square was 28.9%. Subjects 9 and 15 (circled points in Figure 3) were determined to have an influence on the least-squares fit. By removing outliers 9 and 15 (Cook, 1977), the R-square increased from 28.9% to 54.8% (Figure 4). To preserve the integrity of this analysis, subjects 9 and 15 were not removed from the model. Their influence on R-square and possible explanations for their outlier tendencies are discussed in chapter 6.

Table 6

Regression Analysis of BULIT-R Versus Confidence for the 30 Subjects

The regression equation was

$$\text{Bulimia} = 145 - 0.576 \cdot \text{Confidence}$$

Predictor	Coefficient	SD	T	p
Constant	145.33	11.68	12.44	0.000
Confidence	-0.5761	0.1709	-3.37	0.002

$S = 17.17$ $R\text{-square} = 28.9\%$ $R\text{-square (adj.)} = 26.3\%$

ANOVA

Source	DF	SS	MS	F	p
Regression	1	3348.4	3348.4	11.36	0.002
Residual Error	28	8254.8	294.8		
Total	29	11603.2			

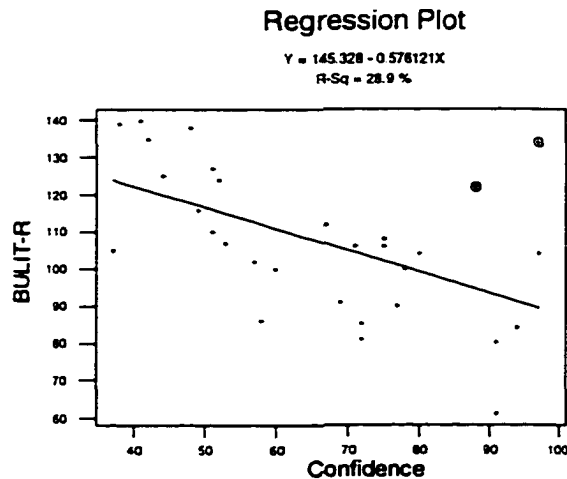
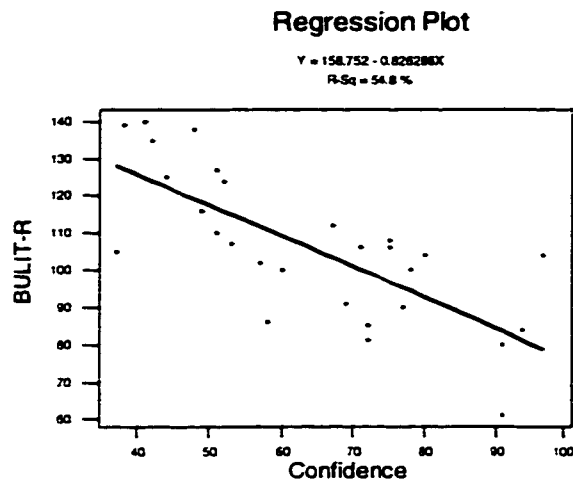


Figure 3. Scatter plot of BULIT-R and Confidence.



correlation analysis is found on Table 7. Correlations between the variables and the canonical variate, standardized canonical variate coefficients, within-set variance accounted for by the canonical variates (percent of variance), redundancies, and canonical correlation are shown.

With all three canonical correlations included, $F_{(12,61)} = 4.33$, $p = 0.0001$. With the first canonical correlation removed, the F ratio was not significant. Therefore, only the first pair of canonical variate was interpreted.

The first canonical correlation was 0.887, representing 89% overlapping variance for the first and only significant pair of canonical variates. With a cutoff correlation of 0.3 (Tabachnick and Fidell, 1996), this pair of variate has interpretable loadings on Confidence (-0.99), Sexual Identity (-0.78) and Body and Appearance (-0.57) of the Identity set and Alienation (0.93), Insecure Attachment (0.79), Egocentricity (0.72), and Social Incompetence (0.76) of the Object Relations set. This result suggests that those who were low in Confidence, Body and Appearance and Sexual Identity appear to be high in Alienation, Insecure Attachment, Egocentricity, and Social Incompetence. The percent of variance suggested that the canonical variate pair extracts about 64% of variance from the Identity set and 64% of variance from the Object

Table 7

Canonical Correlation Analysis of Identity Disturbance and Object Relations Tests

Canonical Correlation	Eigenvalue	Approx. <i>F</i>	Num <i>DF</i>	Den <i>DF</i>	Pr > <i>F</i>	
1	0.887	0.790	4.33	12	61	0.0001
2	0.244	0.059	0.33	6	48	0.9200
3	0.142	0.020	0.26	2	25	0.7800

Variables	First Canonical Variate	
	Correlations	Coefficient
Erwin Identity Scale		
Confidence	-0.99	-0.85
Sexual Identity	-0.78	-0.17
Body and Appearance	-0.57	-0.05
Percent of Variance	63.79	
Redundancy	50.17	
Bell Object Relations Inventory		
Alienation	0.93	0.48
Insecure Attachment	0.79	0.32
Egocentricity	0.72	0.14
Social Incompetence	0.76	0.27
Percent of Variance	64.50	
Redundancy	50.73	
Canonical Correlation	0.89	

Relations set. The redundancy analysis showed that the Object Relations variate accounted for 50% of the variance in the Identity variables while the Identity variate accounted for 50% of the Object Relations variables. Given the percent of variance and the redundancy, it was quite clear that the two sets of variables were quite highly related.

Summary of Results

Three hypotheses were tested for statistical significance. Hypothesis 1 involved testing the severity of a subject's bulimic symptoms and the severity of impairment in a subject's object relations. Hypothesis 2 involved testing severity of a subject's bulimic symptoms and the severity of a subject's identity impairment, and Hypothesis 3 involved testing the linear relationship of object relations and identity impairment. The first two hypotheses were tested using Stepwise Regression Analysis while the third was tested using Canonical Correlations Analysis. All three hypotheses were tested at the 0.05 level of significance.

Null Hypothesis 1 was rejected. Alienation was a significant predictor of one's severity of bulimia accounting for 24% of the variance. Null Hypothesis 2 was also rejected. Confidence was a significant predictor of the severity of bulimia, accounting for 29% of the variance. Null Hypotheses 3 was also rejected. There was a significant linear relationship between Object Relations and Identity Impairment. More severe Object Relations appeared to be related to higher levels of Identity impairment.

CHAPTER V

QUALITATIVE ANALYSIS

This chapter presents the qualitative analysis and is divided into three main sections. The first section includes a presentation of each individual case analysis. Each case includes a brief history of the subject. Ten out of 12 subjects did not appear to be overweight. The subjects are presented in order of their BULIT-R scores from lowest to highest. Each Domain is presented with an Abstract that summarizes the core ideas and content of the Domain. Raw data taken from excerpts of the post-session interview are presented to illustrate the Domain. The second section includes a cross analysis of all the core ideas for each Domain, which are placed into categories. Finally, the third section provides an analysis of how frequently the categories apply to each of the two samples. The Domains selected to organize the data in the research went through several changes and redefinitions. The final Domains remaining to organize the data include: (1) Bulimic symptoms, (2) Object Relations, (3) Identity Issues, and (4) Utilization of Defenses.

Individual Case Analysis

Subject 1

Subject 1 was an 18-year-old White woman who had been involved in therapy intermittently for the last 4 years. She had bulimia for the last 2 years, brought on by her parents' divorce.

Subject 1 completed the three tests described in chapter 4. Table 8 provides the scores on the tests administered to Subject 1.

Table 8

Scores on Bulimia Test-Revised, Erwin Identity Scale, and Bell Object Relations Inventory for Subject 1

Test	Score	Mean Score for all 30 Subjects
BULIT-R (Bulimia Test-Revised)	61	107.40
EIS (Erwin Identity Scale)		
Confidence	91	65.83
Sexual Identity	67	48.33
Body and Appearance	47	43.23
BORI (Bell Objects Relations Inventory)		
Alienation	50	63.17
Insecure Attachment	53	61.23
Egocentricity	37	56.20
Social Incompetence	56	59.30

The section below provides Domains 1 through 4 for Subject 1. Each Domain is presented with an Abstract that summarizes the core ideas and content of the Domain. Raw data are taken from excerpts of the interview to provide an illustration of the Domain.

Domain 1: Bulimic Symptoms.

Abstract: Utilized eating to feel in control. Subject felt relief from purging.

Interview Excerpt: When asked what might contribute to a binge, subject stated, "When I would binge I felt so much more in control--like I didn't have to worry. It's like nothing else mattered at the point--all the stuff I've been through. I'm not sure what really triggered it--except problems with my boyfriend." When asked how she felt after she purged, subject stated, "After I purge there was immediate relief."

Domain 2: Significant Relationships.

Abstract: Perceives father as harsh and critical; mother perceived as a friend, very close, critical, intrusive. Reports strong desire for paternal acceptance.

Interview Excerpt: When talking about her family, subject stated, "My father is sometimes so demanding and critical . . . he yells . . . so unreasonable . . . mean and very rigid." Her statements about her mother included the following: "We're very close--we love each other . . . she's like a friend." She also stated, "Mother can be overly critical too--sometimes too close." When talking about

father, she stated, "I wish he would just love me for who I was."

Domain 3: Identity Issues.

Abstract: Subject would feel great if thin. Perceived self as fat and repulsive, an individual with no discipline.

Interview Excerpt: When asked what it would be like to be very thin, subject stated, "If I was thinner it would be great--more guys would be available. Fat is ugly--I want to run--punish myself."

When asked what it would be like to be 50 pounds heavier, she stated, "Fat people repulse me--no discipline. If I feel skinny - it's like I have more confidence . . . more able to socialize--get out--you know."

Domain 4: Utilization of Defense.

Abstract: Reported tendency to suppress and stuff feelings. Has lack of assertiveness. Perceives herself same as mother. Subject recognizes avoidance of worry about food intake.

Interview Excerpt: When asked how she copes with strong feelings, subject stated, "I don't assert myself--I hold it in. That's half my problem, letting things build up. It gets so hard." She stated, "It's stuffing--the stuff we are talking about--that's me all the time. I catch myself stuffing now--it's so natural and easier at that time. My mother was the same way--we are like the same." She stated, "It helps me escape--avoid any worry-[talking

about boyfriend] like it's so hard. I want the relationship so badly, and he doesn't call."

Subject 2

Subject 2 was a 30-year-old White woman who had been involved in therapy intermittently for most of her adolescent and adult years. She had struggled with anorexia as a teenager. She had been struggling intermittently with bulimia for the past 7 years. She had currently been in therapy for approximately 2 years for marital issues.

Subject 2 completed the three tests described in chapter 4. Table 9 provides the scores on the tests administered to Subject 2. The section below provides Domains 1 through 4 for Subject 2. Each Domain is presented with an Abstract that summarizes the core ideas and content of the Domain. Raw data are taken from excerpts of the post-session interview to provide an illustration of the Domain.

Domain 1: Bulimic Symptoms.

Abstract: Being heavy meant she was weak, undesirable, and had little control over herself.

Interview Excerpt: When asked what it would be like to be heavy, subject stated, "I felt it said I was weak and that I wasn't desirable and that I didn't have any control over myself."

Table 9

Scores on Bulimia Test-Revised, Erwin Identity Scale, and Bell Object Relations Inventory for Subject 2

Test	Score	Mean Score for all 30 Subjects
BULIT-R (Bulimia Test-Revised)	84	107.40
EIS (Erwin Identity Scale)		
Confidence	94	65.83
Sexual Identity	56	48.33
Body and Appearance	34	43.23
BORI (Bell Objects Relations Inventory)		
Alienation	50	63.17
Insecure Attachment	57	61.23
Egocentricity	64	56.20
Social Incompetence	53	59.30

Domain 2: Significant Relationships.

Abstract: Mother perceived as controlling, taking on too much, and taking the martyr role in family. Mother not there when subject was 10-14 years old; subject perceives mother liking her for her looks and not person. Mother controlled eating routine, demanding good manners with limited conversation. Father is alcoholic and made negative references to subject's eating patterns. Father perceived as withholding and only giving compliments when she was thin. Parents pushed her to be traditional, have

children, get married. Felt an unspoken message to take on mother's role.

Interview Excerpt: When asked how she would describe her mother, subject stated, "Mother is a control freak. She takes on too much, doesn't like herself, doesn't take care of herself, beats herself up. We call her the martyr. I had no say in anything." She also stated, "She would take me clothes shopping and if I didn't like what she'd pick off the rack she'd get mad and say 'Fine, just forget it'. And she'd stomp out of the store and I wouldn't get anything at all. And then she'd start buying me things without me being there. When asked how her mother would describe her, subject stated, "I felt like she was saying she liked how I looked but she didn't like me as a person." Later in the interview she added, "There was a long while in there where I felt she just didn't even know I was alive between the ages of 10 and 14."

When asked what were meal times like growing up, subject stated, "My dad was an alcoholic. Often he wasn't home. Mom was angry a lot of the time. I wasn't allowed to eat unless she said I could. I was not allowed to have bad manners or get up from the table or talk."

When asked what comments family members made about eating or weight gain, subject stated, "He [father] comments on what time I eat, or how much I'm eating or "you're going to be as big as a house." My mom says that too. When asked what expectations her parents had for her, subject stated,

"I think in a lot of ways I'm supposed to take on my mother's role. I was the one who was supposed to have a lot of kids and stay at home. So in many ways I think she projects things on me. What she wanted to have she wanted me to do."

Domain 3: Identity Issues.

Abstract: Subject used to think that if she were thinner she'd have more power, she'd be perfect, and everything else would be perfect. When she became heavier it felt like she lost her power, she was weak, undesirable, and she didn't have any control over herself."

Interview Excerpt: When asked what it would be like to be very thin, subject stated, "If I were thinner I'd have more power. More kind of like I was perfect. So I mean I felt like if my body was perfect than everything else would have been perfect. So in a way I felt like that was the key. I felt like every single flaw about me was visible. Whether it was or not just the physical thing but my personality flaw or any other flaw I might have was visible. I didn't feel like I had that power anymore so I didn't feel like I was important. I was embarrassed as to how big I was."

When asked what it would be like if she were 50 pounds heavier, she stated, "I felt like it said I was weak and that I wasn't desirable and that I didn't have any control over myself."

Domain 4: Utilization of Defenses.

Abstract: Equates thin with being perfect, not having any physical or emotional flaws. When coping with strong feelings, she would eat a lot because it would fill up a space or give her a high. When she felt fat, she felt insecure and inadequate. After purging, there is a letdown of feelings, sadness. Felt a loss of control and was purging because she was not happy with herself or her weight. And the evidence was there on her body.

Interview Excerpt: When asked what it would be like to be thin, subject stated, "Being thin means more power." She also stated: Being thin equals happiness . . . not having to worry about being fat or ugly, not having to worry about other people seeing my flaws. So it took away a lot of that for a while. But then, it kind of, the table turned and then it was like I think it was like that for a while and then after I got used to being thin I realized that stuff wasn't taken away.

When asked what it would be like if she were heavier, subject stated, "When heavier I felt like every single flaw about me was visible. Whether it was not just the physical thing but my personality flaws or any other flaw I might have was visible. I didn't feel like I had that power anymore so I didn't feel like I was important. I felt like it said I was weak and that I wasn't desirable and that I didn't have any control over myself."

When asked how she would cope with strong feelings, subject stated, "When coping with strong feelings . . . I'd eat a lot. It was kind of like I felt like eating because it would fill a space or give me a high."

When asked how she felt after she purged, subject responded, "It was kind of like it relieved pressure. Feeling that depression after I binged and purged it was like I lost control or I was obviously purging because I wasn't happy with myself or my weight. And if it was bad to me it was like the evidence was there on my body and so I would do that."

Subject 3

Subject 3 was a 27-year-old, White, married woman. She had been in treatment for 3 years. She continued to place a great emphasis on appearance. Currently she was approximately 20 pounds below her ideal weight. Her stepfather was alcoholic and abusive. She was currently experiencing marital problems.

Subject 3 completed the three tests described in chapter 4. Table 10 provides the scores on the tests administered to Subject 3.

The section below provides Domains 1 through 4 for Subject 3. Each Domain is presented with an Abstract that summarizes the core ideas and content of the Domain.

Table 10

Scores on Bulimia Test-Revised, Erwin Identity Scale, and Bell Object Relations Inventory for Subject 3

Test	Score	Mean Score for all 30 Subjects
BULIT-R (Bulimia Test-Revised)	86	107.40
EIS (Erwin Identity Scale)		
Confidence	58	65.83
Sexual Identity	44	48.33
Body and Appearance	35	43.23
BORI (Bell Objects Relations Inventory)		
Alienation	59	63.17
Insecure Attachment	67	61.23
Egocentricity	55	56.20
Social Incompetence	56	59.30

Raw data are taken from excerpts of the interview to provide an illustration of the Domain.

Domain 1: Bulimic Symptoms.

Abstract: Subject felt father was controlling. She would control her weight because that was something he could not control.

Interview Excerpt: When asked about her wanting to be thinner, she stated, "I just thought my dad was very controlling and I thought if I could control my weight that was something he couldn't take away from me and people try."

Domain 2: Significant Relationships.

Abstract: Dad was controlling and alcoholic. Mom was fragile, weak, did not express an opinion or advocate for the children; was dominated by father. Subject acted as mother's "parent". Father gave contrary messages and derogatory messages relating to eating too much and eating too little. Subject was passive toward father, had a strong need for approval and very sensitive to his anger; feeling she could never meet up to his expectations. Mother views her as strong because subject was strong for mother. Indicates when it comes to protecting herself she is weak. Subject kept her feelings bottled up.

Interview Excerpt: When talking about her eating behaviors as a child, subject stated, "I couldn't voice my opinion to my father. It was 'Shut up I don't want to hear it.' He was an alcoholic and he was still trying to control me and wasn't happy with anything I was trying to do." She added, "If I would eat something I had a tendency to, when I would get depressed cause that was my comfort, and when I would eat he would puff out his cheeks and say 'Now you're going to start looking like Miss Piggy' or whatever."

When asked to describe her mother, subject stated, "Growing up, when I was in high school, I felt like I had to protect my mom. She was so weak and so fragile. Fragile is a better word. Everything and anything anybody says hurts her and it makes me angry and it hurts me. And, I just felt like I had to push some things. I guess maybe that's why my

dad and I clash so much because I hated the way he treated her and I would rather him take it out on me."

When asked how mother would describe her, she stated, "I think she thinks I'm strong because I've always been strong with her. But in a way, I'm weak. When it comes to protecting myself, defending myself in the way that I feel, I'm very weak."

Domain 3: Identity Issues.

Abstract: If she were overweight there would be embarrassment and self-hatred because she wasn't in control. Often compares herself to others' weight to get affirmation of self-worth.

Interview Excerpt: When asked what it would be like to be very thin, subject responded, "Bright, bright sunshine, and I don't know sunshine and rainbows. When I got down and my lowest weight was 108 and when I was there it was like I was floating. It was like I was so light, I just floated. I felt like, I don't know, it was a nice light feeling, like on a cloud." When asked what it would be like if she were heavy, subject responded, "I don't know if it would just be the embarrassment or just the self-hatred more than anything that I was not in control of my weight anymore."

Subject began to talk about her father's attitude toward women's appearance. She stated, "It made me want to be and struggle that much harder to be the perfect weight, the perfect size, the perfect shape because I just grew up thinking how all men are and if I didn't look like these

women on TV and if I didn't look like what my dad thought women were supposed to look like. If I grew up looking like my mom it wasn't good enough because I didn't want to get married to someone whose gonna look at other women the way my dad does."

Domain 4: Utilization of Defenses.

Abstract: Uses weight as a measure of her feelings of happiness. Subject kept her feelings bottled up. Displaces her emotional problems onto food. When she is really upset about something she eats as a way of not thinking about her problems. When she purges, her emotional problems go away.

Interview Excerpt: When talking about her desire to be thinner, subject stated, "I didn't have a grip on my depression. I think I thought, now looking back on it, controlling my weight was controlling my depression. If I were thinner I was less depressed but it wasn't just my weight and I know that now." She later stated, "But, I was afraid to open my mouth with my dad. And so I would keep it all bottled." She added, "When my feelings eat at me I try to deal with it with my eating. If I don't eat and I feel hungry, I'll feel better. I don't know why. I wonder, I'm concentrating on something else. I'm not thinking about the problem at hand, it's something to think about."

When asked how she felt after she purges, subject responded, "After I purge I feel empty. Not just physically empty. I think, it's like, I throw up the food, now all my problems go with it. You know, kind of like eating a lot."

I'm just wallowing in all my troubles. When I'm really upset about something and I eat and eat and I just don't want to think about it. Then I feel bad because I ate so much and it all comes up . . . all the problems are down the toilet. I feel better."

Subject 4

Subject 4 was a 27-year-old White, single female. She had been actively bulimic for the past 9 years. She had been through several treatment programs. She had been in treatment intermittently with the current therapist for the past 5 years. She had recently broken off a relationship and was dealing with her loss.

Subject 4 completed the three tests described in chapter 4. Table 11 provides the scores on the tests administered to Subject 4.

The section below provides Domains 1 through 4 for Subject 4. Each Domain is presented with an Abstract that summarizes the core ideas and content of the Domain. Raw data are taken from excerpts of the interview to provide an illustration of the Domain.

Domain 1: Bulimic Symptoms.

Abstract: What leads to a binge is a sense of not having anything to do versus actually feeling something. Years ago subject was anorexic. Lately she has been more bulimic because she knows she can purge.

Table 11

Scores on Bulimia Test-Revised, Erwin Identity Scale, and Bell Object Relations Inventory for Subject 4

Test	Score	Mean Score for all 30 Subjects
BULIT-R (Bulimia Test-Revised)	100	107.40
EIS (Erwin Identity Scale)		
Confidence	60	65.83
Sexual Identity	49	48.33
Body and Appearance	37	43.23
BORI (Bell Objects Relations Inventory)		
Alienation	72	63.17
Insecure Attachment	59	61.23
Egocentricity	62	56.20
Social Incompetence	68	59.30

Interview Excerpt: When asked what feelings might lead to a binge, subject stated, "What leads to a binge is more of a sense of having nothing to do versus actually feeling something. Years ago, when I was first diagnosed, it was anorexia that went into bulimia. So I just, kind of like, I guess it's been more bulimic because I know I could just throw it up."

Domain 2: Significant Relationships.

Abstract: Subject is scared to tell mother about her eating disorder because she fears she may be seen as a

failure and disappoint her. Subject angry regarding issue of older sister getting more attention. Perceived covert competition with her older sister. Older sister perceived as emphasizing her lower dress size. Indicates she has disappointed her parents because she dropped out of school and is living with a man.

Interview Excerpt: When asked how she would describe her mother, subject stated, "She's bubbly, happy, caring. I was afraid to tell her about the eating disorder because of her guilt side. I'm scared to tell her about the eating disorder because she would see me as a failure." She later added, "I disappointed her again. I didn't want her to feel she's a bad mother."

When talking about what her parents' expectations were for her, she stated, "I feel like I let my parents down. I feel like I disappointed them but they wouldn't tell me that. I feel like I let them down, dropping out of school twice because of my eating disorder, illegally engaged."

When asked what comments her family made about eating and weight gain as she was growing up, subject responded, "I know once my older sister and I, my sister is 2 years older than I am, it never came like a quote competition but I think it was there. But I don't know whether she felt that way or it was something that I brought on. It bothers me when she says she's wearing a certain size or, you know."

Domain 3: Identity Issues.

Abstract: Subject states when she is thinner she feels more confident, when she's heavier she feels like a cow. Doesn't like meeting people. Strong sense of disappointing parents.

Interview Excerpt: When asked what it would be like if she were thin, she stated, "More confidence, I felt better when I was thinner." When asked what it would be like if she were 50 pounds heavier, she stated, "When I was 50 pounds heavier I felt like a cow."

Domain 4: Utilization of Defenses.

Abstract: Scared to death of other people but likes the attention. Struggles with her strong feelings. Suppresses her feelings rather than have them be acknowledged.

Interview Excerpt: When asked what it would be like to be very thin, subject responded, "Very, very thin. I probably would have more confidence in myself. Definitely. Um, I realized when I was thin, I did have more confidence in myself. But, me being nervous around, I mean, I'm scared to death of other people so it's not all the attention, you know, that I go for. I just, kind of like, I feel better. I felt better when I was thinner."

When asked what she does with strong feelings, subject stated, "Strong feelings . . . I fight and struggle big time. A part of me wants to escape and not worry about it, I think, well, I can just throw up and still do that. But then the flip part of me just says, well, just I just, I

just don't want to do anything. I do my homework or I exercise, or I just feel crazy. I mean, I just I bite my tongue a lot."

When asked if there are any feelings or events that might lead to a binge, subject responded, "I would think it's that part of me that is more, well, bored."

When asked if she was aware of any emotions when she is overwhelmed with feelings of being fat, she stated, "You know, I'm pulling from both sides. I've got one side telling me you're fat, you're ugly, they're laughing. The other side is going, I don't think so. Chill man. And it's sometimes I fall into both sides."

Subject 5

Subject 5 was a 38-year-old White, married female who had been involved intermittently with drugs and alcohol as well as with her eating disorder. She had been in numerous treatment programs. She had been consistently involved with her current therapist for the past year and a half. She had been purging for the past 8 years. She had a history of sexual abuse.

Subject 5 completed the three tests described in chapter 4. Table 12 provides the scores on the tests administered to Subject 5.

The section below provides Domains 1 through 4 for Subject 5. Each Domain is presented with an Abstract that summarizes the core ideas and content of the Domain. Raw

data are taken from excerpts of the interview to provide an illustration of the Domain.

Table 12

Scores on Bulimia Test-Revised, Erwin Identity Scale, and Bell Object Relations Inventory for Subject 5

Test	Score	Mean Score for all 30 Subjects
BULIT-R (Bulimia Test-Revised)	105	107.40
EIS (Erwin Identity Scale)		
Confidence	37	65.83
Sexual Identity	36	48.33
Body and Appearance	37	43.23
BORI (Bell Objects Relations Inventory)		
Alienation	80	63.17
Insecure Attachment	68	61.23
Egocentricity	65	56.20
Social Incompetence	66	59.30

Domain 1: Bulimic Symptoms.

Abstract: Subject relates she does not like people seeing her as fat. Subject states when she is faced with a loss she eats a lot.

Interview Excerpt: When asked about what feelings or events might trigger a binge, the subject responded, "The

death of someone close." When asked about feelings about being thin she stated, "I don't like looking in the mirror and seeing a fat person. I couldn't get thinner--the thinner I got, the thinner I had to get. I don't like people seeing me fat. I don't like feeling fat."

Domain 2: Significant Relationships.

Abstract: Describes mother as contrary, cold, unsupportive, uncaring; views her as emotionally and verbally abusive. Poor communication and fighting in parental marriage. Felt she hurt her father with her acting-out behaviors which causes her guilt and sadness.

Interview Excerpt: When asked about her mother's personality, subject responded, "My mother is very cold, very uncaring, I think. She's never been one to show unconditional love toward her kids. I would say emotionally abusive." When talking about meal times she added, "From what I can remember meal times weren't very good. A lot of tension, a lot of coldness. My mom and dad didn't communicate unless they had to talk about bills or one of the kids or something so it wasn't very pleasant. There was a lot of fighting."

When asked about her relationships with parents, subject responded, "Well my mother was the kind of mother that the child was supposed to be seen and not heard." When asked about feelings she was aware of when feeling overwhelmed, she talked about her father. She stated, "My father was very supportive when I was sick. He stood by me."

So that was a real big loss, he died recently within the last 2 years. And that bothers me a lot still. I feel a lot of guilt about that."

Domain 3: Identity Issues.

Abstract: Felt better about herself when she was thin. States she could not get thin enough. Does not like people seeing her as fat.

Interview Excerpt: When asked what it was like being thin, subject stated, "I felt better about myself but then again the thinner I got, the thinner I had to get." When asked about being heavy, she stated, "It would be horrible. It would be absolutely horrible. I couldn't live with myself, I couldn't do it."

Domain 4: Utilization of Defenses.

Abstract: Tends to isolate and avoid problems. With anger she stuffs her feelings until she blows up. Holds a lot in.

Interview Excerpt: When asked what she does with strong feelings, subject responded, "I like to isolate, um, anger, anger. I pretty much let it, let it keep stuffing and stuffing until it finally blows up." When asked about relationship with mother, she stated, "I tried to avoid her as much as possible. When I was home from school and I was having a tough time with her I isolated a lot. We just didn't see eye to eye. She contradicted everything I said." She later added, "In early high school which is what I remember I wasn't eating very much then. I ate what I had

to just so I could get away from the table."

Subject 6

Subject 6 was a 34-year-old White, single female. She had been in therapy for 7 years. She had been purging for the past 8 years. She had been diagnosed with borderline characteristics. She was sexually abused at the age of 7.

Subject 6 completed the three tests described in chapter 4. Table 13 provides the scores on the tests administered to Subject 6.

Table 13

Scores on Bulimia Test-Revised, Erwin Identity Scale, and Bell Object Relations Inventory for Subject 6

Test	Score	Mean Score for all 30 Subjects
BULIT-R (Bulimia Test-Revised)	112	107.40
EIS (Erwin Identity Scale)		
Confidence	67	65.83
Sexual Identity	46	48.33
Body and Appearance	44	43.23
BORI (Bell Objects Relations Inventory)		
Alienation	57	63.17
Insecure Attachment	53	61.23
Egocentricity	54	56.20
Social Incompetence	63	59.30

The section below provides Domains 1 through 4 for Subject 6. Each Domain is presented with an Abstract that summarizes the core ideas and content of the Domain. Raw data are taken from excerpts of the interview to provide an illustration of the Domain.

Domain 1: Bulimic Symptoms.

Abstract: Subject starts to compare herself to someone who is thinner; she binges as a form of punishment. Subject feels she has no control over her binge. When she is out of control she becomes angrier at herself.

Interview Excerpt: When asked what events lead to a binge, subject responded, "I see somebody that's skinny, and I'll start beating myself up, which I would think I would starve myself, so I could look like them but instead, you know I do the opposite. I binge." She added, "It soothes me when I'm lonely. I have no control over my binge. It's in my mouth and in my stomach before I realize I even ate it. So it's about being out of control and then being angry with myself. That's the eating disorder, I am out of control."

Domain 2: Significant Relationships.

Abstract: Relationship with mother is close but has no depth. No discussion in the family about anything that is emotionally laden. Demeaned and terrorized by brothers who inferred she was fat and ugly. She is angry at mom for not knowing she was sexually abused and putting emphasis on weight and not on sexual incident.

Interview Excerpt: When asked how mother would describe her she stated, "I remember growing up because I have a friend, she is still to this day a twig. I mean, she can eat anything and I remember we were 10 years old we went shopping. Of course, she had a skinny size, you know, pair of jeans and whatever and what I tried on didn't fit and my mom was like, why can't you be like her? That stuff every once in a while pops in my head." When asked to describe their relationship, she stated, "I'm close, I mean, like I went down 2 weeks in December and spent with her and I mean, we had fun shopping and whatever, playing games and watching T.V., um, but as far as actually sitting down and talking about something in depth . . . that doesn't happen. We talk about family, we talk about things that are going on but not anything real serious. I mean, I'd never, I think once I told her I had an eating disorder and she just doesn't get it."

When talking about family comments regarding her appearance, she stated, "My brothers have always told me I was fat. Fat and ugly. Fat and ugly."

When asked what comments family made about weight gain, she stated, "Ten must have like been the natural age because my mom, one night she bought ice cream. Anyway, I obviously got too much in the bowl or something and she said if you eat all of that you're going to get fat. When she said that, it was like major, you know, I must be this big, fat pig. I don't deserve to eat this. I mean that is all

that stuff that I'm doing now." Later in the interview she added, "But when I was 10 and she said, "Why can't you look like her or be that size," it was like, Why do you care what I look like when you don't even know who I am or what happened?"

Domain 3: Identity Issues.

Abstract: If subject were thinner she'd be happier, have more confidence, and be married. Views mother as wanting her to be the perfect daughter: skinny, popular and married. Brothers called her "fat and ugly." Subject perceives herself as a huge person inside and feels she should not exist as she is taking up space. Subject feels her biggest issue is whether she fits in; if she does not fit in then she will binge.

Interview Excerpt: When asked what it would be like to be thin, subject stated, "If I were thinner I would be happier and married. I would feel better about myself. I'd look better. I'd be more attractive to guys. I'd be in a relationship. I feel like this huge person inside. If I were thinner, it would say that I had my act together, I cared about myself." Subject added, "When I compare myself to others and feel overweight, I start beating myself up and I binge." When asked how family members view her, she added, "Mom would say I'm a very caring person, and I have a lot to offer. I'm a hard worker. Her second version would be overweight, not married. I think she pictures a perfect daughter: skinny, married, and whatever, popular a lot of

friends." She later in the interview stated, "My brothers have told me I was fat and ugly."

Domain 4: Utilization of Defenses.

Abstract: Uses a lot of either/or thinking or splitting. Rationalizes her binges. Has difficulty, is afraid of male relationships so she avoids. Sees herself as real self and an idealized self. Uses displacement by viewing her body as a measure of her self-esteem.

Interview Excerpt: When asked what events or feelings might lead to a binge, subject stated, "My biggest thing is when I compare myself to others. And it depends on what kind of mood, I mean, if I'm in a strange mood, I see somebody that's skinny, I'll never look like that. And, it's just like I start beating myself up. Like the other day I was training this new girl. And she was skinny and really pretty. And I started comparing myself. I started thinking: I'll never be like that, and I'm fat and ugly. And that started the whole thing. I can do this in a matter of minutes and that started the binge. I mean I remember that day that I trained that girl, I called my therapist's answering machine and it was like life or death. And really I didn't even know what was going on. I knew I binged, I knew I trained this girl. But that comparison thing I didn't really know what was happening."

When asked about her eating behaviors, she stated, "Actually I think a lot of the eating disorder started when I was abused, I was like 7 or 8. So I think as far as like

eating food, when I was growing up I didn't date that much because I was afraid of guys. I thought I might as well be fat so they can't ask me out or they won't want to ask me out. Then that will be my excuse. If I were skinny, then there should be no excuse."

Subject began to talk about her therapy, she stated, "I guess one of the biggest things I'm working on is self-acceptance. Realizing that, you know, what's inside is what matters more than what's on the outside. And, I think the biggest thing too, is, I mean, I don't know, if I would be 50 pounds skinnier, if I would feel the same way about myself or if I'd be."

Subject 7

Subject 7 was a 34-year-old White, married woman who has been bulimic for over 10 years. Her bulimic behaviors began in college. She had been in therapy for the past 2 years as well as a treatment program. She was in an emotionally abusive relationship and had a family history of alcoholism.

Subject 7 completed the three tests described in chapter 4. Table 14 provides the scores on the tests administered to Subject 7.

The section below provides Domains 1 through 4 for Subject 7. Each Domain is presented with an Abstract that summarizes the core ideas and content of the Domain.

Raw data are taken from excerpts of the interview to provide an illustration of the Domain.

Table 14

Scores on Bulimia Test-Revised, Erwin Identity Scale, and Bell Object Relations Inventory for Subject 7

Test	Score	Mean Score for all 30 Subjects
BULIT-R (Bulimia Test-Revised)	124	107.40
EIS (Erwin Identity Scale)		
Confidence	52	65.83
Sexual Identity	44	48.33
Body and Appearance	30	43.23
BORI (Bell Objects Relations Inventory)		
Alienation	73	63.17
Insecure Attachment	65	61.23
Egocentricity	63	56.20
Social Incompetence	54	59.30

Domain 1: Bulimic Symptoms.

Abstract: Subject obsesses about her weight. Anything can trigger a binge. Feels guilty because she cannot control herself and purges.

Interview Excerpt: When talking about what it would be like to be thin, subject stated, "I imagine my self-esteem would be much better that it is now. I obsess about my

weight constantly." When asked what events might lead to a binge, subject stated, "Oh, it's so hard to tell anymore because I can binge over the slightest little thing." When asked how she feels after she purges, subject stated, "I feel guilty because I can't control myself."

Domain 2: Significant Relationships.

Abstract: Subject's mother is described as codependent, telling her what she should do. Desires to tell mother to just listen, do not give advice. Father is alcoholic; subject feels she acted as a partner to mother. Both parents emphasized eating and avoidance of weight gain. She always knew she was fat; at 10 years old she went to weight watchers.

Interview Excerpt: When asked to describe her mother's personality, subject stated, "My mother has a very codependent personality. She was codependent with my father. My dad was an alcoholic--he's been sober for 5 or 6 months. I would take over that role of being my mom's partner. She's also very controlling with her children, she wants to direct our lives and tell us. She 'shoulds' me to death and I'm like 'Will you just listen to me?' She wants to give me advice."

When asked what comments family members made about appearance and weight gain, subject responded, "I think the biggest instigator who called me names about my weight was my brother. He would puff out his cheeks and call me fat and things like that you know. Chubby, whatever. I went to

Weight Watchers when I was 10. So I think I always knew, I always knew I was overweight. I can remember 'You shouldn't eat that'. I remember sneaking food."

Domain 3: Identity Issues.

Abstract: Subject had hopes she would be something extraordinary. States she is 25 years old and still fat. Feels when heavy that people assume she is stupid and has no self-control because she cannot control her body. Family members focused on weight when she was 10 years old.

Interview Excerpt: When asked what it would be like to be very thin, subject responded, "I imagine that my self-esteem would be much better than it is now. I imagine that I would have a better quality of life, less depression, I am depressed often. A lot of areas in my life would benefit from being thin. When you are heavy like I am, people don't take you seriously because they assume you are stupid or you are dumb or obviously you have no self-control because you can't control your body, that kind of stuff."

When asked what feelings she is aware of when she is feeling fat, she stated, "A lot of anger, a lot of hurt. I always thought when I was an adult that I would be something special. I would do something extraordinary. I'm just an ordinary person. I never dreamed I'd be 26 years old and still be fat. And that is where the anger comes in."

Domain 4: Utilization of Defenses.

Abstract: Displaces her frustrations and feeling of no credibility with work and relationships onto her weight.

Uses food to fill up time or loneliness. Feels anger and guilt over her eating behaviors instead of recognizing other problematic areas in her life. Before therapy, bingeing was a habit, now she is more aware of what contributed to a binge.

Interview Excerpt: When asked what would life be like if she were thin, subject stated, "My marriage, my life at work, being taken seriously, not being taken seriously, you know a lot of times when you are heavy like I am people don't take you seriously because they assume you are stupid or you are dumb or obviously you have no self-control because you can't control your body, that kind of stuff."

When asked what events or feelings might contribute to a binge, subject stated, "Lately, it's too hard to be by myself. I get this intense panicky feeling that I don't know, it's hard to describe. I've got to get out of here. I've got to be around people. Even if I just go to the store or something. Before I went into treatment, I was bingeing every day and it wasn't that I could tell you I was bingeing over anything in particular but it just became a habit almost. That is just what I did." She added, "Therapy has definitely helped me increase my awareness. I can look back on a binge and say O.K., that was what I was feeling. I can look back and know why it happened. I don't feel better anymore after a binge or after a purge."

Subject 8

Subject 8 was a 51-year-old White, divorced female who had been actively bulimic since 1969. She had been in therapy for 2 years and was also hospitalized.

Subject 8 completed the three tests described in chapter 4. Table 15 provides the scores on the tests administered to Subject 8.

Table 15

Scores on Bulimia Test-Revised, Erwin Identity Scale, and Bell Object Relations Inventory for Subject 8

Test	Score	Mean Score for all 30 Subjects
BULIT-R (Bulimia Test-Revised)	125	107.40
EIS (Erwin Identity Scale)		
Confidence	44	65.83
Sexual Identity	57	48.33
Body and Appearance	22	43.23
BORI (Bell Objects Relations Inventory)		
Alienation	61	63.17
Insecure Attachment	61	61.23
Egocentricity	57	56.20
Social Incompetence	70	59.30

The section below provides Domains 1 through 4 for Subject 8. Each Domain is presented with an Abstract that

summarizes the core ideas and content of the Domain. Raw data are taken from excerpts of the interview to provide an illustration of the Domain.

Domain 1: Bulimic Symptoms.

Abstract: Subject feels she is in control after she purges.

Interview Excerpt: When asked what she feels like after she purges, subjects stated, "After I purged I would feel totally in control. Nobody can . . . nobody can make me stop. Nobody knows I'm doing it. I feel relieved and I feel in total control of myself. Not of anybody else, but of myself."

Domain 2: Significant Relationships.

Abstract: Mother never told subject she was loved; was threatened by her bulimia, called it stupid. Describes relationship with mother as a dependent, enmeshed relationship. Mother would not show subject her true feelings but would tell others about her true feelings; criticized to the point that she felt she had to be perfect. Family let her know she was chubby and mom had a subtle way of letting her know she was heavy; when she was 5 years old she began thinking about calories. Subject strongly desired male approval, in particular father and brother.

Interview Excerpt: When asked how her mother might describe her, she stated, "Mom would never let me know that she was proud of anything I did. She would be more apt to let somebody else know. She was critical so we wouldn't get

a big head. She never told me she loved me. Threatened by my bulimia-she's distancing herself, using words like you're stupid. She would call me chunky."

When asked about the nature of their relationship, subject responded, "I was quiet and didn't create problems." She later added, "Our relationship is enmeshed. More on my part than on hers. I'm extremely dependent for her approval. I became a little kid again when I was around her and she had to take care of me. And I wanted to be daddy's favorite, I wanted approval, I wanted approval big time. And I wanted male approval really badly, my brother and my dad."

When asked what comments her family made about appearance when she was growing up, subject responded, "Family told me I was chubby. I was 5 years old, just before my kindergarten year, when I started discussing calories. My mom had a very subtle way of letting me know that I was heavy. My brother teased me constantly about being fat."

Domain 3: Identity Issues.

Abstract: Mother and brother would call her chubby. Alcoholic husband did not pay any attention to her mind but would focus on body weight. Came to hate curves because of the connotation of a sexual woman. Husband only saw her as a sexual being, did not acknowledge her mind. Felt she had to be perfect to avoid criticism.

Interview Excerpt: When asked what it would be like to be very thin, subject responded, "It would be wonderful. I would be free. I would feel euphoric. I would feel in control of myself. I'd like it, it would be good. I wish I were very, very thin." When asked how it would be if she were 50 pounds overweight, she stated, "Oh I can't. Oh, the whole thought of being 50 pounds heavier would be horrible. I would rather be dead." When asked what it was about being heavy, subject responded, "Curves make me shatter. I don't like the curves. Want to be straight up and down. Um, the curves connote being a woman, sexual being. I hate it."

When asked about her parents' expectations for her, she stated, "It wasn't that they expected me to be perfect, but I was criticized all the time so I kept thinking that I had to be perfect in order for the criticism to stop."

Domain 4: Utilization of Defenses.

Abstract: Tends to suppress strong feelings as they were not allowed. Binges were compensation for critical self-talk. Purges would give her a feeling of being in control again.

Interview Excerpt: When asked what she does when she is feeling strong feelings, subject responded, "Strong feelings . . . I don't know if I can identify with it. I would just stuff it all. I would not acknowledge if I felt lonely, that would mean that I'm feeling sorry for myself. That would go with self-pity. So you don't feel that way, you're not allowed to feel that way." When asked how she felt

after she binged, subject responded, "Oh, totally in control. Like, now I'm in control. Nobody can . . . nobody can make me stop. Nobody knows I'm doing it. Um, I feel relieved and I feel in total control of myself."

When asked what events might contribute to a binge, subject stated, "Other than just having my plans changed, when I think that I have done something stupid, when I've just not quite, I don't know, I, when I've done something stupid. Out socially or you know, said something stupid to somebody else, and I go, Oh God, I can't believe I said that. And, you know, it was just then it would just go round and round in my head and, I would be apt to binge, binge and purge. Or do something." When talking about what she is aware of when feeling fat, subject responded, "Just a lot of emotions, total self-disgust. Desire to withdraw, to hibernate, not go out."

Subject 9

Subject 9 was a 34-year-old White woman who has been through a number of treatment modalities for 10 years. She had in the past binged and purged as often as 10 times per day. She was currently pregnant and continued with her purging behaviors. She was currently married and in a supportive relationship.

Subject 9 completed the three tests described in chapter 4. Table 16 provides the scores on the tests administered to Subject 9.

The section below provides Domains 1 through 4 for Subject 9. Each Domain is presented with an Abstract that summarizes the core ideas and content of the Domain.

Table 16

Scores on Bulimia Test-Revised, Erwin Identity Scale, and Bell Object Relations Inventory for Subject 9

Test	Score	Mean Score for all 30 Subjects
BULIT-R (Bulimia Test-Revised)	134	107.40
EIS (Erwin Identity Scale)		
Confidence	97	65.83
Sexual Identity	68	48.33
Body and Appearance	48	43.23
BORI (Bell Objects Relations Inventory)		
Alienation	47	63.17
Insecure Attachment	51	61.23
Egocentricity	44	56.20
Social Incompetence	51	59.30

Raw data are taken from excerpts of the interview to provide an illustration of the Domain.

Domain 1: Bulimic Symptoms.

Abstract: Everything she eats she must get rid of. Does not associate any feelings with her eating. Used eating to feel in control when perceived failure in class.

Being heavy is perceived as being out of control, having no willpower.

Interview Excerpt: When asked how she would feel if she were 50 pounds heavier, subject stated, "Being heavy would say that I don't take care of myself or I have no willpower. No control over my life, control over me which is true anyway, but it would be manifested outwardly."

When asked what feelings or events contribute to a binge, subject stated, "Everything I eat is a binge, there is no difference. The only thing would be boredom."

Subject made reference to the beginning of her eating disorder. "And, uh, basically the instructor said 'You are going about it all wrong'. It was a major project. It basically, the 9 weeks was the major project, and so there was the failure there. And that really precipitated the beginning of the eating disorder, severe depression, uh, self-mutilation, um, and a really hard spring."

Domain 2: Significant Relationships.

Abstract: Mom told her anger was unacceptable. Father was a college professor; subject felt students were more important than children. Subject was always seeking his approval by pursuing intellectual pursuits or playing sports. Failure in class precipitated feeling out of control and worthless, which led to an eating disorder. Mom would make comments about subject's eating.

Interview Excerpt: When asked what her mother's personality was like, subject stated, "Mother liked having

people home. She was always loving, warm, giving and fixing, cooking, and faithful. She desired an idyllic world. Anger wasn't allowed." Subject later added, "Dad was a college professor. College students were more important than his children. I was always seeking his approval and one way I could get it was on the intellectual level."

When asked about comments family would make about eating or weight gain, subject responded, "I remember situations where mom would say, 'Are you hungry or are you just eating?'" She added, "I was sort of the family garbage can in most cases. I mean, that's as far as the body, that's probably what my dad pushed the most. You need more exercise, you need to get out there and do something."

When asked what her parents' expectations were for her, subject stated, "I felt like I had to be good. Always be good, be the best. Make it perfect. So I got good grades, I practiced the piano, I went to church when I was supposed to. At times when I was angry my mom would say 'This is not acceptable.' The angry feelings were not acceptable."

Domain 3: Identity Issues.

Abstract: Subject states she had to be the best or she is not worth anything. Being heavy would say that she does not take care of her body, has no willpower, or control over her body. Strong family message to be perfect, not upset anyone.

Interview Excerpt: When talking about what it is like to be thin, subject stated, "It is an achievement in a mean sort of way."

When talking about what it means to be heavy, subject stated, "Being heavy would say that I don't take care of myself or I have no willpower. No control over my life, control over me, which is true anyway, but it would be manifested outwardly."

When talking about parental expectations, subject stated, "Be perfect. Succeed at everything you do. If you aren't going to succeed, don't do it. Be good, follow the rules, don't get into trouble. Don't make anybody upset."

Domain 4: Utilization of Defenses.

Abstract: Everything is a binge, purging is cleansing; Food will make you fat so to eliminate the food gives the cleansing of the badness. Failure of project led to critical feelings of failure; compensated by mutilation, depression, and eating disorder. Food and eating was one thing she could control. Subject pushes away her feelings.

Interview Excerpt: When asked what it would be like to be heavier, subject stated, "It would say that I don't take care of myself or I don't, I have no will power. No control over my life, control over me, which is true any way, but it would be manifested outwardly. Eating disorder was something I could control." When asked how she feels after she purges, she stated, "Eating is a binge, I must get rid of it. Getting rid of the food, gives that cleansing of the

badness. Cleansing of what is going to make me fat."

Subject began talking about what precipitated eating disorder. She stated, "It basically the 9 weeks was the major project and so there was the failure there. And that really precipitated the beginning of the eating disorder, severe depression, uh, self-mutilation, um, and a really hard spring. It was a failure, it was, it was a failure. I had no control over it [failure in class]. Until I thought of something that I could control, and that was sort of the time when eating disorders were sort of becoming the vogue."

When talking about what she may be aware of going on emotionally when she is feeling fat, subject stated, "I have really learned or developed the ability to, to not let it overwhelm me and to really push it down and in some ways, I get upset because I just, I learned how to do that. It's not overwhelming. I've learned to push them down. So I cope by not facing it. By not presenting it."

Subject 10

Subject 10 was a 25-year-old Black female who has been in therapy for 1 year. She had a history of eating disorders since her late teens. She was sexually abused from the ages of 5 years to 8 years old. She was currently in an emotionally abusive relationship and suffered significant depression. She had 4 years of college and was interested in pursuing further education.

Subject 10 completed the three tests described in chapter 4. Table 17 provides the scores on the tests administered to Subject 10.

Table 17

Scores on Bulimia Test-Revised, Erwin Identity Scale, and Bell Object Relations Inventory for Subject 10

Test	Score	Mean Score for all 30 Subjects
BULIT-R (Bulimia Test-Revised)	135	107.40
EIS (Erwin Identity Scale)		
Confidence	42	65.83
Sexual Identity	36	48.33
Body and Appearance	31	43.23
BORI (Bell Objects Relations Inventory)		
Alienation	79	63.17
Insecure Attachment	72	61.23
Egocentricity	65	56.20
Social Incompetence	74	59.30

The section below provides Domains 1 through 4 for Subject 10. Each Domain is presented with an Abstract that summarizes the core ideas and content of the Domain. Raw data are taken from excerpts of the interview to provide an illustration of the Domain.

Domain 1: Bulimic Symptoms.

Abstract: When feeling extreme feelings, she binges. If she eats too much her body is going to get out of control. It scares her to think of gaining weight. She purges and feels a tension release. Eating is one way of obtaining control.

Interview Excerpt: When asked how she copes with strong feelings, subject stated, "A lot of times when I'm feeling extreme feelings like that, um, real fat or real depressed about something or real anxious or lonely, you kind of feed yourself to try to feed those feelings and that's when I'm most likely to binge."

When asked what feelings she is aware of when she is feeling fat, subject responded, "I think I feel fear like a fear that my body is going to just get out of control and just get so big that I can't, you know, do anything about it."

When talking about how she feels after she purges, she stated, "You feel like if there is nothing else in your life that makes sense and you feel so powerless to control anything and everything is so chaotic there has got to be something in my life that I can control. I think that that feeling of tension release plays a big factor because I've always been denied the ability to express emotion or get blown off or feeling not heard. This is my way of releasing all that."

Domain 2: Significant Relationships.

Abstract: Subject perceives mother as uncaring, self-centered, and emotionally unavailable; comes across as being distant or cold. Mother has little knowledge of subject's life. Mother perceived as emphasizing the negative aspects of subject's life. Mom viewed subject as the mother in the family, the fixer always trying to make sure everything is taken care of. Was often hurt by sister's comments about her weight.

Interview Excerpt: When talking about how mother would describe her, subject stated, "She doesn't, I guess, it reaffirms that feeling where she doesn't really know me. We don't spend a lot of time together and I feel like she really doesn't know me. And she only catches glimpses of me and usually they're something negative she has to say about when we're out together." Later on she stated, "My mom would describe me as kind of like the fixer or the mother in the family where I'm always trying to make sure everybody's taken care of and everything."

When asked how she would describe her mother, subject stated, "She's kind of cold and distant. And it's kind of like, you know, she cares but she doesn't know how to show, and it comes off that she doesn't really care. She seems kind of self-centered where, you know, she's not emotionally available for you because she's so concerned about what's going on with her."

When asked what comments family made about appearance when she was growing up, subject stated, "When I was probably 10 or 11 years old, and I wish I had a picture, because I was skinny as a rail, my sister started calling me 'Thunder thighs and tons of buns'. Those were her two nicknames for me and she called me it all the time. And I hated it, I couldn't stand it." She added, "My mother would always say I don't want you to be like me and she's very overweight."

Domain 3: Identity Issues.

Abstract: Subject indicates a relationship between being happy and everything working out. Being heavy means being flawed and socially deviant.

Interview Excerpt: When asked what it would be like to be thin, subject stated, "The connotation I make and the relationship I make is that thin is happy. Everything works out for thin people, it seem like, thin people just have fun."

When asked what it would be like to be heavy, subject stated, "When you are heavier, you see yourself as overweight. You see yourself as flawed, or you see yourself as not normal, or you know, not fitting into a certain category or the social normal thing. And it's hard to not feel like a misfit. I think when you're thin or about as close to being thin there's nothing deviant about you."

Domain 4: Utilization of Defenses.

Abstract: Eating and food was one thing subject can control. When subject does not get support from external forces, subject internalizes it and tries to feed herself, tries to feed her feelings; there is comfort attached with food. Keeps stuffing her emotions with food and they build up and there is no release for them. All the tension has to go somewhere so she purges, and not only is food coming out but so is all the tension.

Interview Excerpt: When asked how she copes with strong feelings, subject responded, "I think my first instinct is to kind of close myself off from people. I kind of isolate myself and my next instinct is to eat. And a lot of times when I'm feeling extreme feelings like that, um, real fat or real depressed about something or real anxious or lonely, you kind of feed yourself to try to feed those feelings and that's when I'm most likely to binge."

When asked what might trigger a binge, subject stated, "I think that the best analogy I have with it is it's kind of like you have all these feelings or I tend to really keep my feelings to myself and they build up and build up and build up and as they build up there's no release for them and there's all that tension. And so, by putting things in my mouth or by putting things into my body, it's kind of, almost like shoving that back down and kind of replacing a feeling with food or replacing a negative emotion with food and just kind of you put it in and shove it down and that,

you know, kind of displaces all the feelings that you feel building up inside you." She added, "But, I'm very, very bad at appropriately expressing my feelings and so it's easy for them to start to get built up because I don't instead of risking, okay I'm angry but how'd I act that out. It's like I'm angry so instead of trying to work through that emotion, I'll just hold it in and the more I hold it, the more there is building up inside. You can only keep your feelings inside and unacknowledged for so long before they have to go somewhere and I think that's when the purging comes out. And not only is the food coming out and it's kind of a release for all that tension."

When asked if she was aware of any feelings going on when she is overwhelmed with feeling fat, subject responded, "I think I feel fear like a fear that my body is going to just get out of control and just get so big that I can't, you know, do anything about it."

When asked how she felt after she purges, subject responded, "After I've purged I feel almost cleansed. I don't know if that's the word I'm looking for. But there's just that release."

Subject 11

Subject 11 was a 34-year-old Black female. She had been in therapy for 7 years. She admitted to having an eating disorder for 20 years. She had been hospitalized on numerous occasions for suicide attempts. She had been given

numerous diagnoses, which have included multiple personality and borderline personality disorder.

Subject 11 completed the three tests described in chapter 4. Table 18 provides the scores on the tests administered to Subject 11.

Table 18

Scores on Bulimia Test-Revised, Erwin Identity Scale, and Bell Object Relations Inventory for Subject 11

Test	Score	Mean Score for all 30 Subjects
BULIT-R (Bulimia Test-Revised)	139	107.40
EIS (Erwin Identity Scale)		
Confidence	38	65.83
Sexual Identity	27	48.33
Body and Appearance	41	43.23
BORI (Bell Objects Relations Inventory)		
Alienation	80	63.17
Insecure Attachment	61	61.23
Egocentricity	67	56.20
Social Incompetence	78	59.30

The section below provides Domains 1 through 4 for Subject 11. Each Domain is presented with an Abstract that summarizes the core ideas and content of the Domain.

Raw data are taken from excerpts of the interview to provide an illustration of the Domain.

Domain 1: Bulimic Symptoms.

Abstract: Subject indicates she broke a rule when she ate. After she purges she feels like a "good girl." She feels in control again. Subject relates she binges when she is lonely or if somebody hurts her feelings.

Interview Excerpt: When asked what events might lead to a binge, subject responded, "If I get lonely or if somebody hurts my feelings or if I try on something and it feels too tight, or if someone makes me angry or if someone makes me feel sad." When asked how she feels after she purges, subject stated, "After I purge I feel kind of like a good girl. I feel good because I ate and broke a rule. I purge it up the best way I can and then I feel a little bit better. I feel in control again."

Domain 2: Significant Relationships.

Abstract: Views self as not liked by mother. Punished when not done eating food on time. Parents restricted food with inference she was fat. As a child she was called fat, crazy, stupid, worthless, and never going to amount to anything. Her foster parents would severely reprimand her and she was not allowed to eat certain foods.

Interview Excerpt: When asked how to describe her mother, subject responded, "She [foster mother] didn't like me. Crazy, stupid, fat, um . . . worthless, never going to amount to anything, a little foster girl. She [foster

mother] didn't like me. I was fat. Or if I would pig out I was bad. Or at school I was bad. Or if I didn't eat my food fast enough I was bad." She later added: "They told me I was never going to amount to anything."

When asked what comments family members made about her appearance, she stated, "They would call me fat. My dad would always call me pudgy. They would call me a pig."

When asked about what meal times were like in her family, she stated, "Meal times were not good. Because I was always the last one to start eating and then when the alarm would go off and there wasn't any time left and I wasn't done when the time was up she would hurt me. And then if I got caught with food in the back of my mouth she would hurt me. And my dad wouldn't let me eat corn because he said corn was for hogs and I was too fat to eat corn."

Domain 3: Identity Issues.

Abstract: Subject states if she were thinner she could run, put on any clothes she wanted, and would be noticed more by guys. She was often called a pig if she would eat certain foods. Family comments let her know she would have to own a car, own a house, and make something of herself to be somebody. States she is a nobody because she gets help from the state and does not have a job. When dealing with strong feelings she becomes a different person.

Interview Excerpt: When asked what it would be like if she were thinner, she stated, "I could run, and I could put

on any clothes I wanted to, and I would be noticed a lot more by guys."

When asked what it would be like if she were really heavy she stated, "It's really bad. We went on a choir tour and I felt very self-conscious because people were pushing me in a wheelchair and everything. It was bad. I felt really, really self-conscious."

When asked what foster parents' expectations were she stated, "You had to grow up to be able to have your own car and have your own house and you had to make something of yourself. Because if you didn't you were a nobody. I'm a nobody. I get help from the state and I don't have a job."

Domain 4: Utilization of Defenses.

Abstract: Uses purging to feel in control again because she broke a rule. Subject becomes a different person when she is angry. States when she feels she is fat she is feeling inadequate.

Interview Excerpt: When asked how she feels after she purges, subject stated, "After I purge I feel kind of like a good girl. I feel good because I ate and I broke a rule, I purge it up in the best way I can. And then I feel a little bit better. I feel in control again."

When asked what she does when she feels strong emotions, subject responded, "When I'm angry I get to be a different person."

When asked what feelings she is aware of when she is overwhelmed with feeling fat, subject responded, "When I'm

overwhelmed with feeling fat what's going on emotionally for me is that I'm not good enough. I'm not pretty enough."

Subject 12

Subject 12 was an 18-year-old White female who was currently living at home. She had been hospitalized on one occasion for her eating disorder, which according to client was a very bad experience. She had seen three to four therapists. Her family reported being extremely discouraged with her costly and resistant eating behaviors. She stated that her father was at a point where he wanted to give up on her. She was finishing her senior year. She had taken time off from school in the past due to her eating disorder.

Subject 12 completed the three tests described in chapter 4. Table 19 provides the scores on the tests administered to Subject 12.

The section below provides Domains 1 through 4 for Subject 12. Each Domain is presented with an Abstract that summarizes the core ideas and content of the Domain. Raw data are taken from excerpts of the interview to provide an illustration of the Domain.

Domain 1: Bulimic Symptoms.

Abstract: Does not like feeling like she is fat; does not want anyone to see her. When she eats, she forgets about things. Keeps eating past the point of feeling full and then feels panicky. Has to get it all out or else she will feel real fat.

Table 19

Scores on Bulimia Test-Revised, Erwin Identity Scale, and Bell Object Relations Inventory for Subject 12

Test	Score	Mean Score for all 30 Subjects
BULIT-R (Bulimia Test-Revised)	140	107.40
EIS (Erwin Identity Scale)		
Confidence	41	65.83
Sexual Identity	39	48.33
Body and Appearance	40	43.23
BORI (Bell Objects Relations Inventory)		
Alienation	79	63.17
Insecure Attachment	80	61.23
Egocentricity	70	56.20
Social Incompetence	56	59.30

Interview Excerpt: When asked what it would be like to be 50 pounds heavier, subject stated, "I've been 50 pounds heavier and I didn't like it. I'd be very upset. I wouldn't want anyone to see me. I felt fat."

When asked what events might lead to a binge, subject stated, "All of these negative feelings or thoughts like loneliness or sadness or if something bad happens." When asked what it is like to binge, subject stated, "I don't know, I just forget about things . . . I just eat. I like to eat. I don't know. It just makes everything better. I

eat past the point of being full and I keep eating and eating until I feel like my stomach's going to explode and then I feel real like panicky, like I've just got to get everything out of me. If I don't get everything out of me I'm going to get real fat."

Domain 2: Significant Relationships.

Abstract: Subject perceives mother as phony. Mom would say subject is a spoiled brat who is breaking apart the family. She and her father are going to divorce because she is putting so much stress on them. Mother views everything as bad and dramatic and does not allow the subject to speak. Mother never listens to her and subject does not listen to mother. Everybody in family is on a diet for appearance. Father would make references to her physical appearance.

Interview Excerpt: When asked how she would describe her mother, she stated, "My mom talks a lot. . . . She's kind of phony a lot of the times. I mean, she wasn't but recently she's been really, really phony like 'Oh doesn't your hair look nice this morning!' And you know before she even turns the light on you know. Everything is bad and everything freaks her out."

When asked how mother would describe her, subject stated, "Mom would call me a spoiled little brat and I'm ruining the family and breaking apart the family because, I don't know. And her and dad are going to end up getting a divorce because I'm putting so much stress on them and stuff like that."

When asked about their relationship, subject stated, "We're not really close. I mean, we try but really we're not. We do a lot of things together but really we don't see eye to eye on anything. We don't understand each other, we don't, I mean, we never have . . . ever since we've tried and started talking things out and going to therapy and everything, but she'll never listen to me and I guess I'll never listen to her but she never shuts up. You just can't get a word in edgewise with her so there is really no point. It just ends up in a big fight."

When asked what comments her family made about eating and weight gain, subject stated, "They complimented me until I started gaining weight and then they said 'Oh stop eating so much' or 'Oh look your face is getting chubby.' And my dad was like 'Oh look your arms are getting chubby.' Even before I was bulimic I was 120 pounds and it was my birthday and I was eating a piece of my birthday cake and my mom took it away from me and she's like 'Oh, you don't want to eat this.' She's like you will put on all that weight you just lost. On my birthday!"

Domain 3: Identity Issues.

Abstract: This year she is more fun and more popular than before. She is not sure which feels more like her, does not know what she likes better. Has not felt comfortable with who she is since she was in fifth grade.

Interview Excerpt: When asked what it would be like to be very thin, subject responded, "I'd be happier. I

wouldn't have to worry so much about gaining weight. I wouldn't have to worry so much about how much I eat."

When asked what it would be like to be 50 pounds heavier, subject stated, "Well, you know, it's not just about being fat, it's everything. I don't know, it just doesn't look good. It's just . . . I didn't like being fat. I don't know."

When asked how mom would describe her, subject had difficult time. When she was asked how she saw herself, she stated, "Well last year when I went to a different school I had a reputation of being really bad. People were afraid of me. This year I'm more fun to be around. Even though I don't get good grades, I'm more popular. I don't know." She added, "I don't know which I like better. I don't know which feels more like me. When I was fifth grade I felt more comfortable."

Domain 4: Utilization of Defenses.

Abstract: When she feels lonely or has negative feelings subject states she eats. When she binges she just forgets about things and it makes everything better. Eats past the point of being full. Keeps eating until she feels panicky. If she does not get everything out, she will get real fat.

Interview Excerpt: When asked what it would be like to be heavy, subject stated, "Well, you know, it's not just about being fat, it's everything. I don't know, it just

doesn't look good. It's just . . . I didn't like being fat. I don't know."

When asked how she copes with strong feelings, subject stated, "When I am angry or lonely or depressed I usually get something to eat or kick something or yell a lot. When I am lonely like today when my mom dropped me off and said I'm going to get my mail and I said O.K. and than I ate and I puked. Maybe I wasn't that lonely. Maybe I just felt like throwing up. A lot of times I just feel like throwing up."

When asked what feelings would contribute to a binge, subject stated, "Feelings that would contribute to binge are negative feelings or thoughts like loneliness or sadness or if something bad happens like a boyfriend dumps me or, you know, any of that kind of stuff." She also stated, "When I binge I don't know, I just forget about things. I just eat. I like to eat I guess, I don't know. It just makes everything better."

When asked how she feels when she binges, she stated, "I eat past the point of being full and I keep eating and eating until I feel like my stomach is going to explode and than I feel real panicky like I've just got to get everything out of me. If I don't get everything out of me I'm going to get real fat."

Cross Analysis of Total Samples

A cross analysis was performed on all cases to explore

consistencies among the total samples. Significant consistencies identified under each domain were called categories. Applying Elliott's (1989, cited in Hill et al., 1997) Conventions, a category that applied to all cases was considered *general*. A category that applied to half the cases was considered *typical*, whereas if it applied to less than half, it was considered *variant*. For the purpose of this research study, categories that applied to 3 to 4 of the cases were considered *variant*, 6 to 9 were considered *typical*, whereas greater than 10 to 12 were considered *general*.

When analyzing the data under the Domain Bulimic Symptoms, one category was identified. This category was Utilization of eating as a defense to maintain control. This was identified in 9 out of 12 cases; therefore, it was considered *typical*.

**Category for the Domain
Bulimic Symptoms for
the Total Sample**

Category 1: Utilization of eating as a defense to maintain control. The 9 subjects below reported they recognized their eating patterns as one mechanism of control in their world.

Case 1: Subject stated, "When I would binge, I felt so much more in control. Like I didn't have to worry."

Case 2: Subject stated, "I felt it said I was weak and

that I wasn't desirable and that I didn't have any control over myself."

Case 3: Subject stated, "I just thought my dad was very controlling and I thought if I could control my weight that was something he couldn't take away from me and people try."

Case 6: Subject stated, "I have no control over my binge. It's in my mouth and in my stomach before I realize I even ate it. So it's about being out of control and then being angry at myself."

Case 7: Subject stated, "I feel guilty because I can't control myself."

Case 8: Subject stated, "After I purged I would feel totally in control. Nobody can . . . nobody can make me stop. Nobody knows I'm doing it. I feel relieved and I feel in total control of myself. Not of anybody else, but of myself."

Case 9: Subject stated, "Being heavy would say that I don't take care of myself or I have no willpower. No control over my life, control over me which is true anyway, but it would be manifested outwardly."

Case 10: Subject stated, "You feel like there is nothing else in your life that makes sense and feel so powerless to control anything and everything is so chaotic there has got to be something in my life that I can control."

Case 11: Subject stated, "After I purge I feel kind of like a good girl. I feel good because I ate and broke a

rule. I purge it up the best way I can and then I feel a little bit better. I feel in control again."

**Categories for the Domain
Significant Relationships
for the Total Sample**

Under the Domain of Significant Relationships, six categories were identified. The first category was called Disavowal of aspects of subject's personality by family members creating superficiality or lack of depth. This category was found in 12 of 12 cases; therefore, it was considered *general*. The second category was Strong emphasis on food intake and appearance in family. This was found in 10 out of 12 cases; therefore, it was considered *general*. The third category was Punishing behaviors toward food intake or appearance in family. This was found in 9 out of 12 cases; therefore, it was considered *typical*. The fourth category was Strong desire for paternal acceptance. This was found in 5 out of 12 cases; therefore, it was considered *variant*. The fifth category was Controlling, critical maternal figure. This was found in 11 out of 12 cases; therefore, it was considered *general*. The sixth category was Enmeshed relationship with mother. This was found in 7 out of 12 cases; therefore, it was considered *typical*. The category Disavowal of aspects of subject's personality by family members creating superficiality or lack of depth is presented now.

Category 1: Disavowal of aspects of subject's personality by family members creating a superficiality or lack of depth. The 12 subjects below reported that one or both parents conveyed negative attitudes towards aspects of the subject's personality.

Case 1: Subject stated, "I wish he [father] would love me for who I was."

Case 2: Subject stated, "I think in a lot of ways I'm supposed to take on my mother's role. I was the one who was supposed to have a lot of kids and stay at home. So in many ways I think she projects things on me. What she wanted to have she wanted me to do."

Case 3: Subject stated, "I couldn't voice my opinion to my father. It was 'Shut up I don't want to hear it'."

Case 4: Subject stated, "I feel like I let my parents down. I feel like I disappointed them but they wouldn't tell me that."

Case 5: Subject stated, "My mother was the kind of mother that the child was supposed to be seen and not heard."

Case 6: Subject stated, "As far as actually sitting down and talking about something in depth . . . that doesn't happen. We talk about family, we talk about things that are going on, but not anything real serious. I mean, I'd never, I think once I told her I had an eating disorder and she just doesn't get it."

Case 7: Subject stated, "She's very controlling with her children, she wants to direct our lives and tell us. She 'shoulds' me to death and I'm like 'Will you listen to me?' She wants to give me advice."

Case 8: Subject stated, "Mom would never let me know that she was proud of anything I did. She would be more apt to let somebody else know. She was critical so we wouldn't get a big head."

Case 9: Subject stated, "Mother liked having people home. She was always loving, warm, giving, and fixing, cooking and faithful. She desired an idyllic world. Anger wasn't allowed."

Case 10: Subject stated, "I guess it reaffirms that feeling where she doesn't really know me. We don't spend a lot of time together and I feel like she really doesn't know me. And she only catches glimpses of me and usually they're something negative she has to say about when we're out together."

Case 11: Subject stated, "She [foster mother] didn't like me. I was fat. Or if I would pig out I was bad. Or at school I was bad [crying]. Or if I didn't eat my food fast enough I was bad."

Case 12: Subject stated, "We do a lot of things together but really we don't see eye to eye on anything. We don't understand each other."

Category 2: Strong emphasis on food intake and appearance in family. The 10 subjects below reported a strong emphasis on food intake and appearance in the family.

Case 2: Subject stated, "She was saying she liked how I looked but she didn't like me as a person. Later she stated I wasn't allowed to eat unless she said I could."

Case 3: Subject stated, "If I would eat something I had a tendency to, when I would get depressed because that was my comfort and when I would eat he would puff out his cheeks and say 'Now you're going to look like Miss Piggy' or whatever."

Case 4: Subject stated, "I know once my older sister and I, my sister is 2 years older than I am, it never came like a quote competition but I think it was there. But I don't know whether she felt that way or it was something that I brought on. It bothers me when she says she's wearing a certain size or, you know."

Case 6: Subject stated, "I remember growing up because I have a friend, she is still to this day a twig. I mean, she can eat anything and I remember we were 10 years old we went shopping, of course she had a skinny size, you know, pair of jeans and whatever, and what I tried on didn't fit and my mom was like, why can't you be like her? That stuff every once in a while pops in my head. You know, I don't understand why you can't wear that size."

Case 7: Subject stated, "I think the biggest instigator who called me names about my weight was my brother."

He would puff out his cheeks and call me fat and things like that, you know. Chubby, whatever. I went to Weight Watchers when I was 10. So I think I always knew, I always knew I was overweight."

Case 8: Subject stated, "Family told me I was chubby. I was 5 years old, just before my kindergarten year, when I started discussing calories."

Case 9: Subject stated, "I was sort of the family garbage can in most cases. I mean, that's as far as the body, that's probably what my dad pushed the most. You need more exercise, you need to get out there and do something."

Case 10: Subject stated, "When I was probably 10 or 11 years old, and I wish I had a picture, because I was skinny as a rail. My sister started calling me 'thunder thighs and tons of buns'. Those were her two nicknames for me and she called me it all the time. And I hated it, I couldn't stand it."

Case 11: Subject stated, "They would call me fat. My dad would always call me pudgy. They would call me a pig."

Case 12: Subject stated, "They complimented me until I started gaining weight and then they said 'Oh stop eating so much' or 'Oh look your face is getting chubby.' And my dad was like 'Oh look your arms are getting chubby'."

Category 3: Punishing behaviors toward food intake or appearance in family. The 8 subjects below reported

punishing behaviors toward food intake or appearance in the family.

Case 2: Subject stated, "He [father] comments on what time I eat, or how much I'm eating, or 'You're going to be as big as a house.' My mom says that too."

Case 3: Subject stated, "If I would eat something I had a tendency to, when I would get depressed because that was my comfort, and when I would eat he would puff out his cheeks and say 'Now you're going to start looking like Miss Piggy' or whatever."

Case 6: Subject stated, "Ten must have like been the natural age because my mom, one night she bought ice cream. Anyway, I obviously got too much in the bowl or something and she said if you eat all of that you're going to get fat. When she said that it was like major, you know. I must be this big, fat pig. I don't deserve to eat this. I mean that is all that stuff that I'm doing now."

Case 7: Subject stated, "I can remember 'you shouldn't eat that'. I remember sneaking food."

Case 8: Subject stated, "I was 5 years old, just before my kindergarten year, when I started discussing calories. My mom had a very subtle way of letting me know I was heavy."

Case 9: Subject stated, "I remember situations where mom would say, 'Are you hungry or are you just eating?'"

Case 10: Subject stated, "My mother would always say 'I don't want you to be like me' and she's very overweight."

Case 11: Subject stated, "Meal times were not good. Because I was always the last one to start eating and then when the alarm would go off and there wasn't any time left and I wasn't done when the time was up she would hurt me. And then if I got caught with food in the back of my mouth she would hurt me. And my dad wouldn't let me eat corn because he said corn was for hogs and I was too fat to eat corn."

Case 12: Subject stated, "Even before I was bulimic I was 120 pounds and it was my birthday and I was eating a piece of my birthday cake and my mom took it away from me and she's like 'Oh, you don't want to eat this,' she's like you will put on all that weight you just lost. On my birthday!"

Category 4: Strong desire for paternal acceptance. The 5 subjects below reported a strong desire for paternal acceptance.

Case 1: Subject stated, "I wish he [father] would love me for who I was."

Case 3: Subject stated, "He was always trying to control me and wasn't happy with anything I was trying to do."

Case 5: Subject stated, "My father was very supportive when I was sick. He stood by me. So that was a real big loss, he died recently within the last 2 years. And that

bothers me a lot still. I feel a lot of guilt about that. All the pain I put on my dad."

Case 8: Subject stated, "And I wanted to be daddy's favorite, I wanted approval, I wanted approval big time."

Case 9: Subject stated, "Dad was a college professor. College students were more important than his children. I was always seeking his approval and one way I could get it was on the intellectual level."

Category 5: Controlling, critical maternal figure. The 11 subjects below described their mother (or mothering figure) as critical or controlling.

Case 1: Subject stated, "She can be overly critical too."

Case 2: Subject stated, "She would take me clothes shopping and if I didn't like what she'd pick off the rack she'd get mad and say 'Fine, just forget it.' And she'd stomp out of the store and I wouldn't get anything at all."

Case 4: Subject stated, "I'm scared to tell her about the eating disorder because she would see me as a failure. I disappointed her again. I didn't want her to feel she's a bad mother."

Case 5: Subject stated, "My mother is very cold, very uncaring, I think. She's never been one to show unconditional love toward her kids. I would say emotionally abusive."

Case 6: Subject stated, "But when I was 10 and she said 'Why can't you look like her or be that size,' it was like, why do you care what I look like when you don't even know who I am or what happened?"

Case 7: Subject stated, "She's also very controlling with her children, she wants to direct our lives and tell us."

Case 8: Subject stated, "She never told me she loved me. Threatened by my bulimia--she's distancing herself, using words like you're stupid. She would call me chunky."

Case 9: Subject stated, "I felt like I had to be good. Always be good, be the best. Make it perfect. So I got good grades, I practiced the piano, I went to church when I was supposed to. At times when I was angry my mom would say 'this is not acceptable.' The angry feelings were not acceptable. This is my mom; this is not at all true from my father."

Case 10: Subject stated, "We don't spend a lot of time together and I feel like she really doesn't know me. And she only catches glimpses of me and usually they're something negative she has to say about when we're out together."

Case 11: Subject stated, "[Foster mother would describe her] Crazy, stupid, fat, um . . . worthless, never going to amount to anything, a little foster girl."

Case 12: Subject stated, "We do a lot of things together but really we don't see eye to eye on anything."

We don't understand each other, we don't I mean, we never have . . . ever since we've tried and started talking things out and going to therapy and everything, but she'll never listen to me and I guess I'll never listen to her but I know . . . but she never shuts up. You can't get a word in edgewise with her so there is really no point. It just ends up in a big fight."

Category 6: Enmeshed relationship with mother. The 7 subjects below reported they had an enmeshed relationship with their mother.

Case 1: Subject stated, "We are very close, we love each other. She's like a friend." Subject also stated, "My mother was the same way. We are like the same."

Case 2: Subject stated, "I think in a lot of ways I'm supposed to take on my mother's role. I was the one who was supposed to have a lot of kids and stay at home. So in many ways I think she projects things on me. What she wanted to have she wanted me to do."

Case 3: Subject stated, "Growing up, when I was in high school, I felt like I had to protect my mom. She was so weak and so fragile. Everything and anything anybody says hurts her and it makes me angry and it hurts me. And, I just felt like I had to push some things. I guess maybe that's why my dad and I clash so much because I hated the way he treated her and I would rather him take it out on me."

Case 7: Subject stated, "My mother has a very codependent personality. She was codependent with my father. My dad was an alcoholic--he's been sober for 5 or 6 months. I would take over that role of being my mom's partner."

Case 8: Subject stated, "Our relationship is enmeshed. More on my part than on hers. I'm extremely dependent for her approval. I became a little kid again when I was around her and she had to take care of me."

Case 10: Subject stated, "My mom would describe me as kind of like the fixer or the mother in the family where I'm always trying to make sure everybody's taken care of and everything."

Case 12: Subject stated, "Mom would call me a spoiled little brat and I'm ruining the family and breaking apart the family because I don't know. And her and dad are going to end up getting a divorce because, I'm putting so much stress on them and stuff like that."

**Categories for the Domain
Identity Issues for the
Total Sample**

Under the Domain Identity Issues three categories were identified. The first category was called Positive self-esteem and affects related to being thin. This category was found in 12 out of 12 cases; therefore, it was considered *general*. The second category was called Weight gain-heaviness directly related to inherent badness and

ineptness. This category was found in 12 out of 12 cases; therefore, it was considered *general*. The third category was called Internal strivings for perfection. This category was found in 7 out of 12 cases; therefore, it was considered *typical*. The category Positive self-esteem and affects related to being thin is presented below.

Category 1: Positive self-esteem and affects related to being thin. The 12 subjects below reported having positive self-esteem and affects related to being thin.

Case 1: Subject stated, "If I was thinner it would be great. It's like I would have more confidence, more ability to socialize."

Case 2: Subject stated, "If I were thinner I'd have more power. More kind of like I was perfect. So I mean I felt like if my body was perfect then everything else would have been perfect."

Case 3: Subject stated, "Bright, bright sunshine, and I don't know sunshine and rainbows. When I got down and my lowest weight was 108 and when I was there it was like I was floating. It was like I was so light, I just floated. I felt like, I don't know, it was a nice light feeling, like on a cloud."

Case 4: Subject stated, "More confidence when thinner, I felt better when I was thinner."

Case 5: Subject stated, "Felt better about myself. But then again the thinner I got, the thinner I had to get."

Case 6: Subject stated, "I would probably be happier and married. If I were thinner it would say that I had my act together, I cared about myself."

Case 7: Subject stated, "I imagine that my self-esteem would be much better than it is now so I imagine that I would have a better quality of life, less depression. I am depressed often. A lot of areas in my life would benefit in my life from being thin."

Case 8: Subject stated, "It would be wonderful. It would be free. I would feel euphoric. I would feel in control of myself. I'd like it, it would be good. I wish I were very, very thin."

Case 9: Subject stated, "It is an achievement in a mean sort of way."

Case 10: Subject stated, "The connotation I make and the relationship I make is that thin is happy. Everything works out for thin people; it seems like thin people just have fun."

Case 11: Subject stated, "I could run, and I could put on any clothes I wanted to, and I would be noticed a lot more by guys."

Case 12: Subject stated, "I'd be happier. I wouldn't have to worry so much about gaining weight. I wouldn't have to worry so much about how much I eat."

Category 2: Weight gain-heaviness directly related to inherent badness and ineptness. The 12 subjects below reported inherent badness and ineptness directly related to weight gain.

Case 1: Subject stated, "Fat is ugly. Fat people repulse me, no discipline."

Case 2: Subject stated, "I felt like every single flaw about me was visible. Whether it was or not just the physical thing, but my personality flaw or any other flaw I might have was visible. I didn't feel like I had that power anymore so I didn't feel like I was important. I was embarrassed as to how big I was."

Case 3: Subject stated, "I don't know if it would just be the embarrassment or just the self-hatred more than anything that I was not in control of my weight anymore."

Case 4: Subject stated, "When 50 pounds heavier I feel like a cow."

Case 5: Subject stated, "It would be horrible. It would be absolutely horrible. I couldn't live with myself, I couldn't do it."

Case 6: Subject stated, "I feel like this huge person inside. If I were thinner it would say that I had my act together, I cared about myself."

Case 7: Subject stated, "When you are heavy like I am people don't take you seriously because they assume you are stupid or you are dumb or obviously you have no self-control because you can't control your body, that kind of stuff."

Case 8: Subject stated, "Oh I can't. Oh, the whole thought of being 50 pounds heavier would be horrible. I would rather be dead. Hips, breasts, hips, thighs would all be round. It's that whole sense of being soft and mushy. I hate being mushy."

Case 9: Subject stated, "Being heavy would say that I don't take care of myself or I have no willpower. No control over my life, control over me, which is true anyway, but it would be manifested outwardly."

Case 10: Subject stated, "When you are heavier, you see yourself as overweight. You see yourself as flawed, or you see yourself as not normal, or you know, not fitting into a certain category or the social normal thing. And it's hard to not feel like a misfit."

Case 11: Subject stated, "It's really bad. We went on a choir tour and I felt very self-conscious because people were pushing me in a wheelchair and everything. It was bad. I felt really, really self-conscious."

Case 12: Subject stated, "Well, you know, it's not just about being fat, it's everything. I don't know, it just doesn't look good. It's just . . . I didn't like being fat. I don't know."

Category 3: Internal strivings for perfection. The 7 subjects below reported internal strivings for perfection.

Case 2: Subject stated, "More power. More kind of like I was perfect. So I mean I felt like if my body was perfect

than everything else would have been perfect. So in a way I felt like that was the key."

Case 3: Subject stated, "It made me want to be and struggle that much harder to be the perfect weight, the perfect size, the perfect shape because I just grew up thinking how all men are and if I didn't look like these women on TV and if I didn't look like what my dad thought women were supposed to look like. If I grew up looking like my mom it wasn't good enough because I didn't want to get married to someone whose gonna look at other women the way my dad does."

Case 6: Subject stated, "I think she [mom] pictures a perfect daughter, skinny, married, and whatever, popular, a lot of friends."

Case 7: Subject stated, "I always thought when I was an adult that I would be something special. I would do something extraordinary. I'm just an ordinary person. I never dreamed that I would be 25 years old and still be fat. And that is where a lot of the anger comes in."

Case 8: Subject stated, "It wasn't that they expected me to be perfect, but I was criticized all the time so I kept thinking that I had to be perfect in order for the criticism to stop."

Case 9: Subject stated, "Be perfect. Succeed at everything you do. If you aren't going to succeed, don't do it. Be good, follow the rules, don't get into trouble. Don't make anybody upset."

Case 10: Subject stated, "When you're thin or about, you know, as close to being thin, there's nothing deviant about you."

**Categories for the Domain
Utilization of Defenses
for the Total Sample**

Under the Domain Utilization of Defenses four categories were identified. The first category was called Utilization of isolation and avoidance strategies. This category was found in 6 out of 12 cases; therefore, it was considered *typical*. The second category was Tendency to suppress, stuff, hold in feelings. This category was found in 7 out of 12 cases; therefore, it was considered *typical*. The third category was Tendency to displace negative or strong feelings onto eating and body appearance. This category was found in 10 out of 12 cases; therefore, it was considered *general*. The fourth category was Utilization of splitting defenses. This category was found in 10 out of 12 cases; therefore, it was considered *general*. The first category Utilization of isolation and avoidance strategies is presented below.

Category 1: Utilization of isolation and avoidance strategies. The 6 subjects below reported strategies of isolation and avoidance as a means of coping.

Case 1: Subject stated, "Food helps me escape, avoid any worry."

Case 3: Subject stated, "When my feelings eat at me and I try to deal with it with my eating. If I don't eat and I feel hungry, I'll feel better. I don't know why. I wonder, I'm concentrating on something else. I'm not thinking about the problem at hand, it's something to think about."

Case 5: Subject stated, "I like to isolate, um, anger, anger. I pretty much let it, let it keep stuffing and stuffing until it finally blows up. I tried to avoid her [mother] as much as possible. When I was home from school and I was having a tough time with her I isolated a lot."

Case 6: Subject stated, "Actually I think a lot of the eating disorder started when I was abused, I was 7 like or 8. So I think as far as like eating food, when I was growing up I didn't date that much because I was afraid of guys. I thought I might as well be fat so they can't ask me out or they won't want to ask me out. Then that will be my excuse. If I were skinny then there should be no excuse."

Case 9: Subject stated, "I cope by not facing it. By not presenting it."

Case 10: Subject stated, "I think my first instinct is to kind of close myself off from people. I kind of isolate myself and my next instinct is to eat."

Category 2: Tendency to suppress, stuff, hold in feelings. The 7 subjects below reported a tendency to stuff or hold in feelings.

Case 1: Subject stated, "I hold it in, that's half my problem. Letting things build up. It gets so hard."

Case 3: Subject stated, "I was afraid to open my mouth with my dad. And so I would keep it all bottled in."

Case 4: Subject stated, "Strong feelings . . . I fight and struggle big time. A part of me wants to escape and not worry about it, I think well, I can just throw up and still do that. But then the flip part of me just says well just, I just, I just don't want to do anything. I do my homework or I exercise, or I just feel crazy. I mean, I just, I bite my tongue a lot."

Case 5: Subject stated, "I like to isolate, um, anger, anger, I pretty much let it, let it keep stuffing and stuffing until it finally blows up."

Case 8: Subject stated, "Strong feelings . . . I don't know if I can identify with it. I would just stuff it all. I would not acknowledge if I felt lonely, that would mean that I'm feeling sorry for myself. That would go with self-pity. So you don't feel that way, you're not allowed to feel that way."

Case 9: Subject stated, "I have really learned or developed the ability to, to not let it overwhelm me and to really push it down and in some ways, I get upset because I just, I learned how to do that. I don't get overwhelmed. I've learned to push them down."

Case 10: Subject stated, "I think that the best analogy I have with it is it's kind of like you have all these

feelings, or I tend to really keep my feelings to myself and they build up and build up and build up and as they build up there's no release for them and there's all that tension. And so, by putting things in my mouth or by putting things into my body, it's kind of, almost like shoving that back down and kind of replacing a feeling with food or replacing a negative emotion with food and just kind of you put it in and shove it down and that, you know, kind of displaces all the feelings that you feel building up inside you."

Category 3: Tendency to displace negative or strong feelings onto eating and body appearance. The 10 subjects below reported a tendency to displace negative or strong feelings onto eating and body appearance.

Case 2: Subject stated, "Being thin equals happiness . . . not having to worry about being fat or ugly, not having to worry about other people seeing my flaws. So it took away a lot of that for a while. But then, it kind of, the table turned, and then it was like I think it was like that for a while and then after I got used to being thin I realized that stuff wasn't taken away. When coping with strong feelings . . . I'd eat a lot."

Case 3: Subject stated, "When my feelings eat at me and I try to deal with my eating. If I don't eat and I feel hungry, I'll feel better. I don't know why. I wonder, I'm concentrating on something else. I'm not thinking about the problem at hand, it's something to think about. When I

purge I feel empty. Not just physically empty. I think, it's like, I throw up the food, now all my problems go with it."

Case 4: Subject stated, "A part of me wants to escape and not worry about it, I think, well, I can just throw up and still do that."

Case 6: Subject stated, "My biggest thing is when I compare myself to others. I mean that is really, it's like if I see somebody that's skinny. And it depends on what kind of mood, I mean, if I'm in a strange mood, I see somebody that's skinny, I'll never look like that. And, it's just like I start beating myself up. I guess one of the biggest things I'm working on is self-acceptance. Realizing that, you know, what's inside is what matters more than what's on the outside. And, I think the biggest thing too, is, I mean, I don't know, if I would be 50 pounds skinnier, if I would feel the same way about myself or if I'd be . . . "

Case 7: Subject stated, "My marriage, my life at work, being taken seriously, not being taken seriously, you know a lot of times when you are heavy like I am people don't take you seriously because they assume you are stupid or you are dumb or obviously you have no self-control because you can't control your body, that kind of stuff."

Case 8: Subject stated, "I feel totally in control. Nobody can . . . nobody can make me stop. Nobody knows I'm doing it. I feel relieved and I feel in total control of

myself. [When feeling like she is fat] Um, of just emotions, total self-disgust. Desire to withdraw, to hibernate, not go out. Um, self-hatred, lots of self-hatred. Um, if, if my bodily sensations is fat, which it always is, uh, there's just a lot of hatred."

Case 9: Subject stated, "And not only is the food coming out and it's a release for all that tension. After I've purged I feel almost cleansed. I don't know if that's the word I'm looking for but there's just that release."

Case 10: Subject stated, "I think comparison or competition has gotten me into this eating disorder. I have to be better. Somehow I have to measure up or be better than my peers on a daily basis. I have to be thinner. I think that that was a big motivation. After I've purged I feel almost cleansed. I don't know if that's the word I'm looking for. But there's just that release."

Case 11: Subject stated, "When I'm overwhelmed with feeling fat what's going on emotionally for me is that I'm not good enough."

Case 12: Subject stated, "When I am lonely like today when my mom dropped me off and said I'm going to get my mail and I said O.K. and than I ate and I puked. Maybe I wasn't that lonely. Maybe I just felt like throwing up. A lot of times I just feel like throwing up. Feelings that would contribute to binge are negative feelings or thoughts like loneliness or sadness or if something bad happens like a boyfriend dumps me or, you know, any of that kind of stuff."

When I binge I don't know, I just forget about things . . . I just eat. I like to eat I guess, I don't know. It just makes everything better."

Category 4: Utilization of splitting defenses. The 10 subjects below reported the use of splitting defenses.

Case 2: Subject stated, "When heavier I felt like every single flaw about me was visible. Whether it was not just the physical thing but my personality flaws or any other flaw I might have was visible. I didn't feel like I had that power anymore so I didn't feel like I was important."

Case 3: Subject stated, "When I'm really upset about something and I eat and eat and I just don't want to think about it. Then I feel bad because I ate so much and it all comes up. All the problems are down the toilet. I feel better."

Case 4: Subject stated, "You know, I'm pulling from both sides. I've got one side telling me you're fat, you're ugly, they're laughing. The other side is going, I don't think so. Chill man. And it's sometimes I fall into both sides."

Case 6: Subject stated, "Like the other day I was training this new girl. And she was skinny and really pretty and I started comparing myself. I started thinking: I'll never be like that, and I'm fat and ugly. I can do this in a matter of minutes and that started the binge. I called my therapist's answering machine and it was like life

or death. And really, I didn't even know what was going on. I knew I binged, I knew I trained this girl. But that comparison thing I didn't really know what was happening."

Case 7: Subject stated, "It's too hard to be by myself. I get this intense panicky feeling that I don't know, it's hard to describe. I've got to get out of here. I've got to be around people. Even if I just go to the store or something."

Case 8: Subject stated, "When I think that I have done something stupid, when I've just not quite, I don't know I when I've done something stupid out socially or, you know, said something stupid to somebody else, and I go, Oh God, I can't believe I said that. And, you know, it was just then it would just go round and round in my head, and I would be apt to binge, binge and purge. Uh, or do something."

Case 9: Subject stated, "It basically, the 9 weeks was the major project and so there was the failure there. And that really precipitated the beginning of the eating disorder, severe depression, uh, self-mutilation, um, and a really hard spring. It was a failure, It was, it was a failure."

Case 10: Subject stated, "I think I feel fear like a fear that my body is going to just get out of control and just get so big that I can't, you know, do anything about it."

Case 11: Subject stated, "When I'm angry I get to be a different person."

Case 12: Subject stated, "I eat past the point of being full and I keep eating and eating until I feel like my stomach is going to explode and than I feel real like panicky, like I've just got to get everything out of me. If I don't get everything out of me I'm going to get real fat."

Cross Analysis Between the Two Samples

This section includes a cross analysis performed on each group separately for comparison purposes. When each sample was analyzed individually, no further categories were added for any of the four Domains. The same convention was used for classifying each category. A sample size of 1-2 was considered a *variant* category, a sample size of 3-4 was considered a *typical* category, and a sample size of 5-6 was considered a *general* category. Each Domain is presented individually below addressing the categories for the Low Bulimic group and the High Bulimic group.

When the Domain Bulimic Symptoms was analyzed only one category was identified. This was Utilization of eating as a defense to maintain control that identified 5 out of 6 cases of the High Bulimic scorers; therefore, it was considered a *general* category. The category developed for the Bulimic group under the Domain Eating Symptoms is now presented.

**Category for the Domain
Bulimic Symptoms for the
High Bulimic Group**

Category 1: Utilization of eating as a defense to maintain control.

Case 7: Subject stated, "I feel guilty because I can't control myself."

Case 8: Subject stated, "After I purged I would feel totally in control. Nobody can . . . nobody can make me stop. Nobody knows I'm doing it. I feel relieved and I feel in total control of myself. Not of anybody else, but of myself."

Case 9: Subject stated, "Being heavy would say that I don't take care of myself or I have no willpower. No control over my life, control over me, which is true anyway, but it would be manifested outwardly."

Case 10: Subject stated, "You feel like if there is nothing else in your life that makes sense and feel so powerless to control anything and everything is so chaotic there has got to be something in my life that I can control."

Case 11: Subject stated, "After I purge I feel kind of like a good girl. I feel good because I ate and broke a rule. I purge it up the best way I can and then I feel a little bit better. I feel in control again."

**Category for the Domain
Bulimic Symptoms for the
Low Bulimic Group**

When the Domain Eating Symptoms was analyzed for the Low Bulimic Group, one category was identified. The

category that was identified was Utilization of eating as a defense to maintain control, which was identified in four cases; therefore, it was considered *typical*. The category developed for the Low Bulimic Group under the Domain Eating Symptoms is now presented.

Category 1: Utilization of eating as a defense to maintain control.

Case 1: Subject stated, "When I would binge, I felt so much more in control, like I didn't have to worry."

Case 2: Subject stated, "I felt it said I was weak and that I wasn't desirable and that I didn't have any control over myself."

Case 3: Subject stated, "I just thought my dad was very controlling and I thought if I could control my weight that was something he couldn't take away from me and people try."

Case 6: Subject stated, "I have no control over my binge. It's in my mouth and in my stomach before I realize I even ate it. So it's about being out of control and then being angry at myself."

Categories for the Domain Significant Relationships in the High Bulimic Group

When the Domain Significant Relationships was analyzed six categories were identified. The first category was Disavowal of aspects of subject's personality by family members creating a superficiality or lack of depth, which was found in 6 out of 6 cases; therefore, it was considered a *general* category. The second category was Strong emphasis

on food intake and appearance in family, which was identified in 6 out of 6 categories; therefore, it was considered a *general* category. The third category was Punishing behaviors toward food intake or appearance in family, which was found in 6 out of 6 cases; therefore, it was considered *general*. The fourth category was Strong desire for paternal acceptance, which was found in 2 out of 6; therefore, it was considered *variant*. The fifth category was Controlling, critical maternal figure, which was found in 6 out of 6 cases; therefore, it was considered *general*. The sixth category was Enmeshed relationship with mother, which was found in 4 out of 6 cases; therefore, it was considered *typical*. The categories developed for the High Bulimic Group under the Significant Relationships Domain are now presented.

Category 1: Disavowal of aspects of subject's personality by family members creating a superficiality or lack of depth.

Case 7: Subject stated, "She's very controlling with her children, she wants to direct our lives and tell us. She 'shoulds' me to death and I'm like 'Will you listen to me?' She wants to give me advice."

Case 8: Subject stated, "Mom would never let me know that she was proud of anything I did. She would be more apt to let somebody else know. She was critical so I wouldn't get a big head."

Case 9: Subject stated, "Mother liked having people home. She was always loving, warm, giving and fixing, cooking and faithful. She desired an idyllic world. Anger wasn't allowed."

Case 10: Subject stated, "I guess it reaffirms that feeling where she doesn't really know me. We don't spend a lot of time together and I feel like she really doesn't know me. And she only catches glimpses of me and usually they're something negative she has to say about when we're out together."

Case 11: Subject stated, "She [foster mother] didn't like me. I was fat. Or if I would pig out I was bad. Or at school I was bad [crying]. Or if I didn't eat my food fast enough I was bad."

Case 12: Subject stated, "We do a lot of things together but really we don't see eye to eye on anything."

Category 2: Strong emphasis on food intake and appearance in family.

Case 7: Subject stated, "I think the biggest instigator who called me names about my weight was my brother. He would puff out his cheeks and call me fat and things like that, you know. Chubby, whatever. I went to Weight Watchers when I was 10. So I think I always knew, I always knew I was overweight."

Case 8: Subject stated, "Family told me I was chubby. I was 5 years old, just before my kindergarten year, when I started discussing calories."

Case 9: Subject stated, "I was sort of the family garbage can in most cases. I mean, that's as far as the body, that's probably what my dad pushed the most. You need more exercise, you need to get out there and do something."

Case 10: Subject stated, "When I was probably 10 or 11 years old, and I wish I had a picture, because I was skinny as a rail. My sister started calling me 'thunder thighs and tons of buns'. Those were her two nicknames for me and she called me it all the time. And I hated it, I couldn't stand it."

Case 11: Subject stated, "They would call me fat. My dad would always call me pudgy. They would call me a pig."

Case 12: Subject stated, "They complimented me until I started gaining weight and then they said 'Oh stop eating so much' or 'Oh look your face is getting chubby.' And my dad was like 'Oh look your arms are getting chubby.'"

Category 3: Punishing behaviors toward food intake or appearance in family.

Case 7: Subject stated, "I can remember 'you shouldn't eat that'. I remember sneaking food."

Case 8: Subject stated, "I was 5 years old, just before my kindergarten year, when I started discussing calories. My mom had a very subtle way of letting me know I was heavy."

Case 9: Subject stated, "I remember situations where mom would say 'Are you hungry or are you just eating?'"

Case 10: Subject stated, "My mother would always say 'I don't want you to be like me' and she's very overweight."

Case 11: Subject stated, "Meal times were not good. Because I was always the last one to start eating and then when the alarm would go off and there wasn't any time left and I wasn't done when the time was up she would hurt me. And then if I got caught with food in the back of my mouth she would hurt me. And my dad wouldn't let me eat corn because he said corn was for hogs and I was too fat to eat corn."

Case 12: Subject stated, "Even before I was bulimic I was 120 pounds and it was my birthday and I was eating a piece of my birthday cake and my mom took it away from me and she's like 'Oh, you don't want to eat this,' she's like, you will put on all that weight you just lost.' On my birthday!"

Category 4: Strong desire for paternal acceptance.

Case 8: Subject stated, "And I wanted to be daddy's favorite, I wanted approval, I wanted approval big time."

Case 9: Subject stated, "Dad was a college professor. College students were more important than his children. I was always seeking his approval and one way I could get it was on the intellectual level."

Category 5: Controlling, critical maternal figure.

Case 7: Subject stated, "She's also very controlling

with her children, she wants to direct our lives and tell us."

Case 8: Subject stated, "She never told me she loved me. Threatened by my bulimia--she's distancing herself, using words like you're stupid. She would call me chunky."

Case 9: Subject stated, "I felt like I had to be good. Always be good, be the best. Make it perfect. So I got good grades, I practiced the piano, I went to church when I was supposed to. At times when I was angry my mom would say 'this is not acceptable.' The angry feelings were not acceptable. This is my mom."

Case 10: Subject stated, "We don't spend a lot of time together and I feel like she really doesn't know me. And she only catches glimpses of me and usually they're something negative she has to say about when we're out together."

Case 11: Subject stated that her foster mother would describe her as: "Crazy, stupid, fat, um . . . worthless, never going to amount to anything, a little foster girl."

Case 12: Subject stated, "We do a lot of things together but really we don't see eye to eye on anything. We don't understand each other, we don't, I mean, we never have . . . ever since we've tried and started talking things out and going to therapy and everything but she'll never listen to me and I guess I'll never listen to her but I know . . . but she never shuts up. You can't get a word in edgewise

with her so there is really no point. It just ends up in a big fight."

Category 6: Enmeshed relationship with mother.

Case 7: Subject stated, "My mother has a very codependent personality. She was codependent with my father. My dad was an alcoholic--he's been sober for 5 or 6 months. I would take over that role of being my mom's partner."

Case 8: Subject stated, "Our relationship is enmeshed. More on my part than on hers. I'm extremely dependent for her approval. I became a little kid again when I was around her and she had to take care of me."

Case 10: Subject stated, "My mom would describe me as kind of like the fixer or the mother in the family where I'm always trying to make sure everybody's taken care of and everything."

Case 12: Subject stated, "Mom would call me a spoiled little brat and I'm ruining the family and breaking apart the family because, I don't know. And her and dad are going to end up getting a divorce because I'm putting so much stress on them and stuff like that."

**Categories for the Domain
Significant Relationships
for the Low Bulimic Group**

When the Domain Significant Relationships was analyzed for the low Bulimic Group, six categories were identified. The first category was Disavowal of aspects of subject's

personality by family members creating superficiality or lack of depth, which was found in 6 out of 6 cases; therefore, it was considered a *general* category. The second category was Strong emphasis on food intake and appearance in family, which was found in 4 out of 6 cases; therefore, it was considered a *typical* category. The third category was Punishing behaviors toward food intake or appearance in family, which was found in 3 out of 6 cases; therefore, it was considered a *typical* category. The fourth category was Strong desire for paternal acceptance, which was found in 3 out of 6 cases; therefore, it was considered a *typical* category. The fifth category was Controlling, critical maternal figure, which was found in 5 out of 6 cases; therefore, it was considered a *general* category. The sixth category was Enmeshed relationship with mother, which was found in 3 out of 6 cases; therefore, it was considered a *typical* category. The categories developed for the Low Bulimic Group under the Significant Relationships Domain are now presented.

Category 1: Disavowal of aspects of subject's personality by family members creating a superficiality or lack of depth.

Case 1: Subject stated, "I wish he [father] would love me for who I was."

Case 2: Subject stated, "I think in a lot of ways I'm supposed to take on my mother's role. I was the one who was supposed to have a lot of kids and stay at home. So in many

ways I think she projects things on me. What she wanted to have she wanted me to do.

Case 3: Subject stated, "I couldn't voice my opinion to my father. It was 'shut up I don't want to hear it.'"

Case 4: Subject stated, "I feel like I let my parents down. I feel like I disappointed them but they wouldn't tell me that."

Case 5: Subject stated, "My mother was the kind of mother that the child was supposed to be seen and not heard."

Case 6: Subject stated, "As far as actually sitting down and talking about something in depth . . . that doesn't happen. We talk about family, we talk about things that are going on, but not anything real serious. I mean, I'd never, I think once I told her I had an eating disorder and she just doesn't get it."

Category 2: Strong emphasis on food intake and appearance in family.

Case 2: Subject stated, "She was saying she liked how I looked but she didn't like me as a person." Later she added, "I wasn't allowed to eat unless she said I could."

Case 3: Subject stated, "If I would eat something I had a tendency to, when I would get depressed because that was my comfort and when I would eat he would puff out his cheeks and say 'Now you're going to look like Miss Piggy' or whatever."

Case 4: Subject stated, "I know once my older sister and I, my sister is 2 years older than I am, it never came like a quote competition but I think it was there. But I don't know whether she felt that way or it was something that I brought on. It bothers me when she says she's wearing a certain size or, you know."

Case 6: Subject stated, "I remember growing up because I have a friend, she is still to this day a twig. I mean, she can eat anything and I remember we were 10 years old we went shopping, of course she had a skinny size, you know, pair of jeans and whatever and what I tried on didn't fit and my mom was like, why can't you be like her? That stuff every once in a while pops in my head. You know, I don't understand why you can't wear that size."

Category 3: Punishing behaviors toward food intake or appearance in family.

Case 2: Subject stated, "He [father] comments on what time I eat, or how much I'm eating or 'You're going to be as big as a house.' My mom says that too."

Case 3: Subject stated, "If I would eat something I had a tendency to, when I would get depressed because that was my comfort, and when I would eat he would puff out his cheeks and say 'Now you're going to start looking like Miss Piggy' or whatever."

Case 6: Subject stated, "And, 10 must have like been the natural age because my mom, one night she bought ice cream. Anyway, I obviously got too much in the bowl or

something and she said if you eat all of that you're going to get fat. When she said that it was like major, you know. I must be this big, fat pig. I don't deserve to eat this. I mean that is all that stuff that I'm doing now."

Category 4: Strong desire for paternal acceptance.

Case 1: Subject stated, "I wish he would love me for who I was."

Case 3: Subject stated, "He was always trying to control me and wasn't happy with anything I was trying to do."

Case 5: Subject stated, "My father was very supportive when I was sick. He stood by me. So that was a real big loss, he died recently within the last 2 years. And that bothers me a lot still. I feel a lot of guilt about that. All the pain I put on my dad. I guess I feel a lot of sadness, a lot of guilt. A lot of mixed emotions. I feel a lot of shame."

Category 5: Controlling, critical maternal figure.

Case 1: Subject stated, "Mother can be overly critical too."

Case 2: Subject stated, "She would take me clothes shopping and if I didn't like what she'd pick off the rack she'd get mad and say 'Fine, just forget it.' And she'd stomp out of the store and I wouldn't get anything at all. And then she'd start buying me things without me being there."

Case 4: Subject stated, "I'm scared to tell her about the eating disorder because she would see me as a failure. I disappointed her again. I didn't want her to feel she's a bad mother."

Case 5: Subject stated, "My mother is very cold, very uncaring, I think. She's never been one to show unconditional love toward her kids. I would say emotionally abusive."

Case 6: Subject stated, "But when I was 10 and she said 'Why can't you look like her or be that size', it was like, why do you care what I look like when you don't even know who I am or what happened?"

Category 6: Enmeshed relationship with mother.

Case 1: Subject stated, "We are very close, we love each other. She's like a friend." Subject also stated, "My mother was the same way. We are like the same."

Case 2: Subject stated, "I think in a lot of ways I'm supposed to take on my mother's role. I was the one who was supposed to have a lot of kids and stay at home. So in many ways I think she projects things on me. What she wanted to have she wanted me to do."

Case 3: Subject stated, "Growing up, when I was in high school, I felt like I had to protect my mom. She was so weak and so fragile. Everything and anything anybody says hurts her and it makes me angry and it hurts me. And, I just felt like I had to push some things. I guess maybe

that's why my dad and I clash so much because I hated the way he treated her and I would rather him take it out on me."

**Categories for the Domain
Identity Issues for the
High Bulimic Group**

When the Domain Identity Issues was analyzed three categories were identified. The first category was Positive self-esteem and affects related to being thin, which was found in 6 out of 6 cases; therefore, it was considered a *general* category. The second category was Weight gain-heaviness directly related to inherent badness and ineptness, which was found in 6 out of 6 cases; therefore, it is considered *general*. The third category was Internal strivings for perfection, which was found in 4 out of 6 cases; therefore, it was considered *typical*. The categories developed for the High Bulimic Group under the Domain Identity Issues are now developed.

Category 1: Positive self-esteem and affects related to being thin.

Case 7: Subject stated, "I imagine that my self-esteem would be much better than it is now so I imagine that I would have a better quality of life, less depression. I am depressed often. A lot of areas in my life would benefit in my life from being thin."

Case 8: Subject stated, "It would be wonderful. I would be free. I would feel euphoric. I would feel in

control of myself. I'd like it, it would be good. I wish I were very, very thin."

Case 9: Subject stated, "It is an achievement in a mean sort of way."

Case 10: Subject stated, "The connotation I make and the relationship I make is that thin is happy. Everything works out for thin people, it seems like thin people just have fun."

Case 11: Subject stated, "I could run, and I could put on any clothes I wanted to, and I would be noticed a lot more by guys."

Case 12: Subject stated, "I'd be happier. I wouldn't have to worry so much about gaining weight. I wouldn't have to worry so much about how much I eat."

Category 2: Weight gain-heaviness directly related to inherent badness and ineptness.

Case 7: Subject stated, "When you are heavy like I am people don't take you seriously because they assume you are stupid or you are dumb or obviously you have no self-control because you can't control your body, that kind of stuff."

Case 8: Subject stated, "Oh I can't. Oh, the whole thought of being 50 pounds heavier would be horrible. I would rather be dead. Hips, breasts, hips, thighs would all be round. It's that whole sense of being soft and mushy. I hate being mushy."

Case 9: Subject stated, "Being heavy would say that I don't take care of myself or I have no willpower. No

control over my life, control over me, which is true anyway, but it would be manifested outwardly."

Case 10: Subject stated, "When you are heavier, you see yourself as overweight. You see yourself as flawed, or you see yourself as not normal, or you know, not fitting into a certain category or the social normal thing. And it's hard to not feel like a misfit."

Case 11: Subject stated, "It's really bad. We went on a choir tour and I felt very self-conscious because people were pushing me in a wheelchair and everything. It was bad . . . I felt really, really self-conscious."

Case 12: Subject stated, "Well, you know, it's not just about being fat, it's everything. I don't know, it just doesn't look good. It's just . . . I didn't like being fat. I don't know."

Category 3: Internal strivings for perfection.

Case 7: Subject stated, "I always thought when I was an adult that I would be something special. I would do something extraordinary. I'm just an ordinary person. I never dreamed that I would be 25 years old and still be fat. And that is where a lot of the anger comes in."

Case 8: Subject stated, "It wasn't that they expected me to be perfect, but I was criticized all the time so I kept thinking that I had to be perfect in order for the criticism to stop."

Case 9: Subject stated, "Be perfect. Succeed at everything you do. If you aren't going to succeed, don't do it. Be good, follow the rules, don't get into trouble. Don't make anybody upset."

Case 10: Subject stated, "When you're thin or about, you know, as close to being thin, there's nothing deviant about you."

**Categories for the Domain
Identity Issues for the
Low Bulimic Group**

When the Domain Identity Issues was analyzed for the Low Bulimic Group, three categories were identified. The first category was Positive self-esteem and affects related to being thin, which was identified in 6 out of 6 cases; therefore, it was considered a *general* category. The second category was Weight gain-heaviness directly related to inherent badness and ineptness, which was identified in 6 out of 6 cases; therefore, it was considered a *general* category. The third category was Internal strivings for perfection, which was identified in 3 out of 6 cases; therefore, it was considered a *typical* category. The categories developed for the Low Bulimic Group under the Identity Issues Domain are now presented.

Category 1: Positive self-esteem and affects related to being thin.

Case 1: Subject stated, "If I was thinner it would be great. It's like I would have more confidence, more ability to socialize."

Case 2: Subject stated, "If I were thinner I'd have more power. More kind of like I was perfect. So I mean I felt like if my body was perfect than everything else would have been perfect."

Case 3: Subject stated, "Bright, bright sunshine, and I don't know sunshine and rainbows. When I got down and my lowest weight was 108 and when I was there it was like I was floating. It was like I was so light, I just floated. I felt like, I don't know, it was a nice light feeling, like on a cloud."

Case 4: Subject stated, "More confidence when thinner, I felt better when I was thinner."

Case 5: Subject stated, "Felt better about myself. But then again the thinner I got, the thinner I had to get."

Case 6: Subject stated, "I would probably be happier and married. If I were thinner it would say that I had my act together, I cared about myself."

Category 2: Weight gain-heaviness directly related to inherent badness and ineptness.

Case 1: Subject stated, "Fat is ugly. Fat people repulse me, no discipline."

Case 2: Subject stated, [Being heavy] "I felt like every single flaw about me was visible. Whether it was or not just the physical thing but my personality flaw or any other flaw I might have was visible. I didn't feel like I had that power anymore so I didn't feel like I was important. I was embarrassed as to how big I was."

Case 3: Subject stated, "I don't know if it would just be the embarrassment or just the self-hatred more than anything that I was not in control of my weight anymore."

Case 4: Subject stated, "When 50 pounds heavier I feel like a cow."

Case 5: Subject stated, "It would be horrible. It would be absolutely horrible. I couldn't live with myself, I couldn't do it."

Case 6: Subject stated, "I feel like this huge person inside. If I were thinner it would say that I had my act together, I cared about myself."

Category 3: Internal strivings for perfection.

Case 2: Subject stated, "More power. More kind of like I was perfect. So I mean I felt like if my body was perfect then everything else would have been perfect. So in a way I felt like that was the key."

Case 3: Subject stated, "It made me want to be and struggle that much harder to be the perfect weight, the perfect size, the perfect shape because I just grew up thinking how all men are and if I didn't look like these women on TV and if I didn't look like what my dad thought women were supposed to look like. If I grew up looking like my mom it wasn't good enough because I didn't want to get married to someone whose gonna look at other women the way my dad does."

Case 6: Subject stated, "I think she [mom] pictures a perfect daughter, skinny, married, and whatever, popular, a lot of friends."

**Categories for the Domain
Utilization of Defenses for
the High Bulimic Group**

When the Domain Utilization of Defenses was analyzed for the High Bulimic Group, four categories were identified. The first category was Utilization of isolation and avoidance strategies, which was found in 2 out of 6 cases; therefore, it was considered a *variant* category. The second category was Tendency to suppress, stuff, hold in feelings, which was found in 3 out of 6 cases; therefore, it was considered a *typical* category. The third category was Tendency to displace negative or strong feelings onto eating and body appearance, which was found in 6 out of 6 cases; therefore it was considered a *general* category. The fourth category was Utilization of splitting defenses, which was found in 6 out of 6 cases; therefore, it was considered a *general* category. The categories developed for the High Bulimic Group under the Domain Utilization of Defenses are now presented.

Category 1: Utilization of isolation and avoidance strategies.

Case 9: Subject stated, "I cope by not facing it. By not presenting it."

Case 10: Subject stated, "I think my first instinct is to kind of close myself off from people. I kind of isolate myself and my next instinct is to eat."

Category 2: Tendency to suppress, stuff, hold in feelings.

Case 8: Subject stated, "Strong feelings . . . I don't know if I can identify with it. I would just stuff it all. I would not acknowledge if I felt lonely, that would mean that I'm feeling sorry for myself. That would go with self-pity. So you don't feel that way, you're not allowed to feel that way."

Case 9: Subject stated, "I have really learned or developed the ability to, to not let it overwhelm me and to really push it down and in some ways, I get upset because I just, I learned how to do that. I don't get overwhelmed. I've learned to push them down."

Case 10: Subject stated, "I think that the best analogy I have with it is it's kind of like you have all these feelings or I tend to really keep my feelings to myself and they build up and build up and build up and as they build up there's no release for them and there's all that tension. And so, by putting things in my mouth or by putting things into my body, it's kind of, almost like shoving that back down and kind of replacing a feeling with food or replacing a negative emotion with food and just kind of you put it in and shove it down and that, you know, kind of displaces all the feelings that you feel building up inside you."

Category 3: Tendency to displace negative or strong feelings onto eating and body appearance.

Case 7: Subject stated, "My marriage, my life at work, being taken seriously, not being taken seriously, you know a lot of times when you are heavy like I am people don't take you seriously because they assume you are stupid or you are dumb or obviously you have no self-control because you can't control your body, that kind of stuff."

Case 8: Subject stated, " I feel totally in control [After purging]. Nobody can . . . nobody can make me stop. Nobody knows I'm doing it. I feel relieved and I feel in total control of myself." "[When feeling like she is fat] Um, of just emotions, total self-disgust. Desire to withdraw, to hibernate, not go out. Um, self-hatred, lots of self-hatred. Um, if, if my bodily sensations is fat, which it always is, uh, there's just a lot of hatred."

Case 9: Subject stated, "Getting rid of the food gives the cleansing of badness."

Case 10: Subject stated, "And not only is the food coming out and it's a release for all that tension. After I've purged I feel almost cleansed. I don't know if that's the word I'm looking for. But there's just that release."

Case 11: Subject stated, "When I'm overwhelmed with feeling fat what's going on emotionally for me is that I'm not good enough."

Case 12: Subject stated, "When I am lonely like today when my mom dropped me off and said I'm going to get my mail and I said O.K. and than I ate and I puked. Maybe I wasn't

that lonely. Maybe I just felt like throwing up. A lot of times I just feel like throwing up. Feelings that would contribute to binge are negative feelings or thoughts like loneliness or sadness or if something bad happens like a boyfriend dumps me or, you know, any of that kind of stuff." She later added, "When I binge I don't know, I just forget about things . . . I just eat. I like to eat I guess, I don't know. It just makes everything better."

Category 4: Utilization of splitting defenses.

Case 7: Subject stated, "It's too hard to be by myself. I get this intense panicky feeling that I don't know, it's hard to describe. I've got to get out of here. I've got to be around people. Even if I just go to the store or something."

Case 8: Subject stated, "When I think that I have done something stupid, when I've just not quite, I don't know I when I've done something stupid. Out socially or you know, said something stupid to somebody else, and I go, Oh God, I can't believe I said that. And, you know, it was just then it would just go round and round in my head, and I would be apt to binge, binge and purge. Uh, or do something."

Case 9: Subject stated, "It basically, the 9 weeks was the major project and so there was the failure there. And that really precipitated the beginning of the eating disorder, severe depression, uh, self-mutilation, um, and a

really hard spring. It was a failure, it was, it was a failure."

Case 10: Subject stated, "I think I feel fear like a fear that my body is going to just get out of control and just get so big that I can't, you know, do anything about it."

Case 11: Subject stated, "When I'm angry I get to be a different person."

Case 12: Subject stated, "I eat past the point of being full and I keep eating and eating until I feel like my stomach is going to explode and than I feel real like panicky like I've just got to get everything out of me. If I don't get everything out of me I'm going to get real fat."

**Categories for the Domain
Utilization of Defenses for
the Low Bulimic Group**

When the Domain Utilization of Defenses was analyzed for the Low Bulimic Group, four categories were identified. The first category that was identified was Utilization of isolation and avoidance strategies, which was identified in 4 out of 6 cases; therefore, it was considered a *typical* category. The second category was Tendency to suppress, stuff, hold in feelings, which was identified in 4 out of 6 cases; therefore, it was considered a *typical* category. The third category was Tendency to displace negative or strong feelings onto eating and body appearance, which was identified in 4 out of 6 cases; therefore, it was considered

a *typical* category. The fourth category was Utilization of splitting defenses, which was identified in 4 out of 6 cases; therefore, it was considered a *typical* category. The categories developed for the Low Bulimic Group under the Domain Utilization of Defenses for the Low Bulimic Group are now presented.

Category 1: Utilization of isolation and avoidance strategies.

Case 1: Subject stated, "Food helps me escape, avoid any worry."

Case 3: Subject stated, "When my feelings eat at me and I try to deal with it with my eating. If I don't eat and I feel hungry, I'll feel better. I don't know why. I wonder, I'm concentrating on something else. I'm not thinking about the problem at hand, it's something to think about."

Case 5: Subject stated, "I like to isolate, um, anger, anger. I pretty much let it, let it keep stuffing and stuffing until it finally blows up. I tried to avoid her [mother] as much as possible. When I was home from school and I was having a tough time with her I isolated a lot."

Case 6: Subject stated, "Actually I think a lot of the eating disorder started when I was abused, I was like 7 or 8, so I think as far as like eating food, when I was growing up I didn't date that much because I was afraid of guys. I thought I might as well be fat so they can't ask me out or they won't want to ask me out. Then that will be my excuse. If I were skinny then there should be no excuse."

Category 2: Tendency to suppress, stuff, hold in feelings.

Case 1: Subject stated, "I hold it in, that's half of my problem. Letting things build up, it gets so hard."

Case 3: Subject stated, "I was afraid to open my mouth with my dad. And so I would keep it all bottled in and now if I'm angry I just say what I feel."

Case 4: Subject stated, "Strong feelings . . . I fight and struggle big time. A part of me wants to escape and not worry about it, I think well, I can just throw up and still do that. But then the flip part of me just says, well just, I just, I just don't want to do anything. I do my homework or I exercise, or I just feel crazy. I mean, I just, I bite my tongue a lot."

Case 5: Subject stated, "I like to isolate, um, anger, anger, I pretty much let it, let it keep stuffing and stuffing until it finally blows up.'

Category 3: Tendency to displace negative or strong feelings onto eating and body appearance.

Case 2: Subject stated, "Being thin equals happiness . . . not having to worry about being fat or ugly, not having to worry about other people seeing my flaws. So it took away a lot of that for a while. But then, it kind of, the table turned, and then it was like I think it was like that for a while and then after I got used to being thin I realized that stuff wasn't taken away. So it was kind of a cycle." She later added, "When coping with strong feelings . . . I'd eat a lot . . . I was just . . . it was kind of

like I felt like eating because it would fill a space or give me a high."

Case 3: Subject stated, "When my feelings eat at me and I try to deal with it with my eating. If I don't eat and I feel hungry, I'll feel better. I don't know why. I wonder, I'm concentrating on something else. I'm not thinking about the problem at hand, it's something to think about." She later added, "When I purge I feel empty. Not just physically empty. I think, it's like, I throw up the food, now all my problems go with it."

Case 4: Subject stated, "A part of me wants to escape and not worry about it, I think well, I can just throw up and still do that."

Case 6: Subject stated, "My biggest thing is when I compare myself to others. I mean that is really, it's like if I see somebody that's skinny. And it depends on what kind of mood, I mean, if I'm in a strange mood, I see somebody that's skinny, I'll never look like that. And, it's just like I start beating myself up." She later added: "I guess one of the biggest things I'm working on is self-acceptance. Realizing that, you know, what's inside is what matters more than what's on the outside. And, I think the biggest thing too, is, I mean, I don't know, if I would be 50 pounds skinnier, if I would feel the same way about myself or if I'd be . . ."

Category 4: Utilization of splitting defenses.

Case 2: Subject stated, "When heavier I felt like every single flaw about me was visible. Whether it was not just the physical thing but my personality flaws or any other flaw I might have was visible. I didn't feel like I had that power anymore so I didn't feel like I was important."

Case 3: Subject stated, "When I'm really upset about something and I eat and eat and I just don't want to think about it. Then I feel bad because I ate so much and it all comes up . . . all the problems are down the toilet. I feel better."

Case 4: Subject stated, "You know, I'm pulling from both sides. I've got one side telling me you're fat, you're ugly, they're laughing. The other side is going, I don't think so. Chill man. And it's sometimes I fall into both sides."

Case 6: Subject stated, "Like the other day I was training this new girl. And she was skinny and really pretty and I started comparing myself. I started thinking I'll never be like that, and I'm fat and ugly. I can do this in a matter of minutes and that started the binge. I called my therapist's answering machine and it was like like life or death. And really I didn't even know what was going on. I knew I binged, I knew I trained this girl. But that comparison thing I didn't really know what was happening."

Summary of Cross Analysis

Results on the cross analysis of total samples identified seven *general* categories that included:

1. Disavowal of aspects of subject's personality by family members creating superficiality or lack of depth (12 out of 12 subjects)
2. Strong emphasis on food intake and appearance in family (10 out of 12 subjects)
3. Controlling, critical maternal figure (11 out of 12 subjects)
4. Positive self-esteem and affects related to being thin (12 out of 12 subjects)
5. Weight gain-heaviness directly related to inherent badness and ineptness (12 out of 12 subjects)
6. Tendency to displace negative or strong feelings onto eating and body appearance (10 out of 12 subjects)
7. Utilization of splitting defenses (10 out of 12 subjects)

The six *typical* categories included:

1. Utilization of eating as a defense to maintain control (9 out of 12 subjects)
2. Punishing behaviors toward food intake or appearance in family (9 out of 12 subjects)
3. Enmeshed relationship with mother (7 out of 12 subjects)
4. Internal strivings for perfection (7 out of 12 subjects)

5. Utilization of isolation and avoidance strategies (6 out of 12 subjects)

6. Tendency to suppress, stuff, hold in feelings (7 out of 12 subjects)

The one variant category included:

1. Strong desire for paternal acceptance (5 out of 12 subjects)

When the cross analysis was performed independently on the High Bulimic Group, there were nine *general* categories, three *typical* categories, and two *variant* categories. The nine *general* categories included:

1. Utilization of eating as a defense to maintain control (5 out of 6 subjects)

2. Disavowal of aspects of subject's personality by family members creating a superficiality or lack of depth (6 out of 6 subjects)

3. Strong emphasis on food intake and appearance in family (6 out of 6 subject)

4. Punishing behaviors toward food intake or appearance in family (6 out of 6 subjects)

5. Controlling, critical maternal figure (6 out of 6 subjects)

6. Positive self-esteem and affects related to being thin (6 out of 6 subjects)

7. Weight gain-heaviness directly related to inherent badness and ineptness (6 out of 6 subjects)

8. Tendency to displace negative or strong feelings onto eating and body appearance (6 out of 6 subjects)

9. Utilization of splitting defenses (6 out of 6 subjects)

The three *typical* categories included:

1. Enmeshed relationship with mother (4 out of 6 subjects)

2. Internal strivings for perfection (4 out of 6 subjects)

3. Tendency to suppress, stuff, hold in feelings (3 out of 6 subjects)

The two *variant* categories included:

1. Strong desire for paternal acceptance (2 out of 6 subjects)

2. Utilization of isolation and avoidance strategies (2 out of 6 subjects)

When a cross analysis was performed independently on the Low Bulimic Group there were four *general* and ten *typical* categories.

The four *general* categories were:

1. Disavowal of aspects of subject's personality by family members creating superficiality or lack of depth (6 out of 6 subjects)

2. Controlling, critical maternal figure (5 out of 6 subjects)

3. Positive self-esteem and affects to being thin (6 out of 6 subjects)

4. Weight gain-heaviness directly related to inherent badness and ineptness (6 out of 6 subjects)

The 10 *typical* categories were:

1. Utilization of eating as defense to maintain control (4 out of 6 subjects)

2. Strong emphasis on food intake and appearance in family (4 out of 6 subjects)

3. Punishing behaviors toward food intake or appearance in family (3 out of 6 subjects)

4. Strong desire for paternal acceptance (3 out of 6 subjects)

5. Enmeshed relationship with mother (3 out of 6 subjects)

6. Internal strivings for perfection (3 out of 6 subjects)

7. Utilization of isolation and avoidance strategies (4 out of 6 subjects)

8. Tendency to suppress, stuff, hold in feelings (4 out of 6 subjects)

9. Tendency to displace negative or strong feelings onto eating and body appearance (4 out of 6 subjects)

10. Utilization of splitting defenses (4 out of 6 subjects)

CHAPTER VI

SUMMARY, DISCUSSION, LIMITATIONS, IMPLICATIONS, AND RECOMMENDATIONS

Summary

Problem

Currently more and more women are becoming bulimic. Eating disorders are recognized as a major growing medical and psychiatric problem, affecting millions of women in the United States. According to the *DSM-IV*, the prevalence of bulimia nervosa among adolescent and young adult females is probably 1 to 3%.

Bulimia nervosa is highly refractory to current regimes. The psychiatric literature increasingly illustrates that formally diagnosed patients find it very difficult to fully recover with brief and superficial treatment interventions. According to a pilot study at Massachusetts Hospital in which 30 bulimic subjects were followed up at 35-42 months, the probability of relapse was 63% (Zerbe, 1993).

The eating disorder is a manifestation of other psychological and relational issues. While body identity dissatisfaction is a pivotal treatment issue in bulimia, it

is a part of a larger, complex set of issues that also must be addressed. This study investigated the hypotheses that disturbances in object relations and identity disturbance characterize the more severe bulimic syndrome.

Purpose

The purpose of this research was to investigate the relationship between the severity of bulimia, object relations, and identity. It has been postulated that women who have a more cohesive ego may respond to cognitive behavioral therapy whereas those who have less intact ego resources require more intensive psychodynamic approaches. This study provides empirical information regarding the nature of bulimia. The qualitative aspect of this study provides an understanding of the symptoms from the patient's point of view without relying solely on theoretical ideology. By assessing the severity of the subjects' eating disorder, their capacity for object relations, and their body identity disturbance, as well as assessing their own individual, internalized meanings, it was hoped that some light may be shed on the complex problem of bulimia.

Methodology

The sample for this study consisted of 30 women who were given the diagnosis of bulimia according to the *DSM-IV*. They were recruited through contact with therapists from Southwest Michigan and Northern Indiana. The study

involved the administration of three tests by the subject's primary therapist.

The three tests were: Bulimia Test-Revised, Bell Object Relations Inventory, and the Erwin Identity Scale. The Bulimia Test-Revised is designed to investigate a range of attitudes and behaviors associated with bulimia, categorizing subjects into bulimic and normal eaters. It is a 36-item scale with a 5-point forced-choice Likert format. Predictive ability is high, identifying significant differences between sources of bulimic eaters and normal eaters. The Bell Object Relations Inventory is a 45-item "true-false" test. The essential purpose of this measure is to assess a subject's object relations by determining how the individual experiences him or herself in relation to others and to the world. This conceptualization of object relations follows the definition of object relations as an ego function, which enables the individual to establish and maintain healthy interpersonal relationships. There are four dimensions of the Object Relations Inventory which include Alienation, Egocentricity, Insecure Attachment, and Social Incompetence. The Erwin Identity Scale is a 59-item scale with a 5-point Likert format. The EIS measures three dimensions of a student's self-image. Three dimensions include: Confidence, Sexual Identity, Conceptions about Body and Appearance.

The major statistical analysis methods used to analyze the collected data were correlation, multiple regression, and canonical correlation.

Twelve subjects were asked to participate in a qualitative interview to explore their feelings regarding the nature of their disorder. These 12 subjects were categorized in a "High Bulimic" or "Low Bulimic" group as defined by their BULIT-R score. A qualitative analysis was also performed on the data generated by each subject in both groups.

Discussion

Hypothesis 1

Hypothesis 1 stated: There is no correlation between the severity of the subject's bulimic symptoms as measured by the Bulimia Test-Revised and the severity of impairment in a subject's object relations as measured by the Bell Object Relations Inventory.

The null hypothesis was rejected. There were statistically significant correlations between the BULIT-R and Object Relations, specifically Alienation ($r = .479$, $p = .017$), Egocentricity ($r = .415$, $p = .023$), and Insecure Attachment ($r = .414$, $p = .023$). Social Incompetence did not show a statistically significant relationship ($r = .295$, $p = .113$). Each of these subscales is now discussed separately.

BULIT-R and Alienation. The correlation between the BULIT-R and Alienation indicated a moderate relationship ($r = .479$, $p = .007$) between bulimic symptomatology and feelings of Alienation.

Women with high Alienation scores indicate a basic lack of trust in relationships and problems with intimacy. It may be viewed as a difficulty in regulating appropriate closeness and distance in important relationships.

It is likely that the more actively entrenched in a cycling pattern of binge-purge behavior a bulimic woman is, the more likely it is that she will withdraw from social interaction and into isolation. Because of her inability to safely articulate her feelings, she may feel disconnected from others and socially isolated. In order to relate effectively with another in an intimate relationship, a certain amount of self-acceptance as well as acceptance from another is usually necessary. Bulimics typically suffer from an exaggerated degree of self-loathing and are highly critical. They are also taught their feelings are invalid. These factors contribute to creating difficulties for bulimic women in their successfully forming meaningful and rewarding interpersonal relationships. Negotiating closeness with food is easier than negotiating closeness with people.

Alienation was found to have the strongest relationship with the BULIT-R. A linear regression was conducted for BULIT-R versus Alienation. A scatter plot

with a fitted regression line for BULIT-R versus Alienation indicated a *R*-square of 23.5%. The outlier (Subject 9) contributed to a low correlation. This outlier was examined in order to develop a better understanding of her dynamics. When interviewed, Subject 9 indicated she continued to vomit almost every time she ate. She relied a great deal on denial and intellectualization. Although Subject 9's object-relations scores were low, her responses did indicate difficulty establishing intimate relationships. There was a pervasive theme of her need for control over her feelings. Anger was not allowed. When talking about parental expectations she stated, "Be perfect. Succeed at everything you do. If you aren't going to succeed, don't do it. Don't make anybody upset."

When talking about her awareness of anything else going on emotionally when feeling fat she stated, "I have really learned to not let it overwhelm me and to really push it down. . . . So I cope by not facing it."

On her tests she endorsed items indicating she has difficulty getting close to others. Her responses indicated she may lack basic trust and be sensitive to signs of abandonment. Her interview indicated the high premium she placed on doing things according to others' expectations. She also emphasized her fear of being viewed as a failure. Being viewed as angry was seen as unacceptable. This false self-presentation tends to close the opportunity for any genuine interaction. There is a

lack of connection that is supported by superficiality.

The qualitative analysis identified two themes directly pertaining to the scale of Alienation. These were "Utilization of isolation and avoidance strategies" and "Tendency to suppress, stuff, hold in feelings."

Six of the 12 reported strategies of isolation and avoidance as a means of coping. Only 2 of the 6 were in the "High Bulimic Group." Thus, the qualitative analysis failed to identify any difference between the "High Bulimic" group and the "Low Bulimic" Group in terms of isolation and avoidance.

Seven subjects reported a "Tendency to suppress, stuff hold in feelings." Of these 7, only 3 were in the "High Bulimic" group. Again, the qualitative analysis failed to identify a pattern that would substantiate that women who have more severe bulimic tendencies would have a stronger tendency to stuff or hold in their feelings. One explanation for this might be that the women who scored high on the BULIT-R may be less aware of their strong feelings. Subject 12 indicated a real lack of awareness regarding what her eating represented. She stated, "When I binge I don't know, I just forget about things. . . . I just eat. I like to eat I guess, I don't know. It just makes everything better." Subject 11 was diagnosed with a Multiple Personality Disorder. During her interview, when touching on emotional issues this individual dissociated. Each of these women was unable to clearly identify her

emotions. Their approach to their feelings indicated they struggled in terms of a better understanding.

BULIT-R and Egocentricity. The correlation between the BULIT-R scores and Egocentricity indicates a moderate relationship ($r = .415$, $p = .023$) between bulimic symptomatology and Egocentricity. Individuals who score high on this scale often perceive others only in relationship to themselves. Others may be viewed in a mistrustful, controlling, and exploitative manner. Because others are viewed as likely to defeat or humiliate others, the individual takes on a defensive, self-protective attitude. This attitude towards relationships prevents an individual from developing a mutual, give-and-take relationship.

This is consistent with the research that indicates that the bulimic woman's family possesses deficits in parental nurturance. These parents have been found to be more hostile, less supportive, and less nurturing. Specific analysis of mother-daughter relationships has indicated that the mothers felt their bulimic daughters were hostile, blaming, and rejecting, and they tended to blame their daughters for all their problems (Humphrey, 1986). The bulimic woman may rely on a defensive position to protect some of her real needs. She is unable to negotiate her needs in a more mutual, relational manner. As she withdraws into this defensive posture she may

further rely on her bulimia to maintain a sense of self-preservation.

The qualitative analysis identified a theme that is indirectly related to the theme of Egocentricity. This was "Utilization of splitting defenses." This was found in 10 out of 12 subjects. All 6 women who were categorized as "High Bulimic" described extreme feelings that often times left them feeling extremely panicky or feeling out of control. One theory to explain this is that a harsh, critical super-ego is present in all eating problems. Each bulimic woman may be viewed as having a significant amount of self-hate, as well as a cruel internal critic. It is interesting to note that 11 subjects showed a strong theme of "Controlling, critical maternal figure" as well as "Disavowal of aspects of their own personality." All 12 subjects also showed strong themes of "Positive self-esteem and affects related to being thin" as well as seeing "Weight gain-heaviness directly related to inherent badness and ineptness." These factors set the stage for internalizing a pervasive and often harsh internal critic who views things in a black-and-white manner without developing a more understanding and more integrated approach to her views. The woman who is unable to view her world in a more integrated way is also unlikely to modulate her intense feelings.

Bloom et al. (1994) state that when there are good feelings of being held, cared for, nurtured, and supported

(physically and emotionally), which are continuously repeated, a "home base" develops. There is a place of comfort and safety from which to grow. With the caretaker's attunement to hunger and satiation, the infant gradually comes to feel the environment as trustworthy and reliable. This begins the psychological process that will eventually enable a person to become self-soothing. When this self-soothing does not occur or occurs inconsistently, a process of "splitting" occurs when one views the world as split into all good or all bad. Such individuals lack the ability to self-soothe or to challenge the harsh internal critic and come to a more integrated understanding.

The limited interoceptive awareness of bulimic women is well documented (Bruch, 1973; Gross et al., 1986). When these feelings emerge they are often undifferentiated. They are likely to be felt as overwhelming dysphoria, which results in an experience of helplessness. This "all or nothing" experience of emotion makes it difficult for her to be involved with others yet feel modulated and in control.

The bulimic eating pattern has also been referred to as involving "dichotomous thinking" (Johnson & Connors, 1987), in that it involves the extremes of the pendulum. In a bulimic, one bite of "bad" (high calorie) food may instantly trigger a binge, as the thinking goes, "All is lost, now that I have taken the first bite; I might as well eat everything, then I can always throw it up."

Krueger (1989) asserts that eating "junk" food serves as a confirmation of a negative self-image, an in-turning of rageful feelings. These products literally "become" the bad inner object. Likewise, when one chooses a low-calorie "good" food, one is internalizing a more nurturing and supportive self.

The qualitative analysis indicated that all 6 members of the "High Bulimic" group used splitting defenses as compared to 4 out of 6 in the "Low Bulimic" group. Although the qualitative analysis does not provide a large difference, it does bear out an important observation. A number of the "Low Bulimic" group talked about their defense of splitting in the past tense or in a more modulated way. This may indicate their awareness of their ambivalence. This was with the exception of Subject 6, who expressed an awareness that her thinking about her weight took on a "life or death" quality. The "High Bulimic" group expressed an intensity in their emotions that indicated a "panicky" quality.

Patients who tend towards borderline personality organizations tend to split even more dramatically, unable to tolerate the ambivalence, and thus may develop a severe binge-purge cycle, in part, to alleviate the tension of holding such conflicting feelings simultaneously. It is likely that individuals who rely on "splitting" mechanisms are also more likely to resort to a more self-protective,

egocentric point of view. They may be unable to see things from a different, more modulated perspective.

BULIT-R and Insecure Attachment. The correlation between the BULIT-R and Insecure Attachment indicated a moderate relationship ($r = .414$, $p = .023$) between bulimic symptomatology and feelings of Insecure Attachment. There is a high sensitivity to rejection that many bulimic women face. Most bulimic women experience considerable painfulness in their relationships that revolve around a need for acceptance. These women often tend to blame themselves for problems in their relationships. They are likely to repeat maladaptive patterns of self-defeating behaviors. Because of their need for attachment, with few healthy models for what constitutes a healthy attachment, they may depend on other people or culture's definition of success in relationships, which often is not in tune to their own needs.

According to Bowlby (1973), the quality of an attachment relationship depends on the responsiveness of the caregiver. When the child expresses affect, the caregiver responds, thus providing a context within which the child organizes emotional experiences, including a sense of felt security. Distress is regulated when the attachment figure is available and responsive to the child. Emotional availability is demonstrated by accepting the child's pursuit of comfort and support. Failure to receive

comfort from an attachment figure is theoretically expected to lead to anger and psychological trauma.

The anxiously attached infant, or the compulsive care-seeking personality type, chronically doubts the caregiver's emotional responsiveness and availability (Bowlby, 1973). She lies in constant anxiety of losing the attachment figure and, as a result, attempts to establish a sense of security from the attachment figure by frequently displaying urgent care-seeking behaviors, which may include a tendency to be overly compliant in her relationships with others.

The ambivalent attachment leads to personality traits characterized by angry withdrawal patterns that are activated when the attachment figure is perceived as inaccessible. This attachment type will seek contact with the primary caregiver, but she is also contact-resistant and angry during the reunion phase. Bowlby understands this anger as spiteful, or as an expression of frustrated attachment needs.

The theme "Disavowal of aspects of subject's personality by family members creating a superficiality or lack of depth," as mentioned previously, emerged in all 12 subjects. This may be viewed as closely related to Insecure Attachment. As Subject 10 stated, "I guess it reaffirms that feeling where she doesn't really know me. We don't spend a lot of time together and I feel like she really doesn't know me. And she only catches glimpses of

me and usually they're something negative she has to say about when we're out together." This statement captures the lack of interest in the subject and her feelings.

BULIT-R and Social Incompetence. There was no significant correlation ($r = .295$, $p = .113$) with the BULIT-R and the Social Incompetence scale. One explanation for this may be that many bulimic women are felt to be experts at portraying themselves in a way that is consistent with the expectations of others. Because of their real need for relationships and because of their upbringing it may be hypothesized that they are adept at conforming to the needs of others with little regard or even awareness for their own needs.

Hypothesis 2

Hypothesis 2 stated: There is no correlation between the severity of a subject's bulimic symptoms as assessed by the Bulimia Test-Revised and the severity of a subject's identity impairment as assessed by the Erwin Identity Scale.

The null hypothesis was rejected. There were statistically significant correlations between severity of the BULIT-R and severity of Identity Disturbance, especially Confidence ($r = -.537$, $p = .002$) and Sexual Identity ($r = -.454$, $p = .012$). There did not appear to be a statistically significant relationship between Body and

Appearance and the BULIT-R ($r = -.312$, $p = .093$). Each of these subscales is now discussed separately.

BULIT-R and Confidence. The correlation of Confidence with the BULIT-R indicated a moderate inverse relationship ($r = -.537$, $p = .002$) between bulimic symptomatology and Confidence. Women who have low confidence may be viewed as lacking in a conviction that their needs are valid and appropriate. They may typically be unable to set firm boundaries in terms of defining what is a healthy behavior for them. Because they have not been provided an environment that was more attuned to their needs, they may not know how to effectively attend to their own needs. They may lack the conviction as well as the psychological tools necessary to form a clearer and healthier self-definition in relationship to others.

Confidence was found to have the strongest relationship with the BULIT-R. A linear regression was conducted for BULIT-R versus Confidence. Regression analysis indicated a correlation between the BULIT-R and Confidence (R -square of 28.9). By removing outliers (Subjects 9 and 15), the R -square increased from 28.9% to 54.8%. An explanation for their outlier tendency is examined in order to develop a clearer understanding of their dynamics.

As mentioned previously, Subject 9 was interviewed. She relied a great deal on denial and intellectualization.

At the time of the interview she reported to have vomited almost every time she ate. Although her Confidence score was very high (97), her interview indicated a lack of control and significant feelings of inadequacy. She stated, "I have learned to push [feelings of being fat] them down. So I cope by not facing it. By not presenting it." She talked about her fears of failure.

Subject 15 volunteered that she had purged more than three times a week. She completed the three tests and shortly thereafter indicated she had significant suicidal thoughts. Clinically, she demonstrated she was in significant distress. She was hospitalized at a psychiatric hospital and resumed therapy with another therapist. Five months later she was not interested in participating in the qualitative interview. Although her scores indicated she was confident in herself, her clinical presentation indicated an extremely troubled woman who was in crisis. Although the Bell Object Relations Inventory indicated that she was consistent in her responses, examination of her scores indicated she answered the questions on the Erwin Identity Scale inconsistently. Given her background and her clinical presentation, it is reasonable to question the validity of her scores.

From the qualitative analysis, a theme of "Enmeshed relationship with mother" emerged. There were 7 subjects who reported they had an enmeshed relationship with their mother. Of the 7, 4 were categorized in the "High Bulimic"

category. Subject 8 stated, "Our relationship is enmeshed. More on my part than on hers. I'm extremely dependent for her approval. I became a little kid again when I was around her and she had to take care of me." This example illustrates the tendency to focus on the caregiver's approval thereby neglecting one's own needs and internal feelings.

Bruch (1973) also suggested that lack of appropriate parental responsiveness to a child's developing sense of self is responsible for the personality features that predispose girls to develop eating disorders. Bruch describes the developmental process as follows:

Appropriate responses to clues coming from the infant, in the biological field as well as the intellectual, social, and emotional field, are necessary for the child to organize the significant building stones for the development of self-awareness and self-effectiveness. If confirmation and reinforcement of his own initially rather undifferentiated needs and impulses have been absent, or have been contradictory or inaccurate, then a child will grow up perplexed with trying to differentiate between disturbances and his biological field and emotional and interpersonal experiences, and he will be apt to misinterpret deformities in his self-body concept as externally induced. Thus, he will become an individual deficient in his sense of separateness, with "diffuse ego boundaries", and will feel helpless under the influence of external forces. (p. 56)

A pattern that was identified in 9 out of 12 subjects was "Utilization of eating as a defense to maintain control." Five of the 6 from the "High Bulimic" group were placed in this category. The qualitative analysis failed to identify a large difference between the "High Bulimic"

and "Low Bulimic" group in terms of eating as a defense to maintain control.

It has always been believed within our society that fat people suffer from a "lack of will power." This is felt to be one of the basic issues in bulimia and is related to the bulimic's inability to perceive her needs. Of the 5 bulimic women, only 2 openly stated that purging gave them a feeling of being in control. One referred to the binge-purge cycle, the other 2 discussed the problems of being heavy or out of control. Because bulimic women typically are unable to articulate their feelings and expose their true self, they often bury their feelings. Bloom et al. (1994) theorized that because her needs may be split off, the bulimic woman may at times battle to keep her difficult feelings at bay. Eventually she is unable to tolerate the accumulated stress or denial of her own emotional life. She may feed her feelings with food. Her move toward food may be an attempt to nurture herself. Once she has eaten, she may feel overwhelmed by the food, which may actually be representative of her overwhelming feelings. She may feel defeated, out of control, fat, and filled with self-hate. She reestablishes her boundaries by purging. Thus she can regain her equilibrium.

By displacing one's feelings onto food, one is able to find one area in life in which to maintain a sense of control. These women transpose their distress or trauma to a struggle around their own bodies, unconsciously hoping to

heal the injuries of neglect and exploitation. As Subject 10 stated, "You feel like if there is nothing else in your life that makes sense and feel so powerless to control anything, and everything is so chaotic, there has got to be something in my life that I can control."

From the qualitative interviews, it was noted that the bulimic woman feels overwhelmed and lacks sufficiently organized internal resources to cope with the amount of distress she is experiencing. As Subject 10 stated, "I tend to really keep my feelings to myself, and they build up and there is no release for them, and there's all that tension. It's almost like shoving that back down and replacing the negative emotion with food."

The bulimic has a limited ability to modulate her affect. Affect is experienced as threatening and to be avoided. This self-organization is fragile and easily disrupted. This characteristic is further enhanced by the bulimic's external locus of control. The bulimic woman relies on her environment to define her well-being. The bulimic symptomatology may be related to a desperate attempt to restore and preserve a sense of self.

BULIT-R and Sexual Identity. The correlation between BULIT-R and Sexual Identity indicated a moderate inverse relationship ($r = -.454$, $p = .012$) between bulimic symptomatology and Sexual Identity. One hypothesis to explain this is that coming to terms with sexuality is

intertwined with separation and attachment dilemmas and struggles. With the change in an adolescent's figure, a young girl who is insecure is likely to become more confused. These physical changes can elicit more confusion and fear of being out of control. This fear can be expressed in a displacement onto the physical body. For many women sexual identity is often confused with sexual objectification. This message denies women their selfhood. They are rendered as objects.

Women who have come to understand and discriminate their sexual identity as well as their feelings as a normal part of close love relationships may be better equipped to handle the boundaries inherent in healthy relationships. They may be less likely to be overwhelmed by the need for acceptance and more in touch with the recognition of what a loving relationship means for them. There may be an understanding of what a healthy sexual relationship means in terms of boundaries and discernment.

BULIT-R and Body and Appearance. There was no statistically significant relationship ($r = -.312$, $p = .093$) between the BULIT-R and Body and Appearance. Body and Appearance was defined as including an accurate self-perception and acceptance of one's body and one's appearance. There was a focus on the presentation of dress style as a reflection of oneself. One explanation for this may be that the test placed a great deal of emphasis on

dressing according to the norm rather than on one's actual body figure. It is likely that the test did not measure the emphasis on body figure but rather an individual's comfort with her dress style. Another explanation might be that of the 12 subjects who participated in the qualitative interviews only 2 would be viewed as "overweight" by current standards. Some of the women who were categorized as "High Bulimics" recognized that they were within their "goal" weight. Another explanation for this is that most of these women had all been in therapy for at least 1 year. They may have been forced to examine their own self-acceptance.

Another explanation may be that because their bulimic pattern was so firmly entrenched, they may rely on it for their emotional regulation. With their addiction intact, they may be less defensive and more "in control." Thus they may see themselves as addressing their appearance. Their appearance was concretely addressed through eating behaviors.

The qualitative analysis identified three themes pertaining to Body and Appearance. The first theme was "Strong emphasis on food intake and appearance in family." This is consistent with the theory that attitudes towards the body and appearance become the focus of a bulimic's thinking. This theme was found in 10 out of 12 subjects. This theme was reinforced and perpetuated by all 6 women who were categorized as "High Bulimics." Each woman

discussed feelings of being seen as heavy and being called chubby. Each woman talked about being viewed in a negative way. There are oftentimes a negative and pervasive attitude adopted by family members towards the bulimic woman's body.

Feelings of personalization are felt to be based upon positive parental attitudes toward the child's body. When these are not present, the child's resultant attitude toward his own body will be critically impaired. Bloom et al. (1994) have found in their clinical experience that mothers or parents who were able to advocate for their daughter's unique size and shape were better psychologically adjusted than those parents who put pressure on their daughters to conform because they (parents) could not differentiate from the cultural norms.

A second pattern that was identified as general in the "High Bulimic" group was the theme of "Punishing behaviors toward food intake or appearance in family." This was found in 9 of the 12 subjects. All 6 subjects in the "High Bulimic" group stated that they felt guilty or were reprimanded for their eating. One subject reported feeling self-conscious about what she was eating at the age of 5 years. Another subject reported sneaking food. Each subject relayed a particular stance her family held toward food and the subject's approach to food that was imbued with negativity and neglect towards the young girl's feelings or characteristics. One may conclude that food is

intertwined with psychological phenomena and that the bulimic woman feels that her symptom is the only problem.

A third theme that emerged was "Internal strivings for perfection." Seven subjects reported internal strivings for perfection. Of the 7, 4 were categorized in the "High Bulimic" group. Subject 2 stated, "If my body was perfect than everything else would have been perfect." Subject 10 stated, "When you're thin or about, you know, as close to being thin, there's nothing deviant about you." This need for perfection may be viewed as not really related to the excess weight, but rather to some deep inner dissatisfaction.

Hypothesis 3

Hypothesis 3 stated: There is no correlation between the severity of a subject's object relations as assessed by the Bell Object Relations Inventory and the severity of a subject's identity impairment as assessed by the Erwin Identity Scale.

The null hypothesis was rejected. There were statistically significant correlations between the severity of subject's Object Relations and the severity of a subject's Identity Disturbance ($r = .89, p = .0001$).

Because of the many variables on both the Erwin Identity Scale and the Bell Object Relations Inventory, a statistical analysis using canonical correlations was

carried out. The findings indicated the correlation between the tests.

Relationship between variables of the Erwin Identity Scale and the Bell Object Relations Inventory. Canonical correlations between the variables for the Erwin Identity Scale (Body and Appearance, Sexual Identity, and Confidence) and the variables for the Bell Object Relations Inventory (Alienation, Egocentricity, Social Incompetence, and Insecure Attachment) were conducted. The findings indicated there was an inverse relationship between the Erwin Identity Scale and the Bell Object Relations Inventory. Thus, subjects who scored low in Confidence, Body and Appearance, and Sexual Identity are likely to score high on Alienation, Insecure Attachment, Egocentricity and Social Incompetence.

According to Erwin's definition, Confidence includes a conscious self-reliance while recognizing the necessary dependence on outside sources. Sexual Identity is defined by Erwin as an acceptance and understanding that one's sexual feelings are normal. They are not overwhelming and do not interfere with interactions with other people. The subscale Body and Appearance, according to Erwin, includes an accurate self-perception and acceptance on one's body and one's appearance. The subscale measures how a woman presents herself to the world.

According to Bell (1995), individuals who score high on the Alienation scale defend against the painfulness of relatedness by keeping others at a distance. Relationships for these individuals tend to be unstable and ungratifying. They experience no real connection or belonging. Individuals who obtain high scores on this scale are often suspicious or guarded, and often isolate themselves. Their tendency to alienate is likely to be directly related to their inability to express their feelings with a conviction that they will be heard and valued. These individuals lack the confidence that their interactions will be supported. Bell describes individuals who score high on Insecure Attachment as likely to be very sensitive to rejection and easily hurt by others. There are intense longings for closeness. Separations, losses, and loneliness are poorly tolerated by these individuals. Individuals who score high on Egocentricity, tend to perceive the existence of others as in relation to oneself. They tend to manipulate others for their own self-centered aim. Individuals with a high Egocentricity scale often tend to believe that people are out to humiliate and defeat one another. Individuals who score high on the Social Incompetence scale indicate shyness, nervousness, and uncertainty. They usually see themselves as socially incompetent. Their anxiety usually leads them to withdraw and escape from interpersonal communication.

The results suggest that a person who possesses a high degree of acceptance of herself, her sexual identity and her body and appearance is more likely to establish appropriate boundaries. She recognizes her own feelings and needs and has the belief that they are worthy of respect. She is able to implement relationships that allow her to live according to her own standards of what a supportive, healthy relationship is. In our culture, which places a premium on looks, a woman's body becomes one tool by which she may try to attain power and feelings of status. If she has a firm sense of her identity as well as an intact psychological self, she is able to live within the confines of our culture without being ruled by it. She is less likely to use her body and her looks to define her attachments to others. She is also less likely to rely on her body and appearance as a measure of how she manages her relationships. She is unlikely to take a defensive, egocentric posture in her interactions and more likely to relate from a feeling of competence and self-reliance.

Additional Findings

One interesting finding was that 5 subjects volunteered information about their relationships with their father. The father appears to be a significant figure in the development of cognitive organization (Guidano & Liotti, 1983). Guidano and Liotti emphasize that for the obese bulimic, the father's role is often

viewed as being overprotective and intrusive. These recollections were more powerful in predicting bulimia than recollections of maternal overprotection.

The father provides the first significant arena for the child to explore herself outside of the mother-child relationship. The father being somewhat removed from the direct survival needs of the daughter (i.e., feeding) provides a relationship which fosters needs pertaining to social relatedness and individuation. The father's presence aids the daughter in effectively beginning to separate and in her development of an ego identity, encouraging her ability to function as an independent and autonomous individual. The daughter's growing awareness of and attraction to the father in his role as the first not-mother person pulls her forward in separation-individuation (Mahler et al., 1975). Four of the 5 women who talked about their father indicated in a direct or indirect way their need for their father's approval. Each of these women's needs was felt to be largely unrecognized. This may have impeded their move toward a more cohesive female identity.

Limitations

External Validity and Generalizations

There were a number of limitations to this study. This included limitations involving the size and representativeness of the sample.

Problems with the obtained sample pertained to the size and unique demographics of the sample. As always, the problems of small, idiosyncratic samples, often reported in eating-disorders research, pose a threat to the generalizability of the findings. There were very few therapists and organizations willing to participate. The resulting small number of women in each group reduced the external validity of the study.

The demographics of the obtained sample limit the generalizability of the findings to the larger eating-disordered population. For instance, 60% of the sample was from one outpatient treatment center. With the true demographics of the eating-disordered population largely unknown, and because of the small and idiosyncratic sample, the generalizability of the results must be conservatively considered to be limited.

Another sampling bias pertained to the procedure of asking therapists to refer subjects. Therapists, especially outpatient therapists, might have referred only patients whom they thought could tolerate the intrusiveness of a third party (the researcher) without detriment to the therapy.

The sampling procedures themselves were not sophisticated or controlled. A therapist was presumed to have adequate knowledge and familiarity with the *DSM-IV* system of diagnosis. There was no training or test to standardize the diagnostic accuracy, or uniformity of the

therapists' use of the *DSM-IV* criteria. Stricter controls in the application of the *DSM-IV* criteria would have resulted in an accurate standardized diagnostic approach. However, this would have only increased the difficulties experienced in securing therapist cooperation. The diagnostic sampling probably reflected a "real world," if perhaps imprecise, application of the *DSM-IV* criteria as they are used in actual practice.

Because of the secrecy and shame experienced by eating-disordered people concerning their food, eating, and emotions, it is possible that many persons who qualify for a clinical diagnosis do not come to treatment. This is probably more true for bulimics, who may not be underweight, and who may be able to conceal their food-related difficulties relatively easily. The study included only women in treatment who may therefore differ from women who are not interested in getting help. Furthermore, all of these women were in therapy for at least 1 year. Their responses were likely to reflect their openness and maturity that may be very different from the general population.

The study may be seen as being too broad in scope, with too many measures on too few people, with subsequent compromises in internal and external validity. Although the qualitative analysis identified only small differences between the subjects, it was extremely valuable in understanding the bulimic woman's experience.

If the research questions about diagnosis and relative psychopathology were too broad, they addressed fundamental questions in the research on eating disorders. This study has highlighted some important variables that might merit a closer look in future research.

Design and Internal Validity

The canonical correlations indicated that a multicollinear relationship existed within the variables of the tests. Because these variables were highly correlated, it was difficult to make an interpretation regarding single "cause and effect" relationships. A larger population would allow more sophisticated statistical procedures that might demonstrate a clearer "cause and effect" relationship.

Future research may benefit from establishing stronger statistical variables within the realm of Identity. The variable of Body and Appearance was found to be rather weak.

Another threat to this research design was the lack of random assignment of the qualitative interviews. Because of the real challenge of finding subjects, 8 of the 12 subjects were interviewed from one therapist source. There may be a question of the subjects adopting a learned philosophical outlook on their disorder. Another complication was that these women have been in therapy for an extended period of time. Their views on their disorder

are likely to have been influenced as time progressed.

The procedure utilized for the qualitative analysis was easily applied, although labor intensive. Researcher bias was minimized through the use of a peer debriefer. This facilitated the analysis of the data and aided in interpretation. The coding, analysis, and auditing were done independently, which also corrected a lot of potential errors in the data.

Another procedure utilized to enhance validity included tape-recording and transcribing verbatim the subjects' accounts. Categories were developed only from the exact words from the client so as not to infer meaning or interpretation.

Implications

The data from the qualitative analyses indicated three themes that were present in all 12 subjects. These three themes were: Disavowal of aspects of subject's personality by family members creating a superficiality or lack of depth; Positive self-esteem and affects related to being thin; and Weight gain-heaviness directly related to inherent badness and ineptness.

The critical work of separation, differentiation, and integrating sexuality is thwarted when one's environment does not allow healthy self-expression. Most of the women indicated critical, punishing attitudes toward healthy expression of real feelings. They also indicated a need

for approval that prohibited a genuine expression of feelings. These women indicated that they typically supported the fulfillment of other people's expectations.

All 12 women associated being thin with happiness. Many identified it with perfection. Likewise, all 12 women identified fat as being a failure. The splitting of fat and thin and the consequent internalization of these rigid representations reinforce destructive messages of a woman's right to live in tune to her own needs. It oversimplifies the world into black and white and good and bad. It impedes the development of more complicated thought processes. It also reinforces a sense of being outer directed and seeking approval from others. The black-white body preoccupation thus distracts a woman's energy for a real meaningful interaction.

It is the awareness and articulation of strong, unacknowledged feelings, which involve much of the therapeutic work for eating-disordered women. Clinically, one must understand the client's internalized meanings about a bulimic woman's body, which may initially be understood in terms of fat and thin. From these representations, there are associated meanings and characteristic ways of relating.

Although thinness does represent success and power in the marketplace, it is representative of the "false self." If one listens carefully, it can be understood as

representing vulnerability, inhibition of desires, and lack of power.

The polarities of fat and thin, good and bad, strong and weak need to become less hierarchical and value laden. The attributes need to be named and articulated and disengaged from fat and thin body states. Then, it will be possible to integrate and use them in a supportive, healthy way.

Who a woman becomes depends to a large extent on what she has learned from others throughout her development about what it is to be a woman. The findings of this study suggest that, for the bulimic woman, much if not most of her self-concept is intimately interconnected with and dependent upon her physical appearance as she has internalized it. Therapy directed toward broadening and strengthening the bulimic woman's overall evaluation of herself such that other distinctive aspects of her personhood are recognized--for example, her mind, her spirituality, and her feelings--may constitute a very beneficial intervention. The modification of learned attitudes in a more positive direction surely ought to contribute to the healing and recovery process.

It has been postulated that women who have a more cohesive ego may respond to cognitive-behavioral modalities whereas those who have less intact ego resources require more intensive psychodynamic approaches. This theory is

problematic in that eating disorders occur on a spectrum and are oftentimes fluctuating.

The subjects who were categorized as "Low Bulimics" may have been experiencing few life conflicts at the time of test taking. It is fair to postulate that as problematic situations arise, they may regress to more bulimic behaviors. Much of their bulimic behavior may be a direct reflection of unresolved, internalized conflicts. One may argue that even "resolved" issues at times may resurface and may require reworking. Thus the idea of more cohesive ego resources is a concept that is nebulous and ambiguous.

The findings of this study support the theory that the more entrenched a woman is in her bulimic symptoms, the more disturbed her significant relationships and identity are likely to be. The quantitative analysis indicated there was a relationship between the severity of object relations, identity disturbance, and bulimia. There was a small difference in the qualitative study between the "High Bulimic" and "Low Bulimic" groups in their object relations and identity disturbance. However, many of the women in the "Low Bulimic" group indicated significant disturbances in their relationships as well as in the view of their body.

It is fair to postulate that the women in the "Low Bulimic" group may suffer less psychological distress. They may be less entrenched in their defenses. These women

may be ready to change fairly quickly when exposed to new ideas and information. However, their issues pertaining to object relations and identity must be addressed before the symptom improves.

Controlling the symptoms does not address the conflicts revolving around one's self and relationships. It does not address the lack of assuredness towards one's own feelings and intuitions. For almost all bulimic women, the symptom of bulimia must be understood in terms of intrapsychic, interpersonal, and cultural experience. The meanings behind the obsession must be identified and understood for their adaptive function.

Recommendations

The findings of the present study support the notion that eating-disorder symptoms may parallel other disturbances in individuals' lives. Disturbed relationships are expressed through disturbed relationships to food. Future exploratory research might address the process of recovery from an eating disorder, investigating whether it might be similarly accompanied by a gradual healing of early deficits, and a greater capacity to sustain healthy interpersonal relationships. Further investigation in the area of the relationship between disturbances in body image and object-relations deficits would be valuable. This could specifically address whether disturbances in relation to the concrete representation of

the self, the body, are reflective of underlying disturbances in the capacity for relatedness to self and others.

Another area of interest would be the role of the father in endorsing and supporting the young woman's growth toward a female identity. This would entail encouraging the move toward greater separation and autonomy while still maintaining a healthy relatedness.

APPENDICES

APPENDIX A
CORRESPONDENCE WITH THE HUMAN SUBJECTS REVIEW BOARD

HUMAN SUBJECTS INSTITUTIONAL REVIEW BOARD PROTOCOL OUTLINE

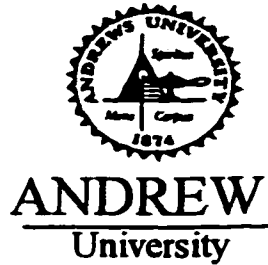
Eating disorders are recognized as major growing medical and psychiatric problem, affecting millions of women in the United States. Current regimes for the treatment of eating disorders have met only limited success. This study will investigate the hypothesis that disturbance in object relations characterize the more severe bulimic syndrome. The principal focus of this study is explore the relationship between the severity of bulimia, as assessed by the Bulimia Test - Revised (BULIT-R). The degree of impairment in one's object relations, as assessed by the Bell Object Relations Inventory (BORI), and one's identity disturbance, as assessed by the Erwin Identity Scale (EIS). Twelve participants of the thirty will be evaluated in an in-depth interview and a comparison of the responses of the interview questions will be carried out in this qualitative study.

Therapists in the area will be contacted by telephone. They will be asked if they can recommend individuals who would be willing to participate in a study that is being conducted with bulimic women. Participants must be eighteen years or older and meet DSM-IV criteria for bulimia. Each therapist will then be met individually by the researcher. The therapist will be given a packet containing a brief statement explaining the purpose of the study and specifications of the research project. Also included is an abstract of the study, a participant's consent form, and a therapist's consent form. Participants will be asked to fill out questionnaires in privacy and then they will be asked to return the questionnaires to the therapist. The therapist will mail the completed packet to the researcher. After the responses have been coded, the questionnaires will be returned to the primary therapist. Based on the results of the questionnaires, twelve participants will be selected for qualitative interviews. The researcher will conduct the interview in the subject's home or a private office.

Some of the questions may bring up feelings that may be upsetting to the participant. A possible benefit to the participant could be that they might identify current issues that may be worth exploring further in therapy. Each participant will be advised of the discomfort that may occur due the sensitive nature of the subject matter. Participants are instructed to discuss with their primary therapist any emotional discomfort or issues resulting from

the process. They are also encouraged to contact an impartial third party not associated with this study with any complaints they may have. Each individual will be advised that their participation is completely voluntary and that she may refuse to participate at any time without experiencing any negative consequences.

A number will be assigned to each participant for identification. The responses will be coded with that number so that no names will be used. Due to the confidential nature of the interview information, the researcher will keep the files, including tapes and transcripts, in a locked file drawer that only the researcher will have access. These files, tapes and transcripts will be destroyed after three years.



May 18, 1998

Kathy Appledorn
7262 Atlantic Ave
South Haven, MI 49090

Dear Kathy:

RE: APPLICATION FOR APPROVAL OF RESEARCH INVOLVING HUMAN SUBJECTS

HSRB Protocol # : 97-98 : 249 Application Type : *Original* Dept : *Ed & Couns Psyc - 0104*
Review Category : *Expedited* Action Taken : *Approved*
Protocol Title : *Object Relations and Identity Disturbance in Bulimic Women*

On behalf of the Human Subjects Review Board (HSRB) I want to advise you that your proposal has been reviewed and approved. You have been given clearance to proceed with your research plans.

All changes made to the study design and/or consent form after initiation of the project require prior approval from the HSRB before such changes are implemented. Feel free to contact our office if you have any questions.

The duration of the present approval is for one year. If your research is going to take more than one year, you must apply for an extension of your approval in order to be authorized to continue with this project.

Some proposal and research designs may be of such a nature that participation in the project may involve certain risks to human subjects. If your project is one of this nature and in the implementation of your project an incidence occurs which results in a research-related adverse reaction and/or physical injury, such an occurrence must be reported immediately in writing to the Human Subjects Review Board. Any project-related physical injury must also be reported immediately to the University physician, Dr. Loren Hamel, by calling (616) 473-2222.

We wish you success as you implement the research project as outlined in the approved protocol.

Sincerely,

Andrew S. Thorman

Human Subjects Review Board

c: Rick Kosinski

You can start as you receive permission from each therapist

APPENDIX B
RESEARCH PACKET MATERIAL FOR SUBJECTS



REQUEST FOR VOLUNTEERS TO PARTICIPATE IN RESEARCH STUDY

Project Title: Object Relations and Identity Disturbances
in Bulimic Women

PURPOSE OF REQUEST

I am pursuing a Ph.D. in counseling psychology at Andrews University in Berrien Springs, Michigan. I am asking therapists if they could recommend individuals who would be willing to participate in a study that is being conducted with bulimic women. Participants must be 18 years or older and meet the DSM-IV criteria for bulimia.

STUDY PROCEDURES

Data collection for this study is expected to begin in July 1998 through April 1999. The research explores the correlation between the severity of bulimia and the degree of object relations, and body identity.

Each prospective participant will be asked to complete three questionnaires. This will require approximately one hour of their time. One of the questionnaires will inquire about behaviors and feelings associated with eating (Bulimia Test - Revised). Another questionnaire will ask

about the nature of one's relationships and their interactions with others (Bell Object Relations Inventory). Finally, the third questionnaire will examine one's perceptions around their identity (Erwin Identity Scale). From the results of the questionnaires, subjects may be later asked questions regarding their feelings about the nature of their bulimia as well as the nature of their relationships.

RISKS AND BENEFITS

Some of the questions may bring up feelings that may be upsetting to the participant. A possible benefit to the participant could be that they would identify current issues, which may be worth exploring further in therapy.

CONFIDENTIALITY

The information collected will be coded, studied, and used for the purposes of increasing the general understanding of eating disorders. All of the responses will be kept confidential and will not be associated with a name: a code number will be assigned for all of the questionnaires. After the responses have been coded, I will return the questionnaires to the client's therapist so that they may become a part of the client's permanent file.



Educational and Counseling Psychology Department

CONSENT

Object Relations and Identity Disturbances in Bulimic Women

I have been told that the primary reason for conducting this research is to find out the nature of the bulimic' inner world and the characteristics of her interpersonal relationships with the purpose of the study being to provide empirical information regarding the nature of bulimia.

I have been told that I will complete three tests as part of the study: Bulimia Test - Revised (BULIT-R), Bell Object Relations Inventory (BORI), and, the Erwin Identity Scale (EIS).

I have been told that the researcher may request to conduct an interview in my home or private office, and it will be approximately one hour long. The interview will consist of a series of eleven questions with respect to how I feel about my parents and myself. Question about relationships will be asked along with eating and bingeing. I have been told that the interview session will be audio taped solely for the purposes of transcription and then will be erased. I have been told that all of my responses will be kept anonymous and will be used solely for research purposes to further expand the understanding of the dynamics of bulimic women.

I have been told that this information could help me individually, as well as benefit those close to me, by identifying emotional and behavioral characteristics that may be detrimental to the process of developing more mature and satisfying relationships.

I have been told that the benefits to me and those close to me include awareness of potential limitations of the characteristics of my relationships, increased understanding of myself and my unique attributes as well as characteristics of those close to me and what they may contribute to our relationship. I may gain knowledge regarding patterns of relating and healthier ways of communicating in relationships.

I have been told by the researcher that individual counseling from my primary therapist will be made available to me should I experience emotional discomfort resulting directly from the interview process.

I have been told that there may be some discomfort experienced by memories or feelings during discussions. I have been advised that my participation is completely voluntary and that I may refuse to participate at any time without experiencing negative consequences.

As in all research, there maybe unforeseen risks to the participant. If an accidental injury occurs, appropriate emergency measures will be taken; however, no compensation or additional treatment will be made available to the subject except as otherwise stated in this consent form.

I have been told that if I wish to contact an impartial third party not associated with this study regarding any complaints about the study, I may contact Dr. Elsie Jackson, Andrews University, Educational and Counseling Psychology Department, Berrien Springs, MI 49104, telephone number: 616-471-3308 for information and assistance.

I may also contact the researcher, Kathy Appledorn at 616-639-2134 or her advisor, Dr. Rick Kosinski, at Andrews University, Educational and Counseling Psychology Department, Berrien Springs, MI 49104, telephone number: 616-471-3466 should I need any further information, assistance or have any questions.

I have read the contents of this consent document and have listened to the verbal explanations given by the researcher. I agree that I will not disclose the content of the interview to my spouse or members of my immediate family, until I have completed the interview process. My questions concerning this study have been answered to my satisfaction. I hereby give voluntary consent to participate in this study. I have also been given a copy of this consent form.

Adult Participant

Date

Witness

Date



Educational and Counseling Psychology Department

Therapist Informed Consent

Object Relations and Identity Disturbances in Bulimic Women

I have been told that the primary reason for conducting this research is to investigate the relationship between the severity of bulimia, object relations and identity. I have been told that this information may be helpful in determining treatment approaches in women with varying degrees of bulimic symptomatology.

I have been told that the prospective participant will be asked to complete three questionnaires. This will require approximately one hour. One of the questionnaires will inquire about behaviors and feelings associated with eating (Bulimia Test - Revised). Another questionnaire will ask about one's relationships and their interactions with others (Bell Object Relations Inventory). The third questionnaire will examine one's perceptions around their identity (Erwin Identity Scale). Based on the results of the questionnaires my client may be asked questions regarding their feelings about the nature of their bulimia as well as the nature of their relationships.

I am aware that this interview will be conducted in a private office or my client's home and will be approximately one hour long. The interview will consist of a series of several questions with respect to how the client feels about herself and her parents as well as how

she manages strong emotions. The interview session will be audio-taped solely for the purposes of transcription and then will be erased. I have been told that all of my client's responses will be kept anonymous and will be used solely for research purposes.

I am currently seeing individuals who have been given the diagnosis of Bulimia Nervosa according to the DSM-IV criteria. I am willing to participate in the development of this research by asking individuals with the diagnosis of Bulimia Nervosa if they would be willing to participate.

I concur with the parameters defined for the project. I have read the contents of this consent form and have listened to the verbal explanations given by the researcher. I agree that I will not disclose the content of the test results to anyone except my client. My questions concerning this study have been answered to my satisfaction. I hereby give voluntary consent to participate in this study. I have also been given a copy of this consent form.

Therapist's signature

Date

Witness

Date



OBJECT RELATIONS AND IDENTITY DISTURBANCES IN BULIMIC WOMEN

PURPOSE OF THE STUDY

The purpose of this study is to provide empirical information regarding the nature of bulimia. The qualitative aspect of this study will provide an understanding of the symptom without relying solely on a theoretical stance of the client's experience. By assessing the severity of subjects' eating disorder, their capacity for object relations, and their body identity disturbance, as well as assessing their own individual, internalized meanings, it is believed that some light may be shed on the complex problem of bulimia.

The principal focus of this study is to show the following positive correlations: 1) the severity of bulimic symptoms as assessed by the Bulimia Test-Revised (BULIT-R), and the severity of impairment in object relationships, as assessed by the Bell Object Relations Inventory (BORI): 2) the severity of bulimic symptoms as assessed by the Bulimia Test-Revised, and the severity of identity impairment as assessed by the Erwin Identity Scale (EIS): 3) the severity of object relations as assessed by the Bell Object Relations Inventory, and the severity of identity impairment as assessed by the Erwin Identity Scale. Twelve participants of the thirty in total will be evaluated in an in-depth interview and a comparison of the responses of the interview questions will be carried out.

RESEARCH QUESTIONS

The study seeks to examine the relationship between the following questions:

1. What is the severity of subjects' eating disorder?
2. What is their capacity for object relations?
3. What is their body identity disturbance?

POPULATION AND SAMPLE SELECTIONS

The subjects for this dissertation study will be bulimic women aged 18 and over (30 in total) approached by the researcher, through their therapist, in which each has agreed to participate in the clinical interview.

METHODOLOGY AND PROCEDURE

This qualitative case study seeks to correlate the relationship between bulimia, object relations and body identity. This study will include a battery of tests and a followup interview. The study will involve the administration of tests by the therapist. The test instruments included the following: Bulimia Test-Revised, Bell Object Relations Reality Testing Inventory and the Erwin Identity Scale. Women will be recruited through contact with local therapists. Subjects must be 18 years or older and meet the DSM-IV criteria for bulimia nervosa. Therapists in the area will be contacted by telephone. Each therapist will be met with individually by the researcher. The therapist will be given a packet containing a brief statement explaining the purpose of the study and the specifications of the research project. Subjects will be asked to fill out questionnaires in privacy further insuring confidentiality, and then they will be asked to return the questionnaires to the therapist. Twelve subjects will be chosen for qualitative interviews. These interviews will be conducted by the researcher.

CONFIDENTIALITY AND INFORMED RISK

A number will be assigned to each participant for identification. The responses will be coded with that number so that no names will be used in order to maintain

as much confidentiality as possible when referring to each participant.

Due to the confidential nature of the interview information obtained from each participant, the researcher will keep the files, including tapes and transcripts, in a locked file drawer that only the researcher will have access. When the data analysis is completed, the transcripts will be transferred to the office of the Dissertation Chairperson, Dr. Rick Kosinski, and will be kept in a locked file drawer, that only the researcher and Dr. Kosinski have access.

Each participant will be advised of the discomfort that may occur due to the sensitive nature of the subject matter. Each will be advised that their participation is completely voluntary and that she may refuse to participate at any time without experiencing negative consequences.

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OBJECT RELATIONS AND IDENTITY DISTURBANCES IN BULIMIC WOMEN

ABSTRACT

Eating disorders are recognized as a major growing medical and psychiatric problem, affecting millions of women in the United States. Current regimes for the treatment of eating disorders have met only limited success. This study will investigate the hypotheses that disturbance in object relations characterize the more severe bulimic syndrome. The principal focus of this study is to explore the relationship between the severity of bulimia, as assessed by the Bulimia Test-Revised (BULIT-R), the degree of impairment in one's object relations, as assessed by the Bell Object Relations Inventory (BORI), and one's identity disturbance, as assessed by the Erwin Identity Scale (EIS). Twelve participants of the thirty in total will be evaluated in an in-depth interview and a comparison of the responses of the interview questions will be carried out in this qualitative study. It is postulated that women who have been assessed as having a more cohesive ego may respond to cognitive behavioral therapy while those who are assessed as having less intact ego resources may require more intensive psychodynamic approaches.

APPENDIX C
TEST INSTRUMENTS

The BULIT-R

Answer each question by filling the circle on the computer answer sheet. Please respond to each item as honestly as possible; remember all of the information you provide will be kept strictly confidential.

1. I am satisfied with my eating patterns.
 1. agree
 2. neutral
 3. disagree a little
 4. disagree
 5. disagree strongly

2. Would you presently call yourself a "binge eater" ?
 1. yes, absolutely
 2. yes
 3. yes, probably
 4. yes, possibly
 5. no, probably not

3. Do you feel you have control over the amount of food you consume?
 1. most or all of the time
 2. a lot of the time
 3. occasionally
 4. rarely
 5. never

4. I am satisfied with the shape and size of my body.
 1. frequently or always
 2. sometimes
 3. occasionally
 4. rarely
 5. seldom or never

5. When I feel that my eating behavior is out of control, I try to take rather extreme measures to get back on course (strict dieting, fasting, laxatives, diuretics, self-induced vomiting, or vigorous exercise).
 1. always
 2. almost always
 3. frequently
 4. sometimes
 5. never or my eating behavior is never out of control

Page 2

6. I use laxatives or suppositories to help control my weight.
 1. once a day or more
 2. 3-6 times a week
 3. once or twice a week
 4. 2-3 times a month
 5. once a month or less (or never)

7. I am obsessed about the size and shape of my body.
 1. always
 2. almost always
 3. frequently
 4. sometimes
 5. seldom or never

8. There are times when I rapidly eat a very large amount of food.
 1. more than twice a week
 2. twice a week
 3. once a week
 4. 2-3 times a month
 5. once a month or less (or never)

9. How long have you been binge eating (eating uncontrollably to the point of stuffing yourself)?
 1. not applicable; I don't binge eat
 2. less than 3 months
 3. 3 months - 1 year
 4. 1 - 3 years
 5. 3 or more years

10. Most people I know would be amazed if they knew how much food I can consume at one sitting.
 1. without a doubt
 2. very probably
 3. probably
 4. possibly
 5. no

11. I exercise in order to burn calories.
 1. more than 2 hours per day
 2. about 2 hours per day
 3. more than 1 but less than 2 hours per day
 4. one hour or less per day
 5. I exercise but not to burn calories or I don't exercise

Page 3

12. Compared with women your age, how preoccupied are you about your weight and body shape?

1. a great deal more than average
2. much more than average
3. more than average
4. a little more than average
5. average or less than average

13. I am afraid to eat anything for fear that I won't be able to stop.

1. always
2. almost always
3. frequently
4. sometimes
5. seldom or never

14. I feel tormented by the idea that I am fat or might gain weight.

1. always
2. almost always
3. frequently
4. sometimes
5. seldom or never

15. How often do you intentionally vomit after eating?

1. 2 or more times a week
2. once a week
3. 2-3 times a month
4. once a month
5. less than once a month or never

16. I eat a lot of food when I'm not even hungry

1. very frequently
2. frequently
3. occasionally
4. sometimes
5. seldom or never

17. My eating patterns are different from the eating patterns of most people.

1. always
2. almost always
3. frequently
4. sometimes
5. seldom or never

Page 4

18. After I binge eat I turn to one of several strict methods to try to keep from gaining weight (vigorous exercise, strict dieting, fasting, self-induced vomiting, laxatives, or diuretics).

1. never or I don't binge eat
2. rarely
3. occasionally
4. a lot of the time
5. most or all of the time

19. I have tried to lose weight by fasting or going on strict diets.

1. not in the past year
2. once in the past year
3. 2-3 times in the past year
4. 4-5 times in the past year
5. more than 5 times in the past year

20. I exercise vigorously and for long periods of time in order to burn calories.

1. average or less than average
2. a little more than average
3. more than average
4. much more than average
5. a great deal more than average

21. When engaged in an eating binge, I tend to eat foods that are high in carbohydrates (sweets and starches).

1. always
2. almost always
3. frequently
4. sometimes
5. seldom, or I don't binge

22. Compared to most people, my ability to control my eating behavior seems to be:

1. greater than others' ability
2. about the same
3. less
4. much less
5. I have absolutely no control

Page 5

23. I would presently label myself a 'compulsive eater',
(one who engages in episodes of uncontrolled eating).

1. absolutely
2. yes
3. yes, probably
4. yes, possibly
5. no, probably not

24. I hate the way my body looks after I eat too much.

1. seldom or never
2. sometimes
3. frequently
4. almost always
5. always

25. When I am trying to keep from gaining weight, I feel that I have to resort to vigorous exercise, strict dieting, fasting, self-induced vomiting, laxatives, or diuretics.

1. never
2. rarely
3. occasionally
4. a lot of the time
5. most or all of the time

26. Do you believe that it is easier for you to vomit than it is for most people?

1. yes, it's no problem at all for me
2. yes, it's easier
3. yes, it's a little easier
4. about the same
5. no, it's less easy

27. I use diuretics (water pills) to help control my weight.

1. never
2. seldom
3. sometimes
4. frequently
5. very frequently

28. I feel that food controls my life.

1. always
2. almost always
3. frequently
4. sometimes
5. seldom or never

Page 6

29. I try to control my weight by eating little or no food for a day or longer.
1. never
 2. seldom
 3. sometimes
 4. frequently
 5. very frequently
30. When consuming a large quantity of food, at what rate of speed do you usually eat?
1. more rapidly than most people have ever eaten in their lives
 2. a lot more rapidly than most people
 3. a little more rapidly than most people
 4. about the same rate as most people
 5. more slowly than most people (or not applicable)
31. I use laxatives or suppositories to help control my weight.
1. never
 2. seldom
 3. sometimes
 4. frequently
 5. very frequently
32. Right after I binge eat I feel:
1. so fat and bloated I can't stand it
 2. extremely fat
 3. fat
 4. a little fat
 5. OK about how my body looks or I never binge eat
33. Compared to other people of my sex, my ability to always feel in control of how much I eat is:
1. about the same or greater
 2. a little less
 3. less
 4. much less
 5. a great deal less
34. In the last 3 months, on the average how often did you binge eat (eat uncontrollably to the point of stuffing yourself)?
1. once a month or less (or never)
 2. 2-3 times a month
 3. once a week
 4. twice a week
 5. more than twice a week

Page 7

35. Most people I know would be surprised at how fat I look after I eat a lot of food.

1. yes, definitely
2. yes
3. yes, probably
4. yes, possibly
5. no, probably not or I never eat a lot of food

36. I use diuretics (water pills) to help control my weight.

1. 3 times a week or more
2. once or twice a week
3. 2-3 times a month
4. once a month
5. never

EIS - III

Instructions

The following series of statements describes how people sometimes feel about themselves and other people. Please read each statement and record as accurately as possible how true of you each statement is. Sometimes people try to make themselves out to be better than they really are. Therefore, the questionnaire includes some items to check on this. The first thing that comes to your mind is probably the best response. There may be one or two statements that do not directly apply to you; however, try to answer them as they might apply to you in a hypothetical situation. Remember there are no right or wrong answers so do not spend too much time deciding on a correct answer. Respond to the statements in order and do not leave out any responses.

For each statement ask yourself: **How True Is This Of Me?**

After each statement mark a letter from **A** to **E** on the separate answer sheet describing how true the statement is of you.

-
- | | |
|--------------------------------|----------------------------------|
| A - Very True of Me | D - Somewhat Untrue of Me |
| B - Somewhat True of Me | E - Not At All True of Me |
| C - Not Sure or Neutral | |
-

Be sure the number on the answer sheet corresponds to the number of the statement to which you are responding. There is no time limit but work as quickly as possible.

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- I am as sure of myself as most other people seem to be sure of themselves.
- I have found one of the easiest ways to make friends with others is to be the kind of person they would like me to be.
- It seems like when I trust someone to whom I am attracted I get hurt.
- I do not have as strong control over my feelings as I would like.
- It does not bother me that I am not as attractive as other people.
- I rarely express my feelings to a friend for fear I will get hurt.
- When I look in the mirror at myself, I am satisfied with the physical image I see.
- I usually do not have the assurance that what I am doing is the best thing.
- I believe that people should follow an established dress code in order to be accepted in a work environment.
- I sometimes regret my behavior in informal social situations (e.g. parties).
- My feelings often interfere with my interactions with other people.
- It usually takes so much effort to make decisions I wish somebody else would make decisions for me.
- I have many doubts about what I am going to do with my life.

A - Very True of Me
B - Somewhat True of Me
C - Not Sure or Neutral

D - Somewhat Untrue of Me
E - Not At All True of Me

-
14. I feel uncomfortable when I am seen with someone who dresses out of style.
 15. If I really let go of my feelings, I probably would not do anything that I would later regret.
 16. When I compare myself to people whom I think are extremely good looking, I feel inferior.
 17. In most situations, I could not hesitate to express my beliefs to those with opposite beliefs.
 18. Most of the time I am comfortable with my feelings.
 19. I believe there is only one right person for me with whom I could establish a close love relationship.
 20. A person should adapt his or her appearance to the group that happens to be with him or her at the time.
 21. I envy those people who know where they are going in life.
 22. If I did not wear the basic style of dress that other people wear, I would feel left out and excluded.
 23. If I shared my true feelings with a close friend (male or female) s/he would probably think less of me.
 24. No matter how sad I feel, I usually think things will get better.
 25. Each day presents new challenges that I cannot wait to confront.
 26. I feel confident that I have chosen or will choose the best occupational field for me.
 27. I am capable of understanding most ideas I read about.
 28. When I am hurt by someone I care for, I find it hard to trust others for quite a long time.
 29. I often feel inferior when I compare myself to other people.
 30. I often have uneasy thoughts about the way I appear to other people.
 31. I believe there are only a few people (1 or 2) in the world I could be happy with a close love relationship.
 32. I do not mind appearing different in dress from other people because that is me.
 33. No matter how hard I try, I do not feel prepared to enter the working world.
 34. Even though it may be contrary to my normal wishes, I usually dress to fit the situation or wishes of others.
 35. My confidence is really shaken when I see so many capable people with abilities as good or better than mine.
 36. If I seem to be not dressed appropriately for a particular situation, I usually become very anxious and feel out of place.
 37. When I am a stranger in a group, I often introduce myself to others.
 38. When other people discuss how important it is to be handsome and pretty, I feel badly and wish I were more attractive.
 39. I would not change my style of clothes just because my boss indicated that I should dress more like him or her.
 40. When I am in a crowd, I feel uncomfortable about the way I look.
 41. It is uncomfortable for me to speak out in groups for fear my statement may be incorrect.
 42. I realize that most of my feelings and desires are natural and normal.

43. My relationship with people of the opposite sex usually have not lasted as long as I would like.
44. There are certain feelings I have that I do not understand.
45. My feelings often overwhelm me when I try to establish close friendships.
46. I would not pattern my appearance after the dress style expected by my peer group.
47. If a boss or teacher criticizes me, it is usually because they do not understand me.
48. I frequently have doubts that I can have a successful and happy close love relationship.
49. I usually do not smile because I am uncomfortable with the way my smile looks.
50. When I fall in love, I am reasonably sure of my feelings.
51. I still have difficulty making decisions for myself.
52. To satisfy my needs I have to be aggressive or clever.
53. I feel some guilt when I realize how strong my feelings are.
54. I do not understand myself very well.
55. I do not know myself well enough to make a firm occupational choice.
56. It is difficult for me to answer questions like these about myself.
57. I have trouble making decisions when other people disagree with me.
58. Even when I have most of the facts I often postpone making decisions.
59. Other people know what is better for my life than I do.

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BORRTI Form O
Microcomputer Answer Sheet
 Morris D. Bell, Ph.D.

Directions

First fill in the background information. (If you don't know your ID Number, ask your examiner.) Next, read each item with care, then fill in the circle that shows your answer. Respond according to your most recent experience. If a statement tends to be true for you, mark the circle in the column labeled True. If a statement tends to be false for you, mark the circle in the column labeled False. Fill in only one circle for each statement. Please try to respond to all the statements.

Name: _____
 ID Number _____ Age: _____
 Education: _____ Ethnicity:
 Gender: Male Female Asian Hispanic
 Black Native American
 White
 Administration Date: _____ Other _____
 Examiner Name: _____

- | True | False | |
|--------------------------|--------------------------|---|
| <input type="checkbox"/> | <input type="checkbox"/> | 1. I have at least one stable and satisfying relationship. |
| <input type="checkbox"/> | <input type="checkbox"/> | 2. If someone dislikes me, I will always try harder to be nice to that person. |
| <input type="checkbox"/> | <input type="checkbox"/> | 3. I would like to be a hermit forever. |
| <input type="checkbox"/> | <input type="checkbox"/> | 4. I may withdraw and not speak to anyone for weeks at a time. |
| <input type="checkbox"/> | <input type="checkbox"/> | 5. I usually end up hurting those closest to me. |
| <input type="checkbox"/> | <input type="checkbox"/> | 6. My people treat me more like a child than an adult. |
| <input type="checkbox"/> | <input type="checkbox"/> | 7. If someone whom I have known well goes away, I may miss that person. |
| <input type="checkbox"/> | <input type="checkbox"/> | 8. I can deal with disagreements at home without disturbing family relationships. |
| <input type="checkbox"/> | <input type="checkbox"/> | 9. I am extremely sensitive to criticism. |
| <input type="checkbox"/> | <input type="checkbox"/> | 10. Exercising power over other people is a secret pleasure of mine. |
| <input type="checkbox"/> | <input type="checkbox"/> | 11. At times I will do almost anything to get my way. |
| <input type="checkbox"/> | <input type="checkbox"/> | 12. When a person close to me is not giving me his or her full attention, I often feel hurt and rejected. |
| <input type="checkbox"/> | <input type="checkbox"/> | 13. If I become close with someone and he or she proves untrustworthy, I may hate myself for the way things turned out. |
| <input type="checkbox"/> | <input type="checkbox"/> | 14. It is hard for me to get close to anyone. |
| <input type="checkbox"/> | <input type="checkbox"/> | 15. My sex life is satisfactory. |
| <input type="checkbox"/> | <input type="checkbox"/> | 16. I tend to be what others expect me to be. |
| <input type="checkbox"/> | <input type="checkbox"/> | 17. No matter how bad a relationship may get, I will hold on to it. |
| <input type="checkbox"/> | <input type="checkbox"/> | 18. I have no influence on anyone around me. |
| <input type="checkbox"/> | <input type="checkbox"/> | 19. People do not exist when I do not see them. |
| <input type="checkbox"/> | <input type="checkbox"/> | 20. I've been hurt a lot in life. |
| <input type="checkbox"/> | <input type="checkbox"/> | 21. I have someone with whom I can share my innermost feelings and who shares such feelings with me. |
| <input type="checkbox"/> | <input type="checkbox"/> | 22. No matter how hard I try to avoid them, the same difficulties crop up in my most important relationships. |
| <input type="checkbox"/> | <input type="checkbox"/> | 23. I yearn to be completely "at one" with someone. |
| <input type="checkbox"/> | <input type="checkbox"/> | 24. In relationships, I am not satisfied unless I am with the other person all the time. |
| <input type="checkbox"/> | <input type="checkbox"/> | 25. I am a very good judge of other people. |
| <input type="checkbox"/> | <input type="checkbox"/> | 26. Relationships with people of the opposite sex always turn out the same way with me. |
| <input type="checkbox"/> | <input type="checkbox"/> | 27. Others frequently try to humiliate me. |
| <input type="checkbox"/> | <input type="checkbox"/> | 28. I generally rely on others to make my decisions for me. |
| <input type="checkbox"/> | <input type="checkbox"/> | 29. I am usually sorry that I trusted someone. |
| <input type="checkbox"/> | <input type="checkbox"/> | 30. When I am angry with someone close to me, I am able to talk it through. |
| <input type="checkbox"/> | <input type="checkbox"/> | 31. Manipulating others is the best way to get what I want. |
| <input type="checkbox"/> | <input type="checkbox"/> | 32. I often feel nervous when I am around members of the opposite sex. |
| <input type="checkbox"/> | <input type="checkbox"/> | 33. I often worry that I will be left out of things. |
| <input type="checkbox"/> | <input type="checkbox"/> | 34. I feel that I have to please everyone or else they might reject me. |
| <input type="checkbox"/> | <input type="checkbox"/> | 35. I shut myself up and don't see anyone for months at a time. |
| <input type="checkbox"/> | <input type="checkbox"/> | 36. I am sensitive to possible rejection by important people in my life. |
| <input type="checkbox"/> | <input type="checkbox"/> | 37. Making friends is not a problem for me. |
| <input type="checkbox"/> | <input type="checkbox"/> | 38. I do not know how to meet or talk with members of the opposite sex. |
| <input type="checkbox"/> | <input type="checkbox"/> | 39. When I cannot make someone close to me do what I want, I feel hurt or angry. |
| <input type="checkbox"/> | <input type="checkbox"/> | 40. It is my fate to lead a lonely life. |
| <input type="checkbox"/> | <input type="checkbox"/> | 41. People are never honest with each other. |
| <input type="checkbox"/> | <input type="checkbox"/> | 42. I put a lot into relationships and get a lot back. |
| <input type="checkbox"/> | <input type="checkbox"/> | 43. I feel shy about meeting or talking with members of the opposite sex. |
| <input type="checkbox"/> | <input type="checkbox"/> | 44. The most important thing to me in a relationship is to exercise power over the other person. |
| <input type="checkbox"/> | <input type="checkbox"/> | 45. I believe that a good mother should always please her children. |

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