AN INVESTIGATION OF PERSONALITY CHARACTERISTICS OF BULIMIC WOMEN: LATE ADOLESCENT THROUGH ADULT AGES IN THE DALLAS/FORT WORTH METROPLEX

THESIS

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The incidence of bulimia seems to be increasing dramatically as actors, models, dancers, and college populations are seeking help for this eating disorder. In this study, the Adjective Checklist was administered to 21 bulimic women and 17 normal women to compare personality characteristics on the following scales: abasement, affiliation, autonomy, achievement, aggression, personal adjustment, succorance, and self-control. Results showed bulimic women scored higher on abasement and succorance. A multiple regression was performed which elucidated the scales responsible for the greatest amount of variance. These were aggression, autonomy, and self-control. Further studies of personality measures may aid in describing this population more fully.

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1. A Chronic Effort to Perfect the Body. 3

AN INVESTIGATION OF PERSONALITY CHARACTERISTICS OF BULIMIC WOMEN: LATE ADOLESCENT THROUGH ADULT AGES IN THE DALLAS/FORT WORTH METROPLEX

According to the Center for the Study of Anorexia and Bulimia in New York (1981), the incidence of bulimia seems to be increasing dramatically. College counselors speak of an epidemic of binge-purging on American college campuses. Still others remark on the very high percentage of dancers, actors, and models who are bulimic. In fact, the disorder seems to be spreading across class, income, and ethnic lines. It seems imperative to identify some personality characteristics which may typify women who suffer from bulimic symptoms. The purpose of this study is to determine if personality characteristics of bulimics are significantly different from nonbulimics.

There has been considerable confusion as to whether binge eating and/or induced vomiting in normal weight individuals reflect an interphase, a subtype, or a phenomenon from people who want to lose weight (Leitenberg, 1982). A preliminary investigation of personality characteristics will hopefully broaden our understanding of the types of people who develop bulimia, and also of its etiology

Alexander Guiora (1967) outlined some of the main factors concerning the psychopathology of anorexia nervosa and bulimia which has lead to a variety of research perspectives. He described the bulimic episode where eating is a compulsion that cannot be overcome. "Overeating occurs in waves, in savage attacks on food without discrimination as to type or quality. These binges may occur either when the patient is depressed or when she is in a violently aggressive mood." Furthermore, Guiora expressed some of the psychodynamics involved in this symptom as demonstrated in his treatment of these patients. He described them as feeling a chronic lack of gratification which inhibited orderly psychological development and resulted in an oral fixation which established a permanent sadomasochistic orientation. "Extreme egocentricity or primary narcissism may block the way for any meaningful object relation." Feelings of hostility toward the mother may disallow for identification with her, and no proper groundwork for the emergence of womanhood and motherhood will be attained.

According to Guiora (1967), two main motives of the disorder are sex and aggression. The bulimic behavior is an all-destroying rage, directly expressed. "In the background looms large the lesion in the ego structure. The greater the lesion and the weaker the inhibitions, the

more sadistic component will prevail and take the form of overt aggression, i.e., bulimia. The patient will eat the 'others'" (p. 392).

More recent literature (Boskind-Lodahl & Sirlin, 1977) specifies the cyclic character and the type of emotional investment intrinsic to this disorder as follows: "The young woman's effort to perfect herself through dieting had led her to her first eating binge. After the binge came guilt, and after the guilt came a renewed compulsion to lose weight, either by fasting or purging."

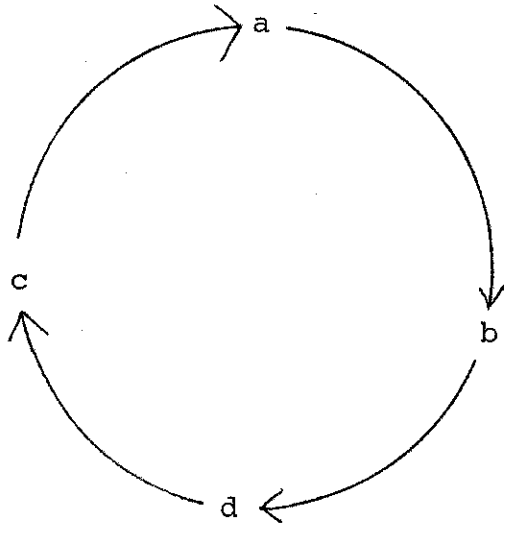

Figure 1. A chronic effort to perfect the body. (a) one way may be through dieting as it is socially appropriate; (b) as a result however, the person may feel deprived of food and feel frustrated; (c) at this point, planning a binge and splurge is likely to rid them of their frustration; and (d) if the binge is carried out, guilty feelings may arise and a renewed impulse to diet or purge may result.

The whole cycle is a destructive and unhappy one. In most cases it leaves its victims little or no energy for any sort of life beyond their own binges and purges. At this point the woman becomes aware that her behavior is not normal and her shame adds to her picture of unattractiveness and inadequacy. An inevitable outcome is her lowered self-esteem. Boskind-Lodahl and Smith (1977) touched on socialization factors influencing women's self-image where male rejection triggered the first binge. Thinness was supposed to bring them love and happiness. They feared sexual contact not from fear of pregnancy, but fear of rejection and inadequate performance. The discrepancy of interpersonal fear exacerbates an already acute level of anxiety. Part of a bulimic's problem is that she identifies too strongly with what she perceives as the perfect female role. The young woman is brought up trying as hard as she can to be acceptable to a man, which depends on her appearance. Thus, bulimic women are described as dependent and as having feelings of abasement. These women go to great lengths to hide their eating habits. Yet their gorging and fasting habits were acquired for a reason--they had chosen them. These women share feelings of helplessness and express the desire to take control again.

Anorexic patients who tend to exhibit bulimic symptoms are often characterized as sensitive, dependent, anxious, perfectionistic, and stubborn (Bemus, 1978).

Gerald Russell (1979) described bulimics as abnormally concerned with their body size, fearing fatness, which they describe in excessively harsh terms. outside of sensible standards. Thoughts about food filled their minds constantly, resulting in impaired concentration. Thoughts and images about their bodies tended to be associated with negative feelings and self-depreciation. To them being thin means that they are more attractive and cleaner. Obscenity tends to be associated with fat thighs.

According to Russell (1979), depression was one of the most prominent features as evidenced by psychomotor retardation, variation of mood, ideas of self-blame, or general impairment of daily activities. Feelings of gloom and recurrent suicidal thoughts may have led to a greater degree of irritability expressed toward friends and relatives. Some hysterical features prevailed among bulimics such as the adoption of the role to escape stressful situations and struggle through daily routines with these attitudes. The following are some traits which seemed to occur with frequency: anxiety (especially in social relationships with parents or at school), dependence on parents, and antisocial behavior.

An article in Time magazine (November 17, 1980) described bulimics as coming from homes where food was important and was a focal point of power struggles.

Bulimics tend to be extroverted, successful, and perfectionistic, and start gorging in their late teens and often have trouble seeing their problem as more than an idiosyncracy. It seems now that between 20 and 30 percent of women on college campuses are involved to some degree in bulimia and purging (Time, November 17, 1980).

Perfectionism may be one of the causes for bulimics' cyclic behaviors, as it is this unattainable goal which leads man into an everlasting struggle against his limitations and self-acceptance. David Burns (1980) described the type of characteristics which develop from perfectionistic attitudes. He stated the perfectionist appeared to be vulnerable to a number of potentially serious mood disorders, including depression, performance anxiety, social anxiety, writer's block, and obsessive compulsive illness. The implied promise is that perfectionism brings rewards. Many perfectionists set their standards so high it may lead to decreased productivity, impaired health, poor self-control, troubled personal relationships, and low self-esteem. For bulimics, ideas of bodily perfection surrounded by social acceptance and rewards invade their mind. Frequently this

probably increases their level of frustration and anxiety; they are likely to react defensively to criticism which may alienate them from others. In turn, this reinforces their irrational belief that they must be perfect (or slim for a bulimic) to be accepted. Perfectionists also tend to think in all-or-nothing fashion; thus, if they go on a diet and break it, their level of anxiety sky-rockets as they are flooded with self-deprecating statements. One of the paradoxes exhibited by perfectionists is their acute sensitivity to disapproval. This inhibits intimacy and deprives them of the warmth they crave. Sensitivity to rejection tends to over-generalize and invade many aspects of their life, making them feel inadequate and anxious.

In their study, Boskind-White and White (1981) placed primary importance on treating bulimic patients' emphasis on body image, low self-esteem, feelings of helplessness, and the shame due to their maladaptive behavior. They addressed issues on femininity emphasizing the exploration and development of one's own strength as a person and relationships with men as only part of the problem.

Subjects expressed their goals as being "gaining self-control, feeling less anxious and insecure in relationships with men, making close female friends without feeling competitive and mistrustful, and determining why they binged" (White & Boskind-White, 1981, p. 503).

Feelings of shame and inadequacy may stem from overall societal standards which view the gorging-purging act as very abnormal. "Throughout the history of Western civilization a peculiar emphasis has always been placed on eating, weight, and body image. The ancient Romans revelled in their gluttony. Their eating orgies were full of ceremony. In fact, they even constructed a special edifice, a vomitorium, where they could relieve themselves and then return to their binging" (Kubistant, 1982).

Around college campuses where such attributes as vitality, freedom, attractiveness, and experimentation are the zeitgeist, college students impose expectations and pressure to fulfill these characteristics. As a result, members of sororities and students living in dormitories privately starve themselves through the use of laxatives and diuretics or by vomiting. Publicly they are admired as people who possess control and discipline. The family background of bulimics describes them as bright, successful, and achievement-oriented. They are viewed as "good girls" of the community; their achievement or orientation, however, may be rooted in their need to be accepted and loved by their parents, especially their fathers. Bulimics, as do others with psychosomatic illness, are likely to be used to mask other familial or marital problems (Minuchin, Baker, Rosman, Liebman, Mulman, & Todd, 1975). Kubistant

addressed the issues of control and perfectionism as the outcome of a variety of fears. These fears primarily consist of "fears of rejection and failure, never being accepted by parents, fears of being imperfect and out of control, fear of discovery, and fear of being unable to change eating habits, fear of embarrassment" (Kubistant, 1982, p. 336).

Given this extreme variety of symptoms, diverse helping strategies have emerged. One of these is through behavior modification self-monitoring food intake, and reinforcement after eating. From a psychodynamic perspective, bulimics are aided in exploring ways in which they can express their frustrations with food, society, and familial forces. Other organizations have sprung up to run support groups especially on college campuses. Smead (1982) suggested that after a bulimic has eaten, the resulting fear and guilt rather than the person's appetite should be the focus of the sufferer's battle. Food must not be used as a reinforcer, yet hunger should be ceased. Many times throwing away a scale and caloric intake list is a good start.

Not only are bulimics wrapped up in psychological distress, they often exhibit physical discomfort. The most common ones are classified into three categories (see Appendix C, National Association of Anorexia and Nervosa and Associated Disorders, 1982).

Kim Chernin (1981) addressing eating disorders stated: "If we have begun to live our lives within these bodies as if they were enemies, struggling against them, inflicting penances upon them, subjecting them to extremes and rigors which might have done justice to a desert saint, how much, indeed, this tells us about the way in which we approach this same fundamental task of coming to terms with what is problematic and uncontrollable in existence - how we deal with the same primordial experience of being helpless and out of control and anxious and impotent and dependent."

One of the most widely used references for the diagnosis of bulimic tendencies is the DSM III, which describes bulimia under the category of Disorders Usually First Evident in Infancy, Childhood, or Adolescence - Eating Disorders (see Appendix A).

The specific personality characteristics to be assessed, as derived from the literature, were a high level of narcissism, antisocial behaviors or tendencies, impaired self-control, feelings of inadequacy and a high likelihood to be headstrong (Bemus, 1978; Guiora, 1967; Russell, 1979; & Burns, 1980). These characteristics are most like scales six and 15 on the Adjective Checklist (see Appendix B). Also, the literature suggests bulimics suffer from high levels of anxiety, which may lead them to variable moods and gloomy feelings (Burns, 1980; Chernin, 1981; Bemus,

1978; & Russell, 1979). These characteristics are most like scale eight on the ACL (see Appendix B). Time magazine (November 17, 1980) and Minuchin (1975) reported that bulimics are successful, bright, and achievement-oriented. Scale nine on the ACL describes similar characteristics. Bemus, Russell and Chernin all mentioned dependence to be a pervasive characteristic for bulimics in general. Scale 18 on the ACL describes these characteristics. Irritability and frustration were referred to by Russell and Burns, which are similar to scale 19 on the ACL. Feelings of inadequacy along with high dependency needs as mentioned by Burns, Bemus, and Russell are similar to Scale 21 on the ACL (see Appendix B). Finally, the last group of characteristics to be assessed were: anxiety, gloominess, self-blame, guilt, and feelings of inadequacy. These are very similar to those descriptors listed for Scale 22 on the ACL (see Appendix B).

Method

The present study was intended to determine if personality characteristics of bulimic women in late adolescence to early adult years are significantly different from nonbulimic women within the same age range in the Dallas/Fort Worth metroplex.

Subjects

Thirty-eight subjects were recruited from the Dallas/ Fort Worth metroplex. It was required that they all be over the age of 18. Twenty-one of them were suffering from bulimic symptoms as defined by the DSM-III (see Appendix A). Seventeen normal women were recruited from the same area. The tests were administered individually at the North Texas State University Psychology Clinic. The mean age for the bulimic women was 22, ranging from 17 to 35. The median age for this group was 23. The mean age for the 17 normal women was 29, ranging from 23 to 39. The median age for this group was 27.

Instruments

The Adjective Check List (ACL) was used to assess personality characteristics. The value of the ACL is that it can offer words and ideas commonly used for description in everyday life, in a format which is standardized and systematic. The ACL can be employed by an individual in self-description, to describe a commercial product, a city or state, etc. The ACL contains 300 words which have emerged from the language itself, past study, intuitive and subjective appraisal, empirical testing, and a three-year overall evaluation. The greatest value of the ACL may come from accruing, noting, pondering, or

analyzing those specific words which an individual or group of individuals has checked as self-descriptive.

Three facets were used to establish the reliability of the ACL: (a) test-retest reliability of the list of words. The mean reliability is +.54 with a range of +.01 to +.86. One hundred men were sampled. They filled out the checklist twice. The adjectives checked both times were counted and phi coefficients were computed for each of the 100 distributions; (b) test-retest reliability of the scales: 56 college males, 23 college females were tested, ten weeks apart, 100 adult males, six months apart, and 34 medical students were tested five and one-half years apart. Most scales possess adequate reliability over the ten week interval, and some over the five and one-half year interval; and (c) agreement among judges - from the 100 men aforementioned, five were drawn, the 20th, 40th, 60th, 80th, and 100th. The Spearman-Brown prophecy formula was used for the inter-group reliability which yielded .70, .63, .61, .75, and .61. This demonstrated that the ACL can be used by trained observers to describe others with adequate reliability.

Validity of the ACL. A variety of scales have been pulled and correlated with other tests. The ACL correlated with the Edwards Personal Preference Schedule at +.60 on

rank order of needs. Number of items checked on the ACL showed an expected relationship to Ma (hypomania) on the Minnesota Multiphasic Personality Inventory (MMPI), and the expected negative correlation with Welsh's R-scale (repression) on the same inventory. Df correlated -.40 with Welsh's A-scale (anxiety) on the MMPI, but only +.19 with the MMPI scale K.

For intercorrelations of men, women, and the combined sample, coefficients were low enough to show an adequate degree of independency among scales. Some overlap highly; yet to date there has been no way devised to reduce overlap without reducing validity.

The scales used from the ACL were as follows: Self-Control (S-Cn). This scale was developed empirically and is intended to parallel the responsibility-socialization cluster on the California Psychological Inventory; Personal Adjustment (Per. Adj.). This was derived from item analysis of assessment subjects, Achievement (Ach.), the definition of which is to strive to be outstanding in pursuit of socially recognized significance; Affiliation (Aff.), used to seek and sustain numerous personal friendships; Aggression (Agg.), to engage in behaviors which attack or hurt others; Autonomy (Aut.), to act independently of others or of set values and expectations; Succorance (Suc.), to solicit sympathy, or emotional support from others;

and Abasement (Aba.), to express feelings of inferiority through self-criticism, guilt, or social impotence.

Procedure

This study was conducted in conjunction with a team of researchers at North Texas State University. All data were collected from the same sample.

Subjects were divided into 21 women bulimics, as defined by the DSM-III, where binging occurs three or more times a week, and were over 18 years; and 17 normal women over the age of 18 years. The ACL was administered to each member of each group separately. The instructions were read out loud as part of the administration procedure. There was no time limit on the test taking. When subjects were finished, they turned in their protocols.

Results

The data collected in this study included scores from Harrison Gough's and Alfred B. Heilbrun's Adjective Check List (Gough & Heilbrun, 1965). The instruments used were self-report paper and pencil tests. The level of confidence was set at .05 to test for significance and student *t* tests were used to compare characteristics across the two groups, while a multiple regression procedure was used to determine the weighted contribution of each scale to the total variance.

The mean scores for the bulimic group were Abasement, 3.38; Affiliation, 18.86; Autonomy, 4.09,

Self-Control, 1.76; Achievement, 8.86; Aggression, -5.0; Personal Adjustment, 8.19; and Succorance, 4.24.

The mean scores for the normal sample were Abasement, -1.41; Affiliation, 20.76; Autonomy, 4.12; Self-Control, 4.18; Achievement, 11.24; Aggression, -8.82; Personal Adjustment, 10.05; and Succorance, -.47.

The selected ACL scales of the two groups were compared implementing the student's t test statistic. The bulimic group scored significantly higher at the predetermined .05 level of confidence on the abasement and succorance scales than did the normal sample. No further significant differences were noted with this analysis.

A multiple regression procedure was performed which elucidated the scales responsible for the greatest amount of variance of the constellation of scales analyzed. Across all scales personal adjustment autonomy, aggression and self-control seemed to control for the greatest amount of variance.

The results of the multiple regression were. Personal adjustment negatively correlated with autonomy ($p < .01$) multiple $r = .90$; aggression negatively correlated with affiliation ($p < .01$) multiple $r = .88$; self-control negatively correlated with autonomy ($p < .05$) multiple $r = .91$; autonomy negatively correlated with self-control

Table 1

T-Tests Comparing Selected ACL Scales

Scale	Mean	Standard Deviation	Pooled T Value	Variance Degrees of Freedom	Estimate 2-Tail Probability
ABA: Group 1	3.3810	6.910	2.32	36	8.026*
Group 2	-1.4118	5.501			
ACH: Group 1	8.8571	4.683	-1.23	36	0.228
Group 2	11.2353	7.207			
Aff: Group 1	18.8571	5.516	-0.88	36	0.383
Group 2	20.7647	7.774			
AGG: Group 1	-5.0000	10.895	1.24	36	0.224
Group 2	-8.8235	7.333			
AUT: Group 1	4.0952	6.617	-0.01	36	0.991
Group 2	4.1176	4.715			
PERADJ: Group 1	8.1905	4.589	-1.22	36	0.229
Group 2	10.0588	4.789			
SCN: Group 1	1.7619	5.881	-1.33	36	0.191
Group 2	4.1765	5.102			
SUC: Group 1	4.2381	4.721	3.54	36	0.001**
Group 2	-0.4706	3.105			

Group 1 = Bulimia (N = 21)

Group 2 = Normal (N = 17)

* p = .05

** p = .01

and personal adjustment ($p < .05$) multiple r = .96; aggression negatively correlated with abasement and affiliation ($p < .01$) multiple r = .96; and succorance positively correlated with abasement ($p < .05$) multiple r = .81.

Aggression, autonomy, self-control, and personal adjustment were all significant at the .01 level ($p < .01$) multiple r < .90 as summarized in Tables 2 through 8.

Table 2

Multiple Regression Summary Table for the Bulimic Group With Dependent Variable: Personal Adjustment

Variable	Standardized Beta	F
Abasement	-0.34	1.13
Affiliation	0.38	2.6
Self-Control	-0.05	0.03
Achievement	-0.01	0.002
Autonomy	-0.73	3.96*
Aggression	0.01	0.00
Succorance	-0.25	1.55

Note. R Square - 0.81
Multiple r - 0.90
F (7, 13) - 7.78*
*$p < .01$

Table 3

Multiple Regression Summary Table for the Bulimic Group With Dependent Variable: Affiliation

Variable	Standardized Beta	F
Abasement	-0.39	1.41
Personal Adjustment	0.43	2.6
Self-Control	-0.16	0.28
Achievement	-0.05	0.06
Autonomy	0.69	2.94
Aggression	-1.21	13.28*
Succorance	0.17	0.62

Note. R Square - 0.78
Multiple r - 0.88
F (7, 13) - 6.57
*p < .01

Table 4

Multiple Regression Summary Table for the Bulimic Group With Dependent Variable: Self-Control

Variable	Standardized Beta	F
Abasement	-0.29	0.59
Affiliation	-0.13	0.28
Personal Adjustment	-0.05	0.03
Achievement	0.21	1.69
Autonomy	-0.69	3.89*

Table 4--Continued

Variable	Standardized Beta	F
Aggression	-0.52	1.71
Succorance	0.19	0.93

Note. R Square - 0.82
Multiple r - 0.91
F (7, 13) - 8.71*
*p < .01

Table 5

Multiple Regression Summary Table for the Bulimic Group With Dependent Variable: Achievement

Variable	Standardized Beta	F
Abasement	-0.68	2.08
Affiliation	-0.01	0.06
Self-Control	0.55	1.69
Personal Adjustment	-0.02	0.002
Autonomy	0.72	0.35
Aggression	-0.40	0.36
Succorance	0.04	0.02

Note. R Square - 0.53
Multiple r - 0.73
F (7, 13) - 2.08
*p < .01

Table 6

Multiple Regression Summary Table for the Bulimic Group With Dependent Variable: Autonomy

Variable	Standardized Beta	F
Abasement	-0.18	0.76
Affiliation	0.26	2.94
Self-Control	-0.33	3.90*
Achievement	0.13	1.35
Personal Adjustment	-0.32	3.96*
Aggression	0.40	2.18
Succorance	0.02	0.01

Note. R Square - 0.91
Multiple r - 0.96
F (7, 13) - 19.91*
*$p < .01$

Table 7

Multiple Regression Summary Table for the Bulimic Group With Dependent Variable Aggression

Variable	Standardized Beta	F
Abasement	-0.38	4.93*
Affiliation	-0.42	13.28*
Self-Control	-0.22	1.71
Achievement	-0.06	0.36

Table 7--Continued

Variable	Standardized Beta	F
Autonomy	0.36	2.18
Personal Adjustment	0.00	0.00
Succorance	0.14	1.34

Note. R Square - 0.92
Multiple r - 0.96
F (7, 13) - 22.65*
*p < .01

Table 8

Multiple Regression Summary Table for the Bulimic Group With Dependent Variable: Succorance

Variable	Standardized Beta	F
Abasement	0.79	4.54*
Affiliation	0.26	0.62
Self-Control	0.35	0.93
Achievement	0.03	0.01
Autonomy	0.06	0.01
Aggression	0.64	1.34
Personal Adjustment	-0.43	1.55

Note. R Square - 0.66
Multiple r - 0.81
F (7, 13) - 3.68
*p < .01

Discussion

In this study a comparison was drawn between bulimic women and normal women as measured by a self-descriptive personality test. Significant differences were found between the two groups on the scales measuring abasement and succorance. Bulimic women tended to score higher than normals on items which measured personality tendencies that solicit sympathy or emotional support from others as well as the need to express feelings of inferiority through self-criticism, guilt, or social impotence. The literature seems to support these characteristics when addressing bulimic behavior (Burns, 1980; Bemus, 1978; Russell, 1979; Chernin, 1981).

As measured by the Adjective Check List, these data might indicate that a certain level of personal adjustment (as defined by Gough and Heilburn, 1965) is achieved with a sacrifice in autonomy. Representative adjectives for personal adjustment include being alert, calm, fair-minded, loyal, organized, practical, trusting, versatile, and warm. Representative adjectives for autonomy include being adventurous, aggressive, aloof, autocratic, cynical, hard-headed, individualistic, and self-confident. Thus, it is likely a bulimic person will demonstrate the latter behaviors at a lesser frequency and possibly show more behaviors which may include cautiousness, conventionality,

suggestibility and timidity. As a result, their level of personal adjustment is likely to be lesser than optimum due to the complexity and nature of the disorder. According to Bemus (1978), Russell (1979), and Chernin (1981), people suffering from bulimic symptoms are characterized as being very dependent. Burns (1980) and Russell (1976) describe bulimic behavior typified by high levels of anxiety and variable moods. Thus, it would seem likely that as the level of dependency heightened, the less autonomous behavior would be enacted and the more immediate mood fluctuations and high anxiety levels would become apparent. Furthermore, this population may tend to feel the adjustment to their personal life is uncomfortable and embarrassing. This could increase their need for approval from others and decrease autonomous strivings.

Along similar lines, there seems to be a strong inverse relationship between affiliation and aggression. This interaction may reveal a dichotomy composed by strong desires to belong resulting in the suppression of any aggressive tendencies. According to Heilbrun and Gough (1965), some adjectives indicative of high scores on affiliation are being attractive, adaptable, considerate, cooperative, good-natured, kind, mannerly, talkative, and warm. Representative adjectives for a high score for aggression include arrogant, autocratic, cruel, forceful, and sarcastic. The

literature suggests (Russell, 1979; Burns, 1980) there may be underlying anger commonly felt by bulimic women. These results could imply an overcompensation of their aggressive feelings due to such a high need for affiliation. It could be speculated these results may truncate with the autonomy scale as aggressiveness and individualism are part of the descriptors.

Results also show the self-control scale negatively correlates with the autonomy scale. It is possible people suffering from bulimic symptoms do not feel internal (personal) self-control as they fear they cannot control their binging-purging impulses. Thus, it may be that their self-control is more outwardly focused. As bulimia tends to be a "closet disorder, an orientation towards appearing outwardly in control can be expected." These results then imply that as outward self-control increases, autonomy is likely to decrease as their behavior will inevitably be externally defined and controlled. Furthermore, as this population may at times appear to be dependable, consciencious, good-natured, and pleasant to others, it is likely they will not seek autonomous behaviors such as being adventuresome, aggressive, aloof, autocratic, and cynical. The literature (Bemus, 1979; Guiora, 1967; Russell, 1979; Burns, 1980) describe the bulimic population as being narcissistic, feeling inadequate, and showing impairment in self-control. Also, a

high need for dependence on others is likely due to their low self-esteem and feelings of lack of (inner) control. Bemus (1979), Chernin (1981), and Russell (1979) support these findings.

The statistical contribution of abasement seems to create a triad which helps illuminate the inverse relationship between aggression and affiliation. It is possible that as a bulimic person may tend to suppress aggression (by turning it inward), feelings of self-worth are likely to be lowered as they do not have self-control. This could create an interesting style of dealing with others as their feelings of inadequacy and embarrassment may lead them to overcompensate by exhibiting submissive behavior. According to Heilbrun and Gough (1965), self-descriptors for the abasement scale include feeling anxious, cowardly, despondent, gloomy, and being self-punitive. The literature (Bemus, 1978; Russell, 1979; Chernin 1981; Burns, 1980) describe bulimics as feeling anxiety, guilt, gloominess, feelings of inadequacy, and to be self-blaming. Thus, it is likely that as these feelings elevate, a higher need for affiliation may also grow. Yet the interactive style with others is more likely to be one of a submissive nature rather than that of an aggressive nature.

Finally, results show a positive relationship between the succorance scale and the abasement scale. That is, as

their feelings of anxiety, gloominess, and inferiority increase, their need to solicit sympathy and affection may also increase. Behaviors such as being demanding, acting immaturely, being self-centered, whinning and acting submissive are likely to be exhibited when interacting with others. The literature (Bemus, 1979; Russell, 1979) describes the bulimic population as one to show inadequate and dependent behaviors. This could be the result of expecting others to relieve them from their feelings of anxiety and guilt. Therefore, they may tend to demand a lot of affection and attention from others. By doing this their anxiety may be temporarily lowered. Yet when others are not around anxiety levels may rise (due to feelings of lack of control) and the whole binge-purging cycle may commence once more (see Figure 1).

These results seem to imply not only some of the external characteristics shown by a person suffering from bulimic symptoms, but also the types of personal and internal struggles they may be going through. It is recommended further research be done perhaps combining a variety of personality measurements which may aid in a more comprehensive understanding of this eating disorder and of its etiology.

Appendix A

Diagnostic Criteria for Bulimia

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

B. At least three of the following:

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

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

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

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

Appendix B

Similarity of Descriptors to ACL Scales

Authors	Descriptors	Most like ACL Scales
Bemus (1978) Guiora (1967) Russell (1979) Burns (1980)	Narcissism Antisocial behavior Impaired self-control Feelings of inadequacy Likelihood to be headstrong	6 - Self-Control 15 - Affiliation
Burns (1980) Chernin (1981) Bemus (1978) Russell (1976)	High level of anxiety Variable moods	8 - Personal adjustment
Time Magazine (1980) Minuchin (1975)	Successful Bright Achievement oriented	9 - Achievement
Bemus (1978) Russell (1979) Chernin (1981)	Dependent	18 - Autonomy
Russell (1979) Burns (1980)	Irritability Frustration	19 - Aggression
Burns (1980) Bemus (1979) Russell (1979)	Inadequacy Dependency	21 - Succorance
Bemus (1978) Russell (1979) Chernin (1981) Burns (1980)	Anxiety Self-blame Inadequacy Guilt Gloominess	22 - Abasement

Appendix C

Partial Listing of Physical Problems Brought About by Eating Disorders

	External Problems	Internal Problems	Cause
Skin	Dryness	Dehydration	Reduced fluid intake Excessive fluid elimination.
	Fine Rash		Frequent vomiting.
	Pimples		Laxative abuse.
Salivary Glands	Swelling Pain Tenderness	Possible infection but usually not.	Frequent vomiting.
Constipation		Insufficient material. Insufficient fluid. Dulled intestinal nerves.	Failure to take in or retain sufficient food and fluid. Laxative abuse.
Edema (water retention)	Swelling and puffiness more frequently ankles and feet.	Electrolyte imbalance. Perhaps general systems problems.	Malnutrition. Frequent vomiting. Excessive laxatives or diuretics.
Bloating	Swelling over stomach or abdominal area.	Electrolyte imbalance? Time required for body systems to adjust? Insufficient protein intake.	Long periods of starvation and probable excessive vomiting, laxatives or diuretics.

Appendix C--Continued

	External Problems	Internal Problems	Cause
Abdominal Pain		Peptides? Hunger pangs? Changes in the bowel.	Failure to identify hunger? Emotional attitudes? Insufficient intake.
Feeling of Fullness	Slight distention after eating is normal	Normal feeling after eating for everybody.	Fear? Emotional attitudes.
Teeth	Frequent cavities. Frequent cavities plus erosion of enamel.		Inadequate diet. Frequent vomiting or regurgitation. Diet limited to citrus fruits, abnormal carbohydrate intake.
Amenhorrhea	No menstrual period.	Inability to produce hormones.	Lack of body fat, rigorous athletic training, emotional attitudes, sometimes gorging/purging.

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