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# Self-regulatory deficits, relational experiences, and the functions of weight control in bulimic women.

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# SELF-REGULATORY DEFICITS, RELATIONAL EXPERIENCES, AND THE FUNCTIONS OF WEIGHT CONTROL IN BULIMIC WOMEN

by

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ABSTRACT

The purpose of this study was to investigate, within the framework of psychoanalytic self psychology, the ability to regulate affect and self-esteem, and the level of object relations and selfobject experiences, in a group of 30 bulimic women. The relationships between self-regulatory functions and relational experiences, and severity of bulimic symptoms were examined. Comparisons of self-regulatory functions and relational experiences were made between the bulimic group and three control groups composed of 30 depressed women, 30 overweight dieting women, and 30 normal controls who were not overweight, not dieting, not depressed, and not bulimic. In addition, the self-regulatory function of weight control was examined, and compared across groups. The psychometric characteristics of three measures used in the study, namely the Soothing Receptivity Scale (Glassmen, 1988), the Symptoms of Fragmentation Scale (Vipond, 1988), and the Selfobject Needs Scale (Vipond, 1988) were also examined. Results indicated that the bulimic women had more difficulty regulating dysphoric affects and self-esteem, were more vulnerable to fragmentaion experiences, and reported more primitive object relations and selfobject experiences than either the overweight dieters or the normal controls; however, the bulimic group did not differ significantly from the depressed group on these measures.

Statistically significant relationships were found between self-regulatory deficits and levels of object and selfobject relations across groups. In addition, statistically significant relationships were found between self-regulatory deficits and relational experiences, and severity of some symptoms in the bulimic group. When the bulimic group imagined losing five pounds, they reported experiencing greater decreases in anxiety, depression, and symptoms of fragmentation, and greater increases in self-esteem than did subjects in any of the other three groups. When the bulimic group imagined gaining five pounds, however, they reported experiencing increases in anxiety, depression, and symptoms of fragmentaion, and decreases in self-esteem which were greater only than those reported by the depressed group. Implications of the results were discussed as they relate to self psychology theory; to the relationships among bulimia, depression, and self-regulatory deficits; and to the treatment of bulimic women. Directions for future research were suggested.

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# CHAPTER I

# INTRODUCTION

Over the last twenty years, the incidence of eating disorders has increased dramatically in North America. At present, it is estimated that approximately 1% of adolescent and adult women suffer from anorexia nervosa, and that 2-4% have siginificant symptoms of bulimia nervosa (Garfinkel, & Goldbloom, 1988; Leichner, & Gertler, 1988). The incidence of eating disorders is reported to be as high as 10% among college students (Levine, 1987), and still higher among women in careers such as dancing and modelling where low weight is a requirement for success (National Eating Disorders Information Centre, 1988).

Eating disorders are associated with serious emotional, social, and physical problems including anxiety and depression, social isolation, academic and vocational underachievement, physiological effects of malnutrition, and a mortality rate of between 5% and 20% (Garfinkel, & Goldbloom, 1988; Toner, Garfinkel, & Garner, 1986). In addition, these disorders tend to be chronic, and difficult to treat successfully, with only about 50% of anorexics and bulimics maintaining significant symptomatic improvement one to five years after treatment (Goldbloom, & Garfinkel, 1988; Hsu, & Holder, 1986).

The prevalence, seriousness, chronicity, and difficulty in treating eating disorders speaks to the need for a clearer and more comprehensive understanding of their etiology, development, maintenance, and treatment. Increased understanding would lay the groundwork for more effective identification of persons at risk for developing eating disorders, for earlier interventions which could decrease the chronicity of these disorders, and for more effective treatments which could reduce both the recurrence of eating disorder symptoms and the accompanying debilitating effects.

The purpose of this research project is to examine, within the framework of psychoanalytic self psychology, certain aspects of the personality functioning of bulimic women as it relates to their symptomatology. More specifically, the investigator has attempted to identify deficits in the self-regulatory functions, and in the object relationships and selfobject experiences of persons with bulimia; and to relate these deficits to the symptoms of bulimia nervosa.

The goals in conducting this investigation were first, to test some of the postulates of psychoanalytic self psychology using empirical methods; second, to demonstrate a relationship between personality functioning and symptomatology in persons with eating disorders; and third, to test the validity of three self-report measures, namely the Soothing Receptivity Scale, the Selfobject Needs Scale, and the Symptoms of Fragmentation Scale.

The Concept of Self in Psychoanalytic Theory

The use of the concept of self in psychoanalytic theory has a

complex and erratic history, but is currently prominent in psychoanalytic thinking and writing. In the past, the concept of self has been ignored entirely by some theorists, and used in different, sometimes contradictory, ways by others. In this section, the writer will discuss briefly some of the significant precursors to current psychoanalytic views of the concept of self. For a thoughtful and more comprehensive treatment of the development of the concept of self in psychoanalytic thinking, and particularly in object relations theory, the reader is referred to Greenberg and Mitchell (1983).

Although Bettleheim (1984) argues that Freud originally intended the concept "das Ich" (the "I") to refer to deep emotional experience that is "close to us" and encompasses our entire self, "our whole being" (pp. 55-56), it is Hartmann who is usually credited with introducing the concept of self into "mainstream" psychoanalytic theory around 1950. At that time - and continuing to the present - increasing interest in object relations theory led to difficulties in integrating the ideas and concepts relevant to object relations theory into classical (drive/structure model) psychoanalytic theory. Theorists tended to deal with this conundrum in one of two ways: Some declared themselves loyal to classical theory and either ignored new developments in psychoanalytic thinking, or attempted to integrate certain aspects of object relations theory into classical theory. Others declared themselves willing to leave behind some or all of the tenets of drive theory in favour of what has come to be referred to as the "relational model" in which interpersonal rather

than intrapsychic processes have become the building blocks of psychoanalytic theory.

Hartmann placed himself firmly in the "drive model camp", but modified classical psychoanalytic theory by redefining narcissism as the libidinal cathexis of the *self* [italics added] rather than of the system ego. For Hartmann, however, the "self" is still a descriptive rather than an explanatory concept. Hartmann's "self" is a representation or an internal image, a construct that is theoretically parallel to an object representation and has no functional role in the psychic economy except as a "target" of drive energies (Greenberg & Mitchell, 1983).

Jacobson and Mahler, also essentially drive model theorists, adopted Hartmann's definition of self as a representation within the ego. For them, however, the self took on more importance than it had for Hartmann. In Mahler's theory, the self is not a functional unit but a developmental achievement and the benchmark of successful emotional growth (Greenberg & Mitchell, 1983, p. 300). By having the ego carry out the organizing, integrating, and synthesizing functions that give rise to the self, however, and by rejecting the idea that the infant is separate and competent from birth, Mahler is able to preserve the major tenets of the drive structure model.

For Jacobson, the concept of self carries even more weight than it does in the thinking of either Hartmann or Mahler. For Jacobson (1954, 1964) the self is not *only* a representation within the ego. It

also influences ego development (along with the object representations and the interactions between the self- and object-representations). Greenberg and Mitchell comment on Mahler's concept of the self as follows:

> "[Her] statements make it clear that the ego, on the one hand (also the superego), and the self and object images on the other, exert a reciprocal influence on each other's development.... For Jacobson, both normal and pathological development are based on the evolution of images of the self and others. In Jacobson's view, fixations refer not to modes of gratification, but to modes of object relatedness; what is crucial is how solid, stable, realistic, separate, and articulated concepts of the self and of the object are at the time of developmentally critical disappointments" (1983, p. 310).

Thus, Jacobson retains her basic identification with the drive/structure model theorists, but shifts her emphasis to focus more on phenomenological and relational issues, allowing the self to play a more "active" role in psychic development.

Although he used the term "ego" rather than "self", and although he wrote as if he had simply modified Freud's concept of the ego, W. R. D. Fairbairn's theoretical perspective "along with Sullivan's 'interpersonal psychiatry', provides the purest and clearest expression of the shift from the drive/structure model to the relational structure model" (Greenberg & Mitchell, 1983, p. 151). Fairbairn's concept of "ego" has its own libidinal energy, and seeks relationships with real external objects. Furthermore, the state of the ego - whether it is integrated or fragmented - is determined by

the nature of its relationships with these external objects. As Guntrip points out, Fairbairn's concept of ego is

> not the superficial adaptive ego of Freud...formed on the surface of a hypothetical impersonal id as its adjustment to outer reality. Fairbairn's ego is the primary psychic self in its original wholeness, a whole which differentiates into organized structural patterns under the impact of experience of object relations after birth (Guntrip, 1961, p. 279).

It is clear that Fairbairn uses the concept of ego in a way that is functionally much closer to the contemporary use of the concept of self (e.g., Kohut, 1977; Gedo, 1979) than it is to Freud's use of the term ego.

Similarly, both Winnicott and Kernberg claim allegience to Freud, but use the concepts of drive theory idiosyncratically. Winnicott does use the term "self", defining it as "an inherited potential which is experiencing a continuity of being" (1965, p. 46). His interest in the self's immediate inner experience is reflected in this definition, as are his ideas about innate maturational processes. Winnicott's main focus of concern as regards the self is the struggle of the self to be both individuated and connected with others. In his view, self development is possible only in the context of intractions between a child and significant others who organize the child's experience and thereby provide for the development of integrated self-experience. For Winnicott, the concept of the self and its development into either an integrated self-experience or a false-self

organization is central. His "self" is a functional entity rather than a merely descriptive term.

Kernberg (1982) defines the concept of "self" as "an intrapsychic *structure* [italics added] that originates from the ego and is clearly embedded in the ego" (p. 900). As well as emphasizing the interactive nature of the self and making relational factors central to the psychic apparatus, Kernberg takes Hartmann's definition a step further in referring to the self as a "structure", and the "supraordinate organizer of key ego functions such as reality testing, ego synthesis, and, above all, an integrated concept of the self, and of significant others" (1982, p. 914). Kernberg thereby violates the distinction between a representation and a structure which is commonly agreed upon by drive model theorists. He also suggests that the self has the same theoretical and functional importance as the id, ego, and superego, and in so doing aligns himself with the relational model theorists, particularly Kohut.

Kohut's Concept of Self

No psychoanalytic theorist has placed more importance on the concept of self than Kohut. For him, the self is the basic constituent of the psychic apparatus. In his early writings, his thinking about the concept of self was still encumbered by his reluctance to abandon the concepts of the classical drive model. Even in these early writings, however, Kohut describes the self as a structure different from other structures such as the ego and superego but, like them, imbued with energy and enduring in time.

By 1977, when *The Restoration of the Self* was published, Kohut had extricated himself to some extent from the need to "integrate" his ideas into the drive model, and attributed to the self functions which Freud (and many other drive model and object relations theorists) attributed to the id, ego, and superego. By that time, Kohut's definition of the self had broadened considerably, and he describes the self as functioning as "an effective independent centre of initiative, and as a focus of perceptions and experiences - including those of heightened or lowered self-esteem" (1977, p. 94). In this later definition, the centrality of ideas such as self-representations and imagoes (important in his earlier descriptions of the self) were replaced by *processes* such as willing, feeling, and experiencing.

Kohut describes the structure of the self as having two "poles", one organized around ambitions; the other around ideals. According to Kchut these poles, or dimensions of self, evolve in response to early modes of relatedness, with either pole (or both) being capable of forming the core of a cohesive self. If the self is organized around the grandiose, exhibitionistic pole, this will be expressed in healthy ambition and assertiveness derived from the empathic responses of mirroring selfobjects. If, on the other hand, the idealizing selfobject experiences are more prominent, the self will be organized around the expression of healthy, strongly-held ideals and values. These two poles are joined by an "arc" comprising the individual's unique skills and talents which determine the specific ways in which a

person's ambitions or ideals are expressed. According to Kohut, failure to develop at least one of these aspects of the self leads to narcissistic pathology characterized by vulnerability to enfeeblement or fragmentation of the self, and the inability to maintain adequate self-esteem. This "self pathology" will be discussed in more detail in a later section.

Unlike the self of drive/structure model theorists, Kohut's self is not involved in the expression of instinctual drives. Instead it "seeks" relatedness. In his later writings, in fact, Kohut viewed "drive states" as the attempts of an enfeebled or fragmented self to restore its cohesion and vitality. Thus, as Greenberg and Mitchell (1983) note: "Far from being primary, innate motivational forces, the drives are manifestations of underlying psychopathology" (p. 362).

Another way in which Kohut's concept of self differs from earlier conceptualizations, is that Kohut emphasizes the central importance of the immediately-felt *experience* of self more than any psychoanalytic theorist before him. He runs into linguistic difficulties in trying to describe the self as experience, and his use of terms such as "bipolar self" and "selfobject", and the description of the self as "actively craving a developmental move forward" (1984, p. 141), give the impression that Kohut thinks of the self as a "thing". This is not so. The self, for Kohut, is not a "thing". It is, rather, "a singular, non-reducible quality of psychological experience" (Wolfe, 1989, p. 546).

Stolorow (1984) emphasizes that Kohut's conceptualization of the self includes two aspects: First, the self is a psychological structure that serves to organize the ways we feel about ourselves. Second, the self is an existential entity which initiates action based on the feelings we have about ourselves (p.141). In contrast to the concepts "person" or "personality" which are based on inferences made from the observation of behaviour, the self is a concept based on the "structure of inner experience" (ibid).

The Development of a Cohesive Self: Kohut's Theory

According to Kohut (1977) the goal of psychic development is the attainment of a cohesive self. As discussed in the previous section, Kohut defines a cohesive self as a self that is the "organizing centre of the person's skills, talents, and initiative"; a self that allows the individual - guided by his or her ideals - to work toward achieving goals which express his or her unique talents; a self that is able to maintain a healthy self-esteem, regulate internal tension states, and sustain a sense of continuity in time and space. Although Kohut did not specifically enumerate the functions of a cohesive self, Masterson (1985) identified these capacities as continuity of the self, intimacy, commitment to persons or goals, creativity, self-activation and assertion, maintenance of self-esteem, self-entitlement, spontaneity and aliveness of affect, and soothing of painful affects.

Kohut (1971, 1977) explained the development of self-cohesion in the following way: In the early months of an infant's life the parents are the primary selfobjects for the infant. A selfobject is

defined as an object or person who is experienced as not completely separate from one's self, and who performs self functions which one is unable to perform independently. The selfobject thus promotes or maintains the self cohesion of the person for whom he or she acts as a selfobject. In contrast with "true objects", who are valued for their unique, individual qualities, selfobjects are valued for the feeling-experiences they elicit, for the internal functions they perform, and for the emotional stability they provide. In the infant's early life, the parent-selfobjects perform virtually all self functions for the infant who, as yet, has not developed a functioning self. They regulate the infant's tension level by responding empathically to his or her communications of excitement or distress; by providing food to assuage hunger; by providing a safe, comfortable environment; by holding, talking to, and soothing the infant when he or she is frustrated or overstimulated; and by verbally, visually and tactilely resonating with the infant's expressions of pleasure and contentment.

As the young child's self develops, and he or she begins to master the environment, the parents' selfobject functions focus more specifically on what Kohut refers to as "mirroring functions": reflecting the child's joy and growing competence as he or she gains greater mastery over the environment; encouraging, supporting, and empathically resonating with the child's movement toward individuation, and at the same time serving as anchor-points to which the child can return for comfort and renewal. In this way the parents promote the growth of the child's own capacities for self-

assertion, tension-regulation, and the maintenance of healthy ambition and self-esteem.

At a still later developmental stage, according to Kohut, the child's "idealizing needs" become prominent. During this period, the parent-selfobjects function as the representations of the child's idealizations. By accepting and empathizing with the child's wish to merge with the parents' perceived omnipotence, the parents promote the development of the child's capacities to form and express his or her own unique values and ideals.

It is obvious that at every stage of childhood development (as well as in adulthood) the ability to empathize is central to providing adequate selfobject experiences. The American Heritage Dictionary defines empathy as "an understanding so intimate that the feelings, thoughts, and motives of one are readily comprehended by another" (cited in Baker & Baker, 1987, p.2). To empathize with another, then, is to comprehend the other's experience from his or her own unique perspective. Kohut described empathy as "vicarious introspection", the ability to find oneself in the other.

If the parents perform adequately (that is, empathically) as selfobjects for the child, the functions they have performed are gradually internalized by the child and become self-structures. Kohut refers to this process as one of "transmuting internalization". Ideally this developmental process results in a cohesive adult self. If, however, the parents' empathic failures as selfobjects are chronic or severe, the internalization of self functions by the child is

incomplete, and self-structures are not firmly established. The result is a self that is vulnerable to fragmentation ("the threat of permanent or temporary breakup, enfeeblement or distortion of the self" [Kohut, 1977, p. 192]) when a self-selfobject matrix is disrupted, or when a narcissistic injury is experienced. This unhealthy self in adulthood is inordinately dependent on others to perform for it the functions that supply self-esteem, regulate internal tension states, and act as the integrators of ambitions. It is a self that depends on others to act as "the concretely present idealized power that dispenses approval and other forms of narcissistic sustenance" (Kohut, 1977, p.16).

This dependence on a selfobject matrix may in some respects appear similar to the more generalized dependency found, for example, in the "dependent personality": a lack of self-reliance, or a tendency to depend on others to make decisions or to provide comfort or guidance. It differs from that kind of dependency, however, in that dependence on selfobjects is more specific and, in some respects, more circumscribed. For example, someone who has limited self-cohesion (and is therefore relatively more dependent on a selfobject matrix) may, in many respects, function quite independently in a profession or in day-to-day life, making decisions and performing tasks without seeking undue assistance or support from others. In these respects, such a person would not be seen as "dependent" in the generic sense. What he or she may depend on others for, however, is to provide experiences which regulate his or

her self-esteem by providing adequate affirmation, or to fend off feelings of emptiness by providing a feeling of safety and belonging. This dependency on selfobjects is not necessarily present at all times, but becomes prominent when the person who lacks a robust sense of self suffers a narcissistic injury (such as a perceived criticism or rejection), or when a selfobject matrix is disrupted through physical absence or empathic failure. Dependence on selfobjects, then, constitutes a specific type of dependence: a need for others to perform self functions which one is unable to perform adequately for oneself.

In the absence of selfobjects to perform these functions, persons lacking a cohesive self are likely to experience symptoms of fragmentation or "fragmentation anxiety". Kohut (1984) is unambiguous in his assertion that fragmentation anxiety is "the deepest anxiety man can experience" (p.16). He describes it as being similar to the fear of death, except that what is feared is not physical death, but psychological annihilation or loss of humanness. People experience fragmentaion anxiety in a variety of ways such as the loss of a sense of continuity in time and space; a drop in self-esteem; loss of initiative; and feelings of disorganization, anxiety, rage, empty depression, and/or meaninglessness (Brandchaft & Stolorow, 1984).

The "event" that precipitates fragmentation or fragmentation anxiety is typically thought to be the perceived empathic failure of a selfobject. By failing to understand and respond appropriately to the other's need for, for example, affirmation or soothing, the selfobject

fails to perform a necessary self function for the person with a fragile self structure. Unable to perform this function independently, the person with an inadequate self structure then experiences the anxiety and other symptoms associated with loss of self-cohesion. The severity of these symptoms, as well as the severity and nature of the empathic failures which precipitate them are thought to be related to the degree to which self functions have been internalized, as well as to the ability of the person to identify and effectively use appropriate selfobjects.

Experiences of fragmentation inevitably lead to efforts to re-establish self-cohesion. These efforts take many forms and are enacted in an infinite number of individualized ways, but may be viewed as occurring on a continuum of adaptability ranging from methods which are relatively archaic and maladaptive to methods which are relatively mature and adaptive (Glassman, 1988). It has been suggested, for example, that the symptoms of eating disorders such as bingeing, vomiting, and severely restricting food intake are attempts to re-establish self cohesion (Barth, & Wurman,1986; Goodsitt, 1983). On a continuum of adaptability, these methods of self-regulation would be considered relatively archaic and dysfunctional when compared with more adaptive methods such as talking to a friend or becoming involved in a meaningful project.

Self-cohesion, then, is not an all-or-nothing concept, but involves a developmental process which can be more or less successful, and which results in a greater or lesser ability to perform

self functions such as the maintenance of adequate self-esteem and the regulation of affects. Furthermore, Kohut states clearly that the achievement of a cohesive self does not herald the end of the need for selfobjects. What does change as self-cohesion increases is the nature of one's selfobject relationships, with more "mature" selfobject relationships being characterized by (1) the ability to recognize suitable selfobjects and "to create for oneself a self-supportive social matrix" (Wolf, 1984, p. 155); (2) the ability to recognize that one's human selfobjects - while they are felt to be part of oneself - are, in fact, separate selves with their own selfobject needs; (3) the ability to tolerate the physical or emotional loss of one's selfobjects without experiencing severe symptoms of fragmentation; and (4) the ability to conduct one's selfobject relationships at a higher level of abstraction so that, for example, the idealized image of the parent-selfobject is transformed into more abstract ideals which serve the same function as the original selfobject, such as the provision of comfort, strength, and meaningfulness (Basch, 1984). For example, during adolescence the peer group may become an idealized selfobject; and in adulthood social causes or careers may perform idealized selfobject functions.

The Concept of the Selfobject: Theoretical Context

The concept of the selfobject is central to Kohut's theory of self development. Although it is a unique concept, it bears some relationship to other psychoanalytic concepts such as those associated with the separation-individuation process in object

relations theory (e.g., Goodsitt, 1969; Mahler, Pine, & Bergman,1975; Shainess, 1979). According to object relations theory, unresolved early symbiotic attachments with parents result in an impairment in the child's sense of individuality, and in later disturbances in object relationships. These disturbances may be manifested in separation anxiety and/or in fears of engulfment which result in the inability to develop unambivalent, security-promoting relationships with others.

The concept of the selfobject also bears some resemblance to Winnicott's (1953) concept of transitional relatedness in which "the internal reality of wishes, desires, and convictions is blended with external physical reality in the contemplation of an object" (Horton, Louy, & Coppolillo 1974). In Winnicott's terms a transitional object is an object (such as a child's blanket) which is symbolic of another part object (such as the mother's breast), and which serves the same soothing function as the original object. Winnicott describes this quality of relatedness as occurring in an "intermediate area of experience" which incorporates both fantasy and reality; and he believes that any object, thought, or concept can function as a transitional object provided it is experienced in this "intermediate area".

There are also similarities between Kohut's concept of the selfobject and Bowlby's (1982) concept of the attachment system. In Bowlby's theory, the concept of attachment denotes a specific relational element characterized by one person's using another person as a source of security. As Armstrong and Roth (1989) note:

"When anxious or fearful, a person's attachment system activates behaviours intended to secure proximity to the attachment figure, who can then function as a calming agent" (p. 142). In the context of Bowlby's attachment theory, separation anxiety is a normal phenomenon evoked by disruptions in an individual's sense of security and connectedness with his or her attachment system. This explanation of separation anxiety is, in some ways, akin to Kohut's concept of fragmentation anxiety, and both are associated with some of the same behavioral and affective manifestations such as anger, depression, and physical restlessness. For both Kohut and Bowlby, the ability to look to others as sources of security and calm in times of stress is a fundamental human quality which is associated with healthy psychological functioning, and which endures throughout one's life. Both Kohut and Bowlby believe that the inability to relate to others in a self-soothing manner is a significant factor in the etiology of a variety of emotional and psychiatric difficulties.

Unlike Bowlby's attachment figures, however, Kohut's selfobjects are experienced not as separate entities, but as part of oneself. And unlike both attachment figures and transitional objects, selfobjects serve other functions in addition to providing security and soothing. As Wolf (1988) points out:

> Strictly speaking, therefore, selfobjects are neither selfs nor objects, but the subjective aspects of a function performed by a relationship. As such, the selfobject relationship refers to an intrapsychic experience and does not describe an interpersonal relationship between the self and other objects. It denotes the

> subjective experiences...that are needed for the sustenance of the self. (p. 53)

As Ornstein (1981) notes, the uniqueness of the concept of the selfobject is that it "bridges the traditionally established sharp line between internal and external, intrapsychic and interpersonal" (p. 445). In selfobject theory, as contrasted with object relations theory, the separateness and independence of self and other are relative, and the self - even at its most cohesive and mature - does not exist entirely independent of its selfobjects.

Critique of Kohut's Theory

Kohut's self psychology has had a significant impact on psychoanalytic thought, and has been important in bringing to the forefront issues related to the role of self in both normal development and psychoanalytic treatment. Nevertheless, Kohut's theory has been criticized on a number of grounds.

Perhaps the most often heard criticisms relate to the internal inconsistencies in the theory. To a large extent, these internal inconsistencies are the result of Kohut's need to remain loyal to classical psychoanalytic theory. Clearly the tripartite structure of id, ego, and superego; and the sexual and aggressive drives do not comprise the foundation of Kohut's self psychology. As they are interpreted in classical drive theory, these concepts do not "complement" self theory, as Kohut suggests. On the contrary, they are unnecessary encumbrances which Kohut tries unsuccessfully to "integrate" into his theory. The result of this attempt to "ensure the

continuity of psychoanalysis" (Kohut, 1977, p. 172) is that Kohut's writing - particularly his earlier work - becomes convoluted and confusing. His reasoning is, at best, difficult to follow, and at times simply fallacious.. Greenberg and Mitchell (1983) illustrate this difficulty with the following example:

> If impulse results from a deterioration of relationship, how can one have impulse and relationship simultaneously and complementarily? A theory that sees relational configurations as primary, and drive-derived impulses as secondary breakdown products does not complement a theory that sees impulses as the building blocks of relational configurations. Kohut uses complementarity to obscure the necessity for choice (p. 363).

Similarly, Kohut (1977) argues that "The deepest level to be reached is not the drive, but the threat to the organization of the self" (p.123). At the same time, he argues that the drive theory model could explain structural conflict even though it omitted the self, because it left out the self on both sides of the conflict, thereby nullifying the effect of the omission (1977, p. 96-97).

Of this puzzling algebraic logic, Greenberg and Mitchell comment:

> To say that leaving out the self on both sides of the conflict is algebraically insignificant does not address the fact that it also omits a focus on what Kohut claims are the fundamental psychological issues. The 'principle of complementarity' seems less designed to integrate compatible and mutually enriching perspectives than to preserve an older framework that is conceptually incompatible with a newer one (ibid.).

The dimensions Kohut proposed to integrate, then, are not only not complementary; they are mutually exclusive. In his very late writings (e.g., 1984), Kohut seems to drop some of this "pretense" of loyalty to classical psychoanalysis, thus making his ideas more comprehensible and his writings more readable. For the most part, however, it has been left to his successors to bring a modicum of internal consistency and clarity to self psychology theory.

A second criticism that is often made of Kohut is that he makes exaggerated claims about the uniqueness and originality of his ideas. Although he ocassionally makes referance to parallels that exist between his ideas and those of others, he makes no attempt to compare or integrate his ideas with the similar thinking of others; nor does he attrtibute any credit for his ideas to such authors as Sullivan (whose ideas about the importance of empathic interactions in the mother-child dyad are strikingly similar to his own), or to British object relations theorists such as Fairbairn and Winnicott (whose ideas regarding certain aspects of relational configurations and the developmental role of infantile grandiosity are also quite consistent with Kohut's ideas). In spite of these obvious parallels with the ideas of other like thinkers, Kohut claims that the psychology of the self is "unintegrable, despite the 'principle of complementarity', with virtually all other psychoanalytic theorizing" (Greenberg & Mitchell, 1983, p. 368).

Kohut (1980) bases this claim of uniqueness on the misguided belief that virtually all other psychoanalytic developmental theories are founded on the assumption "that man's life from childhood to adulthood is a move forward from a position of helplessness, dependence, and shameful clinging to a position of power, independence, and....autonomy" (p. 480). Kohut (1980) contrasts this view of development, from dependence to autonomy, with his own which stresses the need to feel responded to by others throughout life in order to feel "complete, independent, and strong" (p. 481). In making such statements, Kohut misinterprets the ideas of other theorists - particularly Fairbairn (1952), Searles (1965), and Bergman (1971) - who stress the importance of interdependence in healthy adult relationships.

Finally, Kohut's self psychology has been criticized for being too narrow in its focus. By confining his attention to issues related to narcissism, he sets those issues apart from other aspects of relationships, and thereby loses much of the complexity and richness inherent in all forms of relatedness. He also oversimplifies relatedness by defining relational needs only in terms of mirroring and idealizing rather than also in terms of more global needs for human contact, understanding, and caring.

In spite of these limitations in his theory, Kohut has made a significant cintribution to psychoanalytic thinking, both in terms of his formulations about normal development, and in terms of clinical paychoanalysis. By placing the "subjective self" at the centre of

psychodynamic theory, he has focused attention on the ways in which relatedness affects the quality of self-experience; and the importance of the cohesion, continuity, and integrity of that self-experience.

In terms of normal development, Kohut's focus of self-experience has brought to the forefront the importance of the parents' role in reflecting infantile grandiosity, and in providing opportunities for idealization. In addition, Kohut has stressed that these needs are normal and necessary rather than pathological. In the clinical realm, Kohut's emphasis on the nature of self-experience has led to a greater appreciation of the importance of the therapist's ability to become immersed in the patient's subjective experience. He has also advocated the use of "experience-near" theoretical concepts in psychoanalytic treatment, and has pointed out the paramount importance of the relationship in therapeutic encounters - an importance which, in the psychology of the self, is at least equal to the importance of interpretation in effecting therapeutic change.

## Selfobject Experiences and Eating Disorders: Theoretical Considerations

Kohut did not specifically address the issue of selfobject experiences in persons with eating disorders, and few other self psychology theorists since have addressed this issue. Hilde Bruch, (1961, 1973, 1977, 1978, 1982) though not drawing on self

psychology theory, made many clinical observations of eating-disordered patients which seem to anticipate the observations of psychoanalytic self psychology, and which are relevant to a discussion of selfobject experiences in persons with eating disorders. In one of her earlier works in the area of eating disorders (1973) Bruch states that the pre-illness personality of these patients is a significant contributor to the development of their eating disorders. Bruch (1961) also suggests that lack of appropriate parental responsiveness to a child's developing sense of self is responsible for the personality features which predispose girls to develop anorexia. Bruch describes the developmental process as follows:

> Whether an individual grows up to be healthy or more or less mentally sick, depends on whether there are appropriate responses to the various expressions of behavior that originate in the child. Only when this is forthcoming can he develop autonomy, initiative, and an adequate sense of trust in his own activities and his effectiveness in social situations and in satisfying his bodily needs (p. 52).

In many ways Bruch's understanding of the developmental deficits in her eating-disordered patients seems similar to the explanations offered by self psychology. In addition, Kohut and Bruch seem to share similar ideas as regards the etiology of these deficits, both theorists attributing them to unempathic interactions between parent and child in infancy and childhood.

A number of other self psychology theorists have explained the development of eating disorders in a similar way, viewing the

symptoms of eating disorders as reflections of deficits resulting from selfobject failures, and leading to difficulties in selfobject relationships. Rizzuto (1982), and Rizzuto, Peterson, and Reed (1981), for example, conceive of eating disorders (specifically anorexia nervosa) as resulting from, and reflecting a disturbance in the sense of self. These authors view anorexia nervosa as a particular variant of schizoid personality. Unlike the borderline and narcissistic personality disorders usually associated with inadequate self development as described by Kernberg (1975), and Kohut (1971, 1977), however, the anorexic patients described by Rizzuto et. al. (1982) "lack ambition, have no grandiose fantasies of any sort about themselves, and do not expect any admiration or acclaim. Their compulsion to be perfect anticipates no admiration. In fact they suffer from the pervasive disbelief that they have any relevance for anybody" (p.476). In other words, these patients exhibit strong defenses against narcissistic wishes. Also unlike the narcissistic patients described by Kohut, who were fixated on archaic, grandiose self-configurations or archaic overestimated selfobjects, the anorexic patients described by Rizzuto et. al. have "no grandiose hope or grandiose self-configuration, but a profound shame and remarkably low self-esteem" (ibid.). According to Rizzuto, anorexics are dissimilar to typical narcissistic patients in another way as well: Anorexics never experience psychic selfobject relations, and therefore never develop the capacity to use others to perform selfobject functions for them.

Like Rizzuto, Bauman (1981) views anorexia nervosa as a particular case of schizoid personality resulting from a deficiency in the mother's ability to act as a mirroring selfobject for the infant. Bauman equates the fragmentation of the body in anorexia with the fragmentation of the self. In her words: "Body image and self in childhood are both related to important others who see, hold, admire, and validate the infant and young child" (p. 457).

Bauman (1982), Lerner (1986), and Rizzuto et. al. (1982) also suggest that Winnicott's (1960) concept of the "false self" is important to the understanding of anorexia nervosa. In Winnicott's terms, the mothering which the anorexic has received is not "good enough". When the infant looks at the mother she sees not a reflection of her own self (as she would if the mother were able to be a mirroring selfobject). Instead she sees a reflection of the mother's internal state. Thus, an external perception takes the place of an awareness of the self in relationship with the mother. As a result of this process, the development of an internal sense of self is impeded. Instead the child must comply with the mother's needs, in a sense acting as a selfobject for the mother. This, according to Winnicott, is the beginning of the false self which serves the defensive function of protecting the true self. A number of authors, including Lerner (1983); Rizzuto, Peterson, and Reed (1982); and Stern (1986) have remarked on the frequency with which this compliant, depleted, and environmentally-dependent false self organization is found in patients with anorexia nervosa. Lerner (1983) describes this false

self as "lacking in vitality and affective relatedness, predisposed to anaclitic depression, exquisitely egocentric, and both distrustful of and painfully dependent on the environment...as the only source of gratification, aliveness, and survival" (p. 61).

Chessick (1984-85) also remarks on the presence of an empty depleted self in eating-disordered patients, but explains this lack of vitality as the result of a fixation by these patients on archaic, grandiose self-configurations, and/or on "overestimated, narcissistically-cathected objects" (p. 304). Chessick believes that, in these patients, symptoms such as severe restriction of food intake, bingeing, and vomiting serve to "drain off the rage and paranoia...and focus attention away from the empty depleted self and onto preoccupation with gastro-intestinal tract sensations. In this manner some...sense of being alive is maintained" (p. 306). Unlike Rizzuto, who maintains that eating-disordered patients have never experienced true selfobject relations, Chessick believes that the self deficits in these patients result from the disintegration of the union between the child and her parent-selfobject.

Although the body of theory related to selfobject relationships and eating disorders is sparse, there seems to be agreement in it that the etiology of eating disorders is related to early selfobject failures. There is disagreement as to whether these early parent-selfobjects are deficient in certain respects (such as in their ability to provide mirroring), or whether these parents fail so profoundly as selfobjects that their children are left virtually without the ability to form

selfobject matrices. It would seem likely that the ability to form selfobject matrices is spread across continua of maturity and quality rather than being either present or absent; however these issues remain for future theorists and researchers to explore.

Selfobject Experiences and Eating Disorders: Empirical Findings

There is virtually no empirical literature that investigates selfobject experiences in persons with eating disorders. There is, however, a small number of empirical studies which relate conceptually to the ability of persons with eating disorders to use relationships in performing self functions.

Using an object relations approach, Strauss and Ryan (1987) examined disturbances in autonomy in eating-disordered patients. These authors used the Mutuality of Autonomy Scale to analyze the Rorschach protocols of 33 restricting and bulimic anorexics, and found that, in comparison with a control group, both patient groups exhibited less differentiated self- and other-object representations, a more controlling style of self-regulation, and poorer intra-familial communication. These findings are consistent with the hypothesis that persons with eating disorders tend to have less mature selfobject relationships, and that they may also have more difficulty performing self-regulatory functions independent of selfobjects.

Becker, Bell, and Billington (1987) also investigated object relations ego deficits in bulimic women. Using the Bell Object Relations Inventory (BORT) they reported that bulimic women showed greater disturbances in object relations than did subjects

with non-bulimic eating patterns. Specifically, bulimics' scores on the Insecure Attachment and Egocentricity subscales of the BORT were higher than the scores of non-bulimics. This finding suggests that the bulimic group had greater fears of abondonment, were more suspicious, were more manipulative, and were less autonomous in their relationships than the control group. No differences were found between groups on the Alienation or Social Incompetence subscales of the BORT.

In a descriptive study which explored the relationship between level of ego development and bulimics' conceptualizations of their eating disorders, Teusch (1988) reported that, regardless of level of ego development, a large majority of bulimics identified interpersonal factors as being most important in the development of their eating disorders. She reported that "half the women spontaneously mentioned parental emotional absence, inexpressiveness, or dominance, sibling rivalry, general family stresses and....lack of interpersonal nurturance and connection resulting from dysfunctional parental behavior [as important factors in the development of their eating disorders]" (p. 613). In addition, bulimics commonly associated "difficulties of feeling calm when alone", feelings of emotional isolation, and the absence of close friendships with the development of bulimic behaviors. Teusch also noted that, in conceptualizing their eating disorders, bulimics expressed "a high occurrence of negative interpersonal experiences that were replete with empathic failures, rejections, and abuse....They

vividly described their desire for a totally nurturing relationship, and their inability to ask for nurturance and receive it interpersonally" (p. 613).

In a similar vein, Palmer, Oppenheimer, and Marshall (1988) used the Parental Bonding Instrument to compare eating-disordered subjects and controls in their recollections of their parents during their childhoods. No differences were found between groups on the Protection subscale which measures parental control, intrusion, and overprotection; however, eating-disordered subjects had significantly lower scores than controls on the Care subscale which measures perceived parental warmth, affection, and empathy. This finding is consistent with formulations of self psychology which suggest that eating-disordered patients have parents who were unable to be adequate mirroring selfobjects for their daughters.

Finally, Armstrong and Roth (1989) used Bowlby's attachment theory, and the Separation Anxiety Test to explore attachment and separation difficulties in hospitalized eating-disordered patients. As compared with adolescents and adults undergoing developmentally-based relationship crises, the eating-disordered patients "evidenced significantly more severe separation and attachment difficulties" (p. 149). Most significantly, the eating-disordered subjects were as distressed by "brief everyday leavetakings" as they were by more permanent relationship breaks. In self psychology terms, these findings seem to suggest that the eating-disordered subjects in this sample tended to have more archaic selfobject

relationships, were more dependent on their selfobjects for self-regulation, and had less self-cohesion than the control subjects.

Affect Regulation and Eating Disorders: Theoretical Considerations

In contrast with theorists such as Bruch, Rizzuto, Bauman, and Chessick, who focus on, and attempt to explain, the lack of vitality and the absence of self-entitlement in eating-disordered patients, Swift and Letven (1984) focus on the inability of these patients to regulate internal tension states. Swift and Letven's observations draw on Balint's concept of the "basic fault" (1968). According to Balint the basic fault is a flaw in the ego which develops in early childhood as the result of a mismatch between the needs of the child and the care given by the parent. The manifestations of this basic fault are seen only under conditions of severe stress, but nevertheless result in a poor sense of self and an impairment in the ability to regulate tension. Ornstein (1981) explains the process in the following way:

> The early compromises which an infant makes to assure the "fit" or "harmony" so as to maintain emotional contact with its selfobject environment and thereby maintain self-cohesion, represents the vulnerability of the nuclear self, or what Balint called "the basic fault". The vulnerability in the growing self may remain hidden during childhood and become manifest only in adult life when psychic functions which had not yet been adequately developed during childhood are called upon. (p. 449)

Based on Balint's work, Swift and Letven (1984) view eating disorders, particularly bulimia, as "a defensive reparative maneuvre

which attemps to alleviate intolerable internal tension and bridge the basic fault" (p. 489). Goodsitt (1977, 1983, 1985) expands on these ideas, viewing eating-disordered patients as being deficient in self-regulatory and self-organizing functions in a more general sense. He takes issue with Sugarman and Kurash (1982) who postulate that bulimic symptomatology occurs as the result of the bulimic's using her body as a transitional object, allowing her to experience merger with the symbiotically required mother.

Goodsitt (1983) proposes, rather, that eating-disordered patients reveal a deficit in transitional object relatedness, as well as deficits in self-organization and self-regulation. He understands many of the symptoms of eating disorders (e.g. starving, bingeing, vomiting, and excessive activity) as attempts to deal with overstimulation, and to prevent fragmentation. Goodsitt (1983) uses Tolpin's (1971) concept of the transitional object, an object which serves a tension-regulating function. He also draws on Gedo and Goldberg's (1973) description of the developmental stage at which a child is cognitively able to differentiate between self and object but continues to use the object as part of his or her narcissistic world. In his own writing, Goodsitt (1983) combines these ideas, defining a transitional object as "a cognitively perceived 'not me' which is experienced as part of oneself" (p. 52), a definition which, for practical purposes, bears some similarity to Kohut's definition of a selfobject. Like Tolpin (1971) Goodsitt suggests that transitional relatedness serves as a bridge between external regulation and

internal or self-regulation; and that transitional relatedness becomes redundant when the functions served by the transitional object are internalized to become part of the self structure.

Goodsitt (1983) is more specific than other authors in describing the relationship between the symptoms of eating disorders and the self functions they serve. He describes 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 also views other symptoms as attempts to regulate internal tension states and self-esteem. Compulsive activity, in his view, is a kind of self-stimulation which alleviates feelings of deadness, and allows the eating-disordered patient to experience herself intensely (1977). In addition, the "frantic busyness" of these compulsively active women substitutes for a coherently organized set of goals and values (Gedo, 1979, 1981), and gives the anorexic's or bulimic's life a sense of organization, direction, and meaning. These activities are "the outward manifestation of a disrupted and

overstimulated self-organization" (Goodsitt, 1983, p.55).

Goodsitt (1983) also suggests that the binge-vomit sequence serves an organizing function, as does self-starvation. The disturbing but vague feelings that often precipitate a binge are replaced by intensely-felt affects that can be 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 hold the promise of maintaining a fragile self-esteem and overcoming 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 poor 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 selfobject experiences which 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.

Affect-Regulation and Eating Disorders: Empirical Findings

The ability to regulate internal tension states and to modulate affects is, according to self psychology theory, an important function performed by a cohesive self. Masterson (1985) identified two manifestation of this self-regulatory function: (1) spontaneity and aliveness of affect, and (2) the capacity tc minimize and soothe painful affects.

In general, empirical research in eating disorders suggests that bulimia tends to be associated with poor impulse control (Beaumont, 1977; Casper, Eckert, Halmi, Goldberg, & Davis, 1980; Garfinkel, Moldofsky, & Garner, 1980; Garner Garfinkel,& O'Shaughnessy, 1985; Strober, 1980), and lability of affect, including considerable dysphoric affect (Casper et al., 1980; Garfinkel et al., 1980; Garner et al., 1985). The research is not entirely conclusive as regards differences in affect regulation among subtypes of eating disorders. Some studies suggest that there are no differences in this regard between restricting and bulimic anorexics (e.g., Ben-Tovim, Marilov, & Crisp, 1979), while others suggest that anorexics who use restriction as their only method of weight control exhibit more rigidity of impulse control and more restricted affective expression than other subtypes of eating-disordered patients (e.g., Casper et al., 1980; Strober, 1980, 1981, 1985). Nevertheless, it seems reasonable to conclude that both restricting anorexics and bulimics experience difficulties in regulating tension and affect in adaptive ways, and that these difficulties are expressed behaviorally in tendencies

toward over-control, under-control, or an alternating combination of the two. In this section the author will review the empirical literature that investigates the regulation of affect in eating-disordered patients, as well as the research that explores the relationship between deficits in affect-regulation and eating-disordered behaviors in these patients.

The Regulation of Depression in Eating Disorders

Several authors, among them Blitzer, Rollins and Blackwell (1961); Dally (1969); Halmi, Casper, Eckert, Goldberg, and Davis (1973); Katzman, and Wolchik (1984); and Russell (1979), have suggested that depression is a prominent feature in both anorexia and bulimia. Reports of its frequency range from 20% to 100% (Strober, & Katz, 1988).

Few studies report differences in the severity of depressive symptoms among subtypes of eating disorders, although this may be in part because most studies do not separate restricting and bulimic anorexics in their analyses. Most descriptive studies using standardized, objective measures of depression such as the Beck Depression Inventory (e.g., Hatsukami, Mitchell, & Eckert, 1984; Swift, Kalin, Wamboldt, Kaslow, & Ritholz, 1985), the MMPI (e.g., Norman, & Herzog, 1983; Pyle Mitchell, & Eckert, 1981; Strober, 1983), and the Hamilton Depression Rating Scale (e.g., Sabine, Yonace, Farrington, Barratt, & Wakeling, 1983; Swift et al., 1985) have found that both restricting anorexic and bulimic patients report mild to moderate symptoms of depression, which are nevertheless

significantly less severe than the depressive symptoms reported by patients with a primary diagnosis of depression.

Contrary to these general findings, however, Swift, Andrews, & Barklage (1986) found that bulimic patients were significantly more depressed than restricting anorexics; and Eckert, Goldberg, Halmi, Casper, and Davis (1982) reported that severity of depression in anorexic patients was associated with a number of coexisting complications of the illness such as bizarre eating habits, selectivity of food choices, and abnormal satiety experiences. The same authors reported that depression in anorexics decreased with weight gain and nutritional stabilization. Similarly, Casper et al. (1980) and Strober (1984) reported positive correlations between severity of depression and severity of eating symptomatology in bulimics. Swift et al. (1986) however, reported that whereas both bulimic and restricting anorexic patients became less depressed immediately following treatment and/or weight restoration, these same patients were significantly more depressed at long-term follow-up in spite of having maintained more normal eating patterns. These findings argue against the commonly held belief that depression in eating-disordered patients is the result of chaotic eating patterns, and tends to support the hypothesis that these patients possess a more enduring vulnerability to depression which may be exacerbated by their chaotic eating and the feelings and events that accompany it.

Clearly the relationship between depression and eating disorders is complex and multidetermined. Research, however,

strongly supports the almost universal clinical observation that persons with eating disorders do suffer from significant depressive symptoms. One could hypothesize that these depressive symptoms are manifestations of an enduring vulnerability to depression which reflects a general inability to adequately modulate dysphoric affects. At present there is little empirical evidence to support this notion; however studies of the relationship between anxiety and eating disorders lend further credence to this hypothesis.

The Regulation of Anxiety in Eating Disorders

Findings generally suggest that restricting anorexics, whether chronic (Smart, Beaumont, & George, 1976) or non-chronic (Strober, 1980, 1981), and bulimics (Casper et al., 1980; Dunn & Ondercin, 1981; Pyle et al., 1981) are all typically more anxious than control groups, regardless of whether the control groups are students or clinical patients.

In one of the rare studies comparing levels of anxiety among subtypes of eating-disordered patients, Grace, Jacobson, & Fullager (1985) found no differences in anxiety level between purging and non-purging bulimics. Casper et al. (1980), however, found that restricting anorexics were less anxious, and in general reported siginificantly less psychic distress, than bulimic anorexics.

As well as experiencing more anxiety than control groups, there is some evidence that eating-disordered patients are less able to tolerate feelings of anxiety and hence make a greater effort to avoid these feelings. Keck, and Fiebert (1986), for example,

compared anorexic and bulimic inpatients and outpatients with normal dieting women. Using the Avoidance of Existential Confrontation Scale, these authors found that both anorexics and bulimics were more inclined to avoid situations evoking "existential anxiety" (defined by the authors as the unwillingness to confront life issues such as death, fate, guilt, emptiness, meaninglessness, and isolation) than were the normal dieters. Furthermore, the extent of avoidance correlated positively with severity of the eating disorder. Existential anxiety may not be representative of anxiety in general, and one must therefore be cautious in generalizing these results. They do suggest, however, that eating-disordered patients have difficulty tolerating at least one type of anxiety.

Self-soothing in Eating Disorders

Weisberg, Norman, and Herzog (1987) shed some light on the reasons for the low anxiety tolerance of eating-disordered patients discussed in the previous section. These researchers compared depressed patients with bulimic patients and found that the two groups resembled each other in that both attempted to avoid emotional stimulation, both tended toward emotional lability, and both reported feelings of being emotionally "overloaded". In contrast with the depressed patients, however, the bulimics 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. Weisberg describes 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 dysphoria 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 research literature on eating disorders, although the experience is more often labelled "affective instability" or "low anxiety and frustration tolerance" (e.g., Johnson, & Maddi, 1986). The limited interoceptive awareness of these patients is also well documented (e.g., 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 (i.e., 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.(1985) found that restricting anorexics showed less disturbance in interoceptive awareness than either of two groups of bulimics; and Willmuth, Leitenberg, Rosen, & Cado (1988)

found that non-purging bulimics showed less disturbance in interoceptive awareness than purging bulimics.

Thus, empirical research tends to support clinicians' observations that eating-disordered patients have difficulty recognizing, tolerating, and regulating affects and inner tension states. There is also some research which 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, and thereby re establishing a sense of emotional equilibrium for the bulimic who engages in these behaviors.

The Relationship Between Affect and the Binge-purge Cycle

Attempts to measure affect prior to binge or binge-purge episodes strongly support the thesis that these episodes are often precipitated by negative emotions. Ondercin (1979), for instance, reported that in a sample of college students who were rated as low, medium, or high on a scale of compulsive binge eating, the high scorers, as compared with the other two groups, more often ate in response to unpleasant emotional states - particularly anxiety and depression. High scorers also more often reported that eating reduced tension and made them "feel better".

Casper et al. (1980) found that bulimic patients reported overeating to relieve distressing emotions such as anxiety, depression, and guilt. In addition, these patients reported that feelings of frustration, tension, emptiness and boredom induced

cravings for certain foods; and that the activities associated with eating these foods (e.g., biting, chewing, and swallowing) had an emotionally soothing effect on them. In a number of other similar studies (Abraham, & Beaumont, 1982; Johnson, & Larson, 1982; Loro, & Orleans, 1981) negative mood states were identified as precipitants of bingeing.

Johnson-Sabine, Wood, and Wakeling (1984) conducted a longitudinal study in which 50 bulimic patients completed three mood scales on a daily basis for several weeks. Results indicated that negative mood states were more extreme on days when bingeing and vomiting occurred. Because the mood scales were completed at the beginning of the day (i.e., before bingeing or vomiting had occurred), the findings suggest that the negative emotions were precipitants rather than consequences of the binge-purge episodes; however, as no mood scales were completed later in the day, it is impossible to know what effects the bingeing and purging had on these patients' emotional states, or how long these effects lasted.

In addition to the study by Casper et al. (1980) discussed above, a number of other studies have suggested that bingeing and/or purging soothe the dysphoric affects that seem to precipitate binges. In one of the very few studies that used a controlled environment to investigate the relationship between mood and eating behavior, Kaye, Gwirtsman, George, Weiss, and Jimerson (1986) used both subjective and objective ratings of mood to

investigate patterns of mood change as they related to binge-purge episodes. Before bingeing, bulimics in this study rated themselves as more anxious, more depressed, less hungry, and less confused than a control group of normal eaters. After completing one or more binge-purge cycles, 10 of the 12 bulimic subjects reported a reduction in depression and/or anxiety of at least 50%. Of the 12 bulimics, 8 reported a significant decrease in anxiety, whereas only 4 reported a significant decrease in depression. Although there was considerable variation among subjects, the authors concluded that binge-purge episodes provide many bulimic patients with a mechanism for relieving dysphoric mood. The same conclusion was drawn by Abraham and Beaumont (1982) who found that 66% of a sample of bulimic patients were significantly less anxious following binge episodes than they had been prior to the beginning of the binge.

In a retrospective study of mood changes during the binge-purge cycle, Cooper, Morrison, Bigman, Abramowitz, Levin, and Krener (1988) found that bulimics depicted the period of time between the binge and the purge as the most unpleasant phase in the cycle. At that point in the cycle patients reported feeling low levels of energy and security, and high levels of panic/helplessness, guilt/disgust, and anger. In contrast to this, feelings after purging were relatively calm and pleasurable, with low levels of panic/ helplessness and excitement/energy, and high levels of security/ relief. In addition, these authors found that eating-disordered

subjects with affective disorders did not differ from those without affective disorders in their mood changes during the binge-purge cycle.

Contrary to the results of investigations which suggest that the binge-purge cycle serves a tension-regulating function, is the finding of Johnson and Larson (1982). Although these investigators did not measure feelings of anxiety or depression per se, they reported a general worsening of patients' affective states during bingeing. Changes included increased feelings of guilt, shame, and anger. After completing the binge-purge cycle, Johnson and Larson's subjects reported that they felt sadder and weaker than usual, but alert and completely without anger.

The research reported in this section suggests that the binge-purge cycle serves a self-soothing function for many bulimics. As Weisberg et al. (1987) concluded from their investigation of Rorschach protocols of bulimic women:

> The bulimic feels overwhelmed and lacks sufficient organized internal resources to cope with the amount of distress she is experiencing. Her capacity to modulate her affects is limited. Affects are experienced as threatening and to be avoided [The] self-organization of many bulimics appears fragile and precarious, easily disrupted by affect or external stimulation... These results provide some support to the hypothesis that, at least for some, bulimic symptomatology may be related to a desperate attempt to restore and preserve a sense of self (p. 628).

Further investigation is needed, however, to clarify the nature of the the self-regulatory functions served by the symptoms of eating disorders, and to relate these processes to the chronicity and severity of symptoms, as well as to other aspects of the personality functioning and self-organization of eating-disordered patients.

Research Rationale and Hypotheses

The author proposes that eating disorders develop, in part at least, in response to deficits in self-regulatory functions, and that the symptoms of eating disorders represent attempts to prevent fragmentation or to re-establish self-cohesion. Further, the deficits in self-regulatory functions most relevant in the development of eating disorders are difficulties in regulating self-esteem and tension states, and difficulties in establishing and maintaining adequate object and selfobject relationships and experiences.

The purpose of this research study is to examine, within the framework of psychoanalytic self psychology, certain aspects of the personality functioning of bulimic patients as it relates to their symptomatology. More specifically, the author has attempted to identify deficits in the self-regulatory functions, and in the object- and selfobject relationships/experiences of persons with bulimia; and has attempted to relate these deficits to one another, and to the symptoms of bulimia nervosa.

The goals in conducting this investigation were first, to test some of the postulates of psychoanalytic self psychology using empirical methods; second, to demonstrate a relationship between

personality functioning and symptomatology in persons with eating disorders; and third, to test the validity of three self-report measures, namely the Soothing Receptivity Scale (Glassman, 1988), the Selfobject Needs Scale (Vipond, 1988), and the Symptoms of Fragmentation Scale (Vipond, 1988).

The specific hypotheses tested in this study are as follows:

Hypothesis 1

Bulimic subjects will exhibit more severe deficits in their ability to regulate self-esteem and affective states than the normal control subjects. Depressed subjects will exhibit self-regulatory deficits which are similar in severity to the deficits of the eating-disordered subjects, while the overweight dieters will exhibit self-regulatory deficits which are similar in severity to those of the normal control group.

The hypothesized similarity in the self-regulatory functions of bulimic and depressed subjects is based on self psychology theory which postulates a relationship between both depression and disordered eating, and lack of self-cohesion, including difficulties in self-regulation (e.g., Kahn, 1989; Kohut, 1977; Wolfe, 1989). The hypothesized similarity in self regulatory functions between overweight dieters and the normal control subjects is based on the assumption that being overweight is not per se indicative of psychopathology. This assumption finds some support in the empirical literature (e.g., Dykens & Gerrard, 1986; Reynolds, 1982), although, there is some evidence that persons who are morbidly

obese (i.e., more than 100 pounds above normal weight) may exhibit significant psychopathology similar to that found in persons with eating disorders (e.g., Prather & Williamson, 1988; Scott & Baroffio, 1986). For this reason, morbidly obese subjects were excluded from this study.

Hypothesis 2

Bulimic subjects will exhibit levels of object relations and selfobject experiences that are more primitive than those of the normal and overweight dieting subjects. Subjects in the depressed group will exhibit levels of object relations and selfobject experiences which are more primitive than those of the normal and overweight dieting group, but less primitive than those of the bulimic group.

The prediction that the depressed group will exhibit a level of object and selfobject relatedness intermediate between the bulimic group and the other two groups, is based on the frequently-reported relationship between bulimia and borderline personality organization (e.g., Garfinkel & Garner, 1982; Johnson, Stuckey, Lewis, & Schwartz, 1982; Swift & Stern, 1982), a level of personality organization which is more primitive than that usually associated with depression (e.g., Engelman, 1985).

Hypothesis 3

In all subject groups, more severe self-regulatory deficits will be associated with more primitive object relations and selfobject experiences.

Hypothesis 4

In the bulimic subjects, more severe eating disorder symptoms will be associated with more severe self-regulatory deficits and more primitive object and selfobject experiences.

Hypothesis 5

Weight loss, as imagined by subjects in the bulimic group, will be associated with an increase in self-esteem, and with decreases in dysphoric affects and symptoms of fragmentation. Conversely, imagined weight gain in this group will be associated with decreased self-esteem, and increases in dysphoric affects. These relationships between weight and self-regulatory functions will be significantly weaker in the three control groups, with the weakest relationships being found in the normal subjects and the depressed subjects.

# CHAPTER II

# METHOD AND PROCEDURES

## Subjects

### The Total Sample

The sample used in this study included 120 women between the ages of 18 and 35. The mean age of the women was 25.5 years (SD = 5.6). They reported an average of 14.0 years of education (SD = 1.9 ). All subjects resided in Ontario at the time of their participation in the study. Sixty-five lived in the Toronto area, 44 in Windsor, 4 in London, 4 in Sault Ste. Marie, and 3 in Sudbury.

Subjects were recruited in a variety of ways: Thirty-nine of the women were undergraduate students at the University of Windsor; 28 were recruited through advertisements in a Toronto newapaper; 21 through outpatient hospital and community agency programs; 14 through therapists in private practice; 11 through organized weight-control programs; and 7 were inpatients in 2 Toronto hospitals and were being treated for bulimia or depression. In addition to the 120 women in the sample, 25 women completed questionnaires which were excluded from the sample for various reasons, as explained below. The sample comprised four groups: a bulimic group, a depressed group, a group of overweight dieters, and a normal control group. The groups are described below.

The Bulimic Group

The DSM III-R (American Psychiatric Association [APA], 1987) criteria for bulimia nervosa were used as a basis for determining eligibility for inclusion in the bulimic group. These criteria are as follows:

A. Recurrent episodes of binge eating (rapid consumption of a large amount of food in a discrete period of time).

B. A feeling of lack of control over eating behavior during the eating binges.

C. The person engages in either self-induced vomiting, use of laxatives or diuretics, strict dieting or fasting, or vigorous exercise in order to prevent weight gain.

D. A minimum average of two binge eating episodes a week for at least three months.

E. Persistent overconcern with body shape and weight.

To be included in the bulimic group, subjects had to meet DSM-III-R criteria for bulimia except that average binge frequency over the last three months could be as low as once a week (as compared with the DSM criterion of twice a week). This exception was made to ensure that the obtained sample reflected as wide a range of symptom severity as possible. In addition, subjects in this group were required to use self-induced vomiting as a method of counteracting their bingeing and controlling their weight. The other inclusion criterion was that subjects had to be receiving treatment for bulimia at the time of their participation in the study. Weight

was not used as an inclusion criterion. The bulimic sample (n = 30) includes women who meet the weight criterion for anorexia (i.e., they are 15% or more below the expected weight for their age and height), as well as women who are of average or greater than average weight for their age and height. Eligibility for inclusion in the bulimic group was determined by subjects' responses to items taken from the Eating Disorders Examination, as well as by their responses to questions regarding their age and their involvement in treatment for bulimia.

Subjects were recruited from therapy groups for eating-disordered clients, from therapists who specialized in providing individual therapy to women with eating disorders, and from hospital-based inpatient and day-treatment programs for eating disorders in various cities in Ontario. Nine subjects were attending hospital-based day-treatment programs, 8 were members of therapy groups for women with eating disorders, 8 were in individual therapy for their eating disorders, and 5 were inpatients who were attending a hospital-based eating disorders program.

Women in this group ranged in age from 18 to 35 years ($M$ = 25.1, $SD$ = 5.8). The number of years of education for the group ranged from 10 to 17 years ($M$ = 13.7, $SD$ = 2.25).

In addition to the 30 women who were included in this group, 3 women who completed questionnaires were excluded. One did not use self-induced vomiting as a method of controlling her weight; one

had only sub-clinical symptoms of bulimia; and one returned her questionnaire too late to be included in the sample.

The Depressed Group

The DSM-III-R criteria for major depression were used as a basis for selecting subjects for the depressed group. These criteria are as follows:

A. At least five of the following symptoms have been present during the same two-week period and represent a change from previous functioning; at least one of the symptoms is either (1) depressed mood, or (2) loss of interest or pleasure.

1. depressed mood...most of the day, nearly every day, as indicated by either subjective account or observation by others;
2. markedly diminished interest or pleasure in all, or almost all, activities most of the day, nearly every day...;
3. significant weight loss or weight gain when not dieting (e.g. more than 5% of body weight in a month) or decrease or increase in appetite nearly every day...;
4. insomnia or hypersomnia nearly every day;
5. psychomotor agitation or retardation nearly every day (observable by others..);
6. fatigue or loss of energy nearly every day;
7. feelings of worthlessness or excessive or inappropriate guilt...nearly every day...;

8. diminished ability to think or concentrate, or indecisiveness, nearly every day...;
9. recurrent thoughts of death (not just fear of dying) recurrent suicidal ideation without a specific plan, or a suicide attempt, or a specific plan for committing suicide.

Subjects were required to be have been depressed for at least two weeks at the time of their participation in the study; however the DSM-III-R criterion that the current depressive episode represent a change from previous functioning was not used in this study. There were, in fact, a number of women who reported that they had been chronically depressed for a number of years. The women's self-report of their symptoms was used as the sole source for determining their level of depression. As well as meeting age and depression criteria, the subjects included in the depressed group were required to be receiving treatment for depression at the time of their participation in the study.

In addition, women in this group had to report that they had not been dieting to lose weight, or trying to gain weight, for at least a month prior to taking part in the study; and their weight had to be between 15% below, and 40% above what would be expected for their age and height according to actuarial statistics (see Appendix A). An attempt was made to find women who were within 15% of chart weight in either direction, or had a BMI between 20 and 25; however this was extremely difficult. As a result, the weight

criterion was relaxed partway through the study, and 6 women who were between 16% and 40% above expected weight were included.

The final criterion for inclusion in this group was the absence of significant bulimic symptoms. Bingeing could not occur with feelings of loss of control, and neither diuretics, nor laxatives, nor self-induced vomiting could be used as methods of weight control, or to counteract the effects of bingeing. Subjects' eligibility was determined by their responses to the Major Depression Inventory (MDI); a personal or telephone interview in which they were asked about their depression, their treatment for depression, their weight, and their eating behaviour over the month prior to contact; and their responses to questionnaire items.

Three of the subjects in this group were students at the University of Windsor. The remainder were recruited in the Toronto area. Fourteen were women who responded to a newspaper advertisement; 6 were recruited through therapists in private practice; 5 were being treated as outpatients at the Lakeshore Outpatient Clinic; and 2 were inpatients being treated for depression at Queen Street Mental Health Centre. The average age of the women in the depressed group was 26.7 years (SD = 4.76), and their average education in years was 13.8 (SD = 1.97).

In spite of a rather rigorous screening procedure, 8 women who returned completed questionnaires had to be excluded from the study. Four of these women were being treated for depression but did not meet the criteria for current depression on the MDI. The

other 4 women reported dieting behaviour in the last month that was significant enough to require exclusion from the study; in other words, they met some of the criteria for inclusion in two groups, and therefore could not be included in either group.)

The Overweight Dieting Group

Inclusion criteria for the overweight dieting group were as follows:

A. 15% - 50% above expected weight as determined by actuarial statistics (See Appendix A).

B. Dieting to lose weight "every day" or "almost every day" for at least one month at the time of participation.

C Use of at least one of the following methods of weight control "every day" or "almost every day" for at least one month at the time of participation: daily calorie limits, elimination or reduction of certain types of foods, use of other dietary rules, portion control, rules about time or frequency of food intake.

D. A weight at the time of participation which was at least 4 pounds less than their average weight over the last 3 months.

In addition to meeting the above "overweight" and "dieting" criteria, subjects in this group were excluded if they met criteria for depression as determined by their responses to the MDI; if they were being treated for depression; if they binged with feelings of loss of

control; or if they used laxatives, diuretics, or self-induced vomiting to control their weight.

Subjects' eligibility was determined by their responses to the MDI; a personal or telephone interview in which they were asked about their mood, their involvement in psychotherapy, their weight and their eating behaviours over the month prior to contact; and their responses to questionnaire items.

Six subjects in this group were University of Windsor students. The remainder were recruited from the Toronto area. Of these, 13 responded to an advertisement for research subjects in a Toronto newspaper, 7 were recruited through a weight management program offered by The Toronto Hospital, and 4 were attending a Weight Watchers program.

Subjects in this group had a mean age of 27.8 years (SD = 6.2), and an average of 14.7 years of education (SD = 1.72). Although an attempt was made to match the four groups on the variable of age, this proved extremely difficult in the case of the overweight dieting group, mainly because the younger dieters (of whom there were many) did not meet the weight criterion. That is, although many younger women were dieting to lose weight, they were within 15% of expected weight for their age and height as defined by actuarial statistics.

In addition to the 30 subjects in this group, 2 women completed questionnaires which were excluded because the respondents were more than 50% above expected weight. Also, as

noted in the discussion of the depressed group, 4 women met some criteria for both the depressed and the overweight dieting groups, and their questionnaires were therefore excluded from the study.

The Normal Control Group

To meet criteria for inclusion in the normal control group, subjects had to meet none of the criteria for inclusion in the other three groups. That is, they were required to be:

A. Not bulimic.

B. Not depressed.

C. Within 15% (above or below) of expected weight for their age and height.

D. Not dieting to lose weight.

E. Not trying to gain weight.

In addition, subjects in this group could not be receiving therapy for emotional problems. It should be noted that, although subjects in this group did not meet criteria for inclusion in any of the other groups, some subjects in this group did report some "sub-clinical" symptoms or "sub-criterion" behaviours, related to depression or eating behaviours, which are relevant to the study. For example, a number of subjects in the group reported some "dieting" over the month prior to participation in the study. In order to be included in the normal control group, the dieting had to be infrequent (less than 3 days out of 7), and subjects had to report no weight loss over the last month.

Similarly, two subjects in this group reported binging less often than once a week. However, they reported no feelings of loss of control, and no purging, and were therefore included in the normal control group. No attempt was made to eliminate subjects from this group on the basis of weight or shape preoccupation alone.

As regards symptoms of depression, subjects in this group were eliminated only if they met both of the MDI criteria for depression (i.e. depressed mood or lack of interest, and four additional symptoms). There are in this group, therefore, 7 subjects who might be classified as having "sub-clinical depression". Subjects were included in this group on the basis of their responses to questionnaire items asking about their age, height and weight, mood (MDI), and eating behaviours (EDE).

All 30 subjects in this group were women undergraduate students at the University of Windsor during 1990. They had a mean age of 22.2 years (SD = 4.0), and an average of 13.8 years of education (SD = 1.3).

Because the students were not pre-screened, a larger proportion of them did not meet the inclusion criteria for any of the four groups, and their completed questionnaires had to be excluded. In total, 12 of the student questionnaires were eliminated from the study. All students who met criteria for inclusion in any one of the other three groups were included in the appropriate groups. Of the 12 individuals who were excluded, 5 met criteria for depression but were not receiving treatment for depression, one was in therapy for

depression but did not meet criteria for depression, 3 were dieting but were less than 15% overweight, one was not dieting but was more than 50% overweight, one was trying to gain weight, and one questionnaire was incomplete.

## Materials

### Measure of Symptoms of Eating Disorders

The Eating Disorders Examination (EDE) is a standardized structured interview developed by Cooper and Fairburn (1987). The instrument is suitable for use with both clinical and community samples, and is designed to assess the specific symptomatology of anorexia nervosa and bulimia nervosa. It is capable of identifying respondents who meet DSM-III-R diagnostic criteria for both disorders, and in addition generates five subscales, namely: Overeating, Restraint, Eating concern, Shape concern, and Weight concern.

Cooper and Fairburn (1987) claim that the EDE is superior to self-report instruments such as the Eating Attitudes Test (Garner & Garfinkel, 1979) and the Eating Disorders Inventory (Garner, Olmsted, & Polivy, 1983) in assessing the psychopathology of eating disorders inasmuch as it is more sensitive in eliciting the rigidity and significance of concerns about weight and shape than other instruments. In a study conducted by Wilson and Smith (1989) this claim was supported by data which showed that four of the five subscales on the EDE (Overeating, Eating concern, Shape concern, and Weight concern) successfully discriminated between a group of

bulimics and a group of non-bulimic restrained eaters. The instrument also discriminated groups of anorexic and bulimic subjects from a group of female controls without eating disorders (Cooper, Cooper, & Fairburn, 1989).

In the same investigation, Cooper, Cooper, and Fairburn (1989) reported adequate internal reliabilities for the five EDE subscales. Alpha coefficients ranged from .67 to .90. With two exceptions, items correlated more highly with their own total subscale scores than with other total subscale scores. The two exceptions were the items on the Weight concern subscale which, on average, correlated more highly with the Shape concern subscale total than with its own subscale total; and the items on the Shape concern subscale which correlated more highly with the Weight concern subscale total score than with its own subscale total. The authors believe that this anomaly reflects the close association between weight and shape concerns, as well as "the fact that the most objective and accessible way of assessing body shape for individuals is by means of body weight" (Cooper, Cooper, & Fairburn, 1989, p. 811).

Relevant items taken from the EDE were chosen for use in this investigation for two reasons: First, the items made it possible to identify subjects who met DSM-III-R diagnostic criteria for anorexia nervosa and bulimia nervosa. Secondly, the EDE items were chosen for their sensitivity in identifying the concerns about weight and shape which are central to this investigation.

For purposes of this study, selected items from the EDE were used, in questionnaire format, to identify subjects who met criteria for inclusion in the the group of eating-disordered subjects, as well as to determine the severity of symptoms in these subjects. It was also used to exclude eating-disordered subjects from the three other groups of subjects.

Although the EDE is intended to be administered in its entirety, and in interview format, it was not feasible to do so in this study due to the time required, and the distance from which subjects were recruited. Because the instrument was not used as intended, and because it was being used only to identify DSM-III-R diagnostic criteria for bulimia, no EDE scores or subscale scores were calculated.

Measure of Depression

The Major Depression Inventory (MDI) is a 20-item, true/false questionnaire developed by Wetzel. It is based on the Feighner Criteria, and has been adapted to allow for identification of persons who meet DSM-III-R criteria for major depressive episode.

Feighner, Robins, Guze, Woodruff, Winokur, and Munoz (1972) reported that "validating evidence for [their] diagnostic categories.... consists of studies of both outpatients and inpatients, of family studies, and of follow-up studies". The authors, however, did not cite references for these investigations. In spite of the lack of clear evidence for the validity or reliability of this instrument, it was chosen for use in this investigation because of its brevity, ease of

administration, and ability to identify persons meeting DSM-III-R criteria for current major depressive episode.

This measure was used to determine eligibility for inclusion in the group of depressed subjects, as well as exclusion from the normal control and overweight dieting groups.

Measures of Self-Regulatory Functions

The Soothing Receptivity Scale (SRS) is a 20-item self-report inventory developed by Glassman (1988). Twenty statements are rated on a 5-point Likert-type scale to obtain a score which reflects the ability to modulate negative affective states either independently or with the help of another person. The scale has acceptable alpha coefficient of .81. A factor analysis yielded four factors which accounted for 50% of the variance. These were: Physical soothing, Resiliency, Disclosure, and Self-soothing. Construct validity was demonstrated by a positive correlation of .50 with scores on the Index of Self-Esteem, and a negative correlation of -.56 with the Perceived Stress Scale. Discriminant validity was demonstrated by significant differences in scores between a sample of students and a sample of psychiatric clinic patients, with the clinical group scoring significantly lower on the scale than the students.

This recently-developed instrument has not been used extensively in research, and it is one of the objectives of the present study to generate additional data regarding its validity. In this study it was used as one of the trait measures of self-regulatory deficits.

The Symptoms of Fragmentation Scale (SF) is a 30-item self-report inventory developed by Vipond (1988) to measure vulnerability to fragmentation as conceptualized by Kohut. Respondents rate 30 brief statements on a 6-point Likert-type scale and response values are added to obtain a total score. Depending on the instructions given in its administration, this inventory can be used as either a "state" or a "trait" measure of vulnerability to fragmentation.

The SF Scale demonstrated good internal consistency, with a standardized alpha coefficient of .93. Construct validity of the instrument was demonstrated by negative correlations with the Rosenberg Self-Esteem Scale which, in a number of different conditions, ranged from -.36 in a sample of students to -.86 in a sample of psychiatric patients. Because this scale has not been used in research beyond that involved in its development, it is one of the objectives of the present study to further test its validity. In this study, the SF Scale was used to measure vulnerability to fragmentation as a trait (and by logical extension the general ability to regulate affect and self-esteem, as well as the ability to maintain self cohesion). It was also used to measure changes in vulnerability to fragmentation under the two imagined conditions (weight gain and weight loss).

The State-Trait Anxiety Inventory (STAI) is a 40-item self-report inventory developed by Spielberger (1977). It is comprised of brief statements which respondents rate on a 4-point scale

according to the frequency with which they experience the feelings specified (on the trait scale), or the intensity with which they presently experience specified feelings (on the state scale). Scores for each item are totalled to obtain either state or trait anxiety scores.

The internal consistency of the trait anxiety scale (STAIT) as indexed by coefficient alpha has been found to range from .89-.91 across male and female samples of students, working adults, and military recruits. For the state anxiety scale (STAIS) alphas are similarly high, ranging from .86 to .95. For the STAIT, test-retest reliabilities over periods of one hour to 104 days ranged from .65 to .86, with the coefficients decreasing as time between test and retest increased. For the STAIS, test-retest reliability ranged from .16 to .62. Construct validity of the STAIT is demonstrated in its positive correlations with the Taylor Manifest Anxiety Scale ($r$=.80), and the IPAT Anxiety Scale ($r$=.75). The STAIT has also demonstrated the ability to successfully discriminate between normal adults and various clinical groups (including schizophrenics and persons with anxiety reactions) who scored higher on the STAIT than did the non-clinical groups. Conversely, Spielberger noted that a group of individuals with character disorders in which the absence of anxiety was a diagnostic feature scored lower on the STAIT than did a group of normal adults.

Chaplin (1984) cites convincing evidence for the validity of the STAIS. The instrument discriminates between military recruits

beginning a stressful training program and high school students. In addition, students administered the STAIS under four different conditions (one neutral condition, two stressful conditions, and one relaxed condition) obtained significantly higher scores in the stressful conditions than in the relaxed condition.

In the present study the STAIT was used as one indicator of the general ability to regulate painful affect, and the STAIS was used to measure changes in affect, (and hence self-regulatory deficits, and the self-regulatory function of weight) under the two imagined conditions (weight gain and weight loss).

The Differential Personality Inventory Depression Scale (DPI-D) is one of the fifteen 20-item scales comprising the Differential Personality Inventory (DPI). Twelve of the DPI scales were designed to assess various dimensions of psychopathology, and three were developed as validity scales. For purposes of this study only the Depression scale was used.

The Depression scale of the DPI (DPID) has demonstrated good internal reliability, with an alpha coefficient of .86 in a sample of alcoholics, and an alpha of .87 in a sample on students. Convergent validity was demonstrated in a study of 370 college subjects in which roommate ratings and self-ratings were compared with DPI scores. DPID scores correlated positively with both roommate ratings ($r$=.27) and self-ratings ($r$=.34) of depression. In addition, results of a multi-method factor analysis revealed "a clear organization of 11 trait specific factors on the DPI with high loadings for the relevant

trait measured by each of the three methods" (Jackson & Carlson, 1973). Rotated factor loadings for the DPID, the roommate rating of depression, and the self-rating of depression were .76, .74, and .50 respectively.

These results suggest that it is justifiable to use this scale in a normal population to identify levels of depression that are less severe than those typically encountered in clinical populations. It is for this reason, and because the DPID identifies psychological aspects of depression without including items related to the vegetative symptoms of depression (especially appetite disturbances) that this measure is particularly appropriate for use in the present study. It was used as one of the trait measures which attempt to identify self-regulatory deficits, in this instance the inablity to modulate dysphoric affects.

The Eight State Questionnaire (SQ) is a 96-item self-report inventory using a 4-point Likert-type scale to allow respondents to report on eight emotional states (viz. anxiety, stress, depression, regression, fatigue, guilt, extraversion, and arousal). The instrument was developed at the Institute for Personality and Ability Testing (IPAT) under the direction of Cattell (1975) and is designed to be used in measuring changes in emotional states over time or under different conditions. For purposes of the present investigation, only the 12-item Depression scale (SQD) was used.

Although most of the reliability and validity data on this instrument reports on the inventory as a whole, some limited data is

available for the Depression scale. For the two Forms of the test combined, the immediate test-retest reliability coefficient for a group of male and female undergraduate students was .96. As would be expected on a state measure, reliability coefficients after a one-week interval were considerably lower. They ranged from a high of .48 for a sample using Form A to a low of .22 for a sample using Form B.

The construct validity reported in the manual was defined as "the correlation of the scale score with the pure factor constituting the construct [e.g. depression] the scale was intended to measure" (1975, p.15). These construct validities, then, are derived from factor-analytic research and, according to the manual, "constitute the real proof that the scales are measuring underlying factorial dimensions" (ibid). Using this method of construct validation, the correlations between the SQD and its its underlying factor are reported to range from .58 (Form A) to .90 (Form B). There do not appear to be any studies of discriminant or convergent validity using the Depression scale.

In spite of its limitations, the SQD scale does appear to measure psychological aspects of depression, and is one of very few state measures which purports to do so. As such, it appeared to be the most appropriate state measure of depression for the present investigation. It was used to measure changes in depressive feelings under the two imagined conditions (weight gain and weight loss), and hence to determine subjects' ability to regulate dysphoric affect.

The Rosenberg Self-Esteem Scale (RSE) is a 10-item self-report measure of global self-esteem developed by Rosenberg (1965). Rosenberg (1979) reported that the RSE had a coefficient of reproducibility of .92, and a coefficient of scalability of .72, suggesting that the scale items have satisfactory internal reliability. Silber and Tippett (1965) reported a two-week test-retest reliability of .85. Reporting on the construct validity of the RSE, Rosenberg (1979) reported that scores on the RSE correlated positively with peer group reputaion (no r reported), and negatively with depressive affect ($r$ =-.30) and anxiety ($r$ =-.48). Convergent validity was tested by Silber and Tippett (1965). These authors found that scores on the RSE correlated .67 with the Kelley Repertory Test (a self-ideal discrepancy test), .83 with the Health Self-Image Questionnaire (20 items dealing with self- and social-ideal discrepancy), and .56 with psychiatrists' ratings of self-esteem.

In this study, Rosenberg's recommendations to construct contrived items and to use Guttman's scaling procedure was ignored. Instead a 6-point Likert-type scale was used, and response values for each item were added to obtain a self-esteem score. The RSE was used as both a trait measure (RSET) in determining subjects general ability to regulate self-esteem, and as a state measure (RSEG and RSEL) in determing the effects of weight on the ability to regulate self-esteem. This measure of self-esteem was chosen for this investigation first because it is brief and easily administered, and secondly because it appears to measure those global aspects of self-

esteem which are most relevant to the development of a cohesive self as outlined by Kohut.

Measures of Selfobject and Object Relatedness

The Selfobject Needs Scale (SON) is a 30-item self-report inventory developed by Vipond (1988) to measure selfobject needs - particularly mirroring and idealizing needs - as they were conceptualized by Kohut. Statements are responded to on a 6-point Likert-type scale, and response values for each item are added to yield a single score.

The scale demonstrated acceptable internal reliability, with an alpha coefficient of .80 and a standardized item alpha of .79. No data on the test-retest reliability are available. The scale expressed four factors (need for recognition, need for acceptance, need for ideals, and feelings of alienation) but the factor structure did not support a division of selfobject needs into mirroring and idealizing needs as conceptualized by Kohut.

Construct validity was demonstrated by moderate negative correlations between SON scores and self-esteem in a group of 100 students ($r$ =-.41) and a group of 59 psychiatric patients ($r$ =-.43); and by significant positive correlations between SON scores and vulnerability to fragmentation as measured by the SF scale. These correlations, calculated under different conditions, ranged from .25 for a sample of psychiatric patients to .58 for a sample of students.

Because this scale has not been used in research beyond that involved in its development, it is one of the objectives of the present

study to further test its validity. In this study, the SON Scale was used to measure the nature of selfobject experiences, and to relate these to self-regulatory deficits and severity of symptoms in eating-disordered subjects.

The Bell Object Relations Test (BORT) is comprised of 45 of the 90 items making up the Bell Object Relations and Reality Testing Inventory (Bell, 1983). The BORT is a true/false self-report measure of four aspects of the capacity for relatedness, specific patterns of relating, and specific types of object relations deficits, namely, alienation, insecure attachment, egocentricity, and social incompetence.

Bell and Billington (1986) described the relational features associated with high scores in each of the four aspects of relatedness as follows: The Alienation (ALI) items are suggestive of a basic lack of trust in relationships, an inability to attain closeness with others, and feelings of hopelessness about being able to maintain a stable and satisfying level of intimacy. "High scorers may feel suspicious, guarded, and isolated....Empathy is limited, and the motivations and inner states of others are misjudged or ignored" (p.738).

The Insecure Attachment (IA) items tap themes related to sensitivity to rejection, excessive concern about being accepted and liked by others, and the search for security through relatedness. Fears of object loss among high scorers "leads to oversensitivity to signs of abandonment and interferes with attaining mutuality and autonomy in relationships" (p. 738).

High scorers on the Egocentricity (EGC) items are likely to mistrust others' motives and to manipulate others to achieve their own self-centered ends. They are likely to be exploitive, intrusive, and demanding of others, and may themselves alternate between feelings of grandiosity and powerlessness.

Social Incompetence (SI) items are suggestive of feelings of shyness and uncertainty, especially in interactions with members of the opposite sex. They also tap feelings of social insecurity, difficulty in making friends, and unsatisfactory sexual adjustment.

Taken together, the total BORT score indicates the level of object relatedness at which the respondent typically functions. For purposes of this study, only the total BORT scores were used.

All four subscales of the BORT have demonstrated good internal consistency, with alpha coefficients that range from .78 to .90. Split-half reliabilities also range from .78 to .90 (Bell, Billington, & Becker, 1986).

That BORT scores reflect pervasive, longstanding personality patterns rather than acute psychiatric distress is suggested by its low correlations with the Brief Psychiatric Rating Scale (.19) and the Global Assessment Scale (-.17) (Bell, Billington, & Becker, 1986). In the same validation study, moderate correlations of between .27 and .38 were found between a measure of depressed mood and each of the four subscales; however, the BORT also demonstrated the ability to successfull discriminate patients with affective disorders from

those with borderline and other personality disorders, suggesting that high scores are not a function of depression alone.

Additional construct validity of the instrument was demonstrated by Miropol (1982) who found negative correlations between pathological BORT scores and MMPI social extroversion and family attachment factors. In addition, Becker, Bell, and Billington (1987) demonstrated a strong linear relationship between severity of bulimic symptomatology and degree of pathology on the BORT. In this study, the BORT was used to measure and compare the general level of object relations in subjects in the four groups.

## Procedures

### Recruitment Procedures

Subjects for this study were recruited using four different methods. First, subjects were recruited from among undergraduate students. Second, relevant hospitals, community agencies, and private practitioners were contacted. Third, two separate advertisements were placed in a Toronto newspaper. Fourth, several weight control groups were contacted, and permission was requested to recruit subjects from among each group's membership. The procedures followed differed somewhat depending on the method of recruitment, and will be discussed separately below. A breakdown of subjects by group and recruitment source is presented in Table 1.

#### Recruitment of Students

Subjects for the Normal Control group were recruited from four

Table 1

Recruitment Source of Subjects by Group

| Recruitment Source | Group | | | | |
|---|---|---|---|---|---|
| | Bulimic | Depressed | Dieting | Normal Control | Total |
| U. of W. Student | 0 | 3 | 6 | 30 | 39 |
| Newspaper Advertisement | 1 | 14 | 13 | 0 | 28 |
| Outpatient Program | 16 | 5 | 0 | 0 | 21 |
| Therapist in Private Practice | 8 | 6 | 0 | 0 | 14 |
| Weight Control Priogram | 0 | 0 | 11 | 0 | 11 |
| Inpatient Program | 5 | 2 | 0 | 0 | 7 |
| Total | 30 | 30 | 30 | 30 | 120 |

undergraduate Psychology courses at the University of Windsor. The investigator visited each of the classes to explain the purpose of the study, to outline the eligibility requirements and procedures to be followed, to answer any questions, and to distribute questionnaire packages to the participants. Questionnaires were either returned directly to the investigator by mail, or were collected by the instructor. The questionnaire return rate for subjects recruited in this manner was 95.0%.

Recruitment from Hospitals, Agencies, and Private Practitioners

The investigator sent "Letters of Introduction" (see Appendix B), which described the research project, requested subjects for the study, and outlined the inclusion criteria, to 10 Ontario hospitals, 2 Ontario universities, 2 community agencies, and 5 private practitioners in the Toronto area. These were followed up by phone calls in which the investigator discussed the research in more detail and requested the assistance of relevant professionals in recruiting subjects. In total, 8 hospitals, one university, both community agencies, and 3 private practitioners agreed to make attempts to recruit subjects for the study. Because of administrative delays in 3 of the hospitals, these institutions did not participate in subject recruitment.

After the individual, agency, or hospital had agreed to participate, the writer sent the required number of questionnaire packages to the contact person who in turn distributed the packages to individuals who agreed to participate. The true rate of return for

subjects recruited in this manner could not be calculated, as the investigator does not know how many of the questionnaires sent to contact persons were actually distributed to potential subjects. In total, 65 questionnaires were mailed to contact persons, and 33 were returned, yielding a return rate of 50.8%

Recruitment by Newspaper Advertisement

Subjects responded to one of two newspaper advertisements for research subjects (one requesting women being treated for depression; the other requesting women who were overweight and dieting to lose weight). (See Appendix C for copies of the advertisements.) Women responded by phoning the investigator, and indicating their interest in participating in the study. The investigator then explained the nature and purpose of the research, including information consistent with that contained in the introductory letter sent to subjects who were contacted by mail. She also answered any additional questions the women had about the study. A screening interview was then conducted to determine each subject's eligibility for inclusion in the study. A general outline of the screening interview can be found in Appendix D; however, the interviews were often much more extensive than the interview format suggests, as every attempt was made to recruit only those women who met all the inclusion and exclusion criteria for each group.

The investigator then mailed a questionnaire package to each eligible woman who still wished to participate, giving her a cut-off

date by which the questionnaire had to be returned for her to receive reimbursement. The return rate for subjects recruited in this manner was 74.7%.

Recruitment from Weight Control Programs

The investigator contacted two Toronto hospitals which conducted weight management programs in the community, and three Weight Watchers groups in the Toronto area, in an attempt to obtain overweight dieting subjects for the study. One of the hospitals and two of the Weight Watchers groups agreed to participate.

By arrangement with the group leaders, and with permission of the members, the investigator attended meetings of each of the groups at which she informed group members of the nature and purpose of the study, answered any questions, and pre-screened women who were willing to participate in the study. (Some pre-screening was done later by phone depending on which method was more convenient.) Questionnaire packages were then distributed or sent to eligible subjects who were requested to return their completed questionnaires by a specified date. The questionnaire return rate for subjects recruited in this manner was 100%.

Data Collection Procedures

All subjects were informed of the general nature and purpose of the study (either in person or by phone), and advised that they could receive information about the results of the study by completing a form included on the last page of the questionnaire. They were also informed that their confidentiality would be

protected, and that the information they provided would be used for research purposes only. A screening interview was conducted as required, and eligible subjects were then given (or sent) a questionnaire package.

The questionnaire package contained the following: (1) a letter of introduction explaining the nature and purpose of the study, and the procedures to be followed (see Appendix E); (2) two Consent Forms, one to be returned with the completed questionnaire, the other to be kept by the subject (see Appendix F); (3) the questionnaire (see Appendix G); and (4) a stamped envelope addressed to the investigator in which the subject was asked to return her completed questionnaire and one Consent Form.

All subjects were asked to complete the questionnaire which comprises the symptom measures (viz., the EDE questions and the MDI); the trait measures of self-regulatory functions (viz., the SRS, STAIT, DPID, SFT, and RSET scales); the state measures of self-regulatory functions (viz., the STAIS, SQD, SFS, and RSE) under two conditions ("weight gain" and "weight loss"); and the measures of selfobject and object relations (viz., the BORT and the SON). A pilot study indicated that these procedures took approximately 60-75 minutes to complete. Undergraduate students who participated in the study were given research credits in compensation for their time, and other respondents received a $10.00 payment.

# CHAPTER III

# RESULTS

## Organization of the Chapter

This study had two objectives. The first objective was to examine, within the framework of psychoanalytic self psychology, certain aspects of the personality functioning of bulimic women as it related to their symptomatology. Five hypotheses were tested which predicted relationships between self-regulatory functions, various aspects of relational experiences, and the severity and function of symptoms in bulimic women. The second objective was to examine some of the psychometric characteristics of three measures which have not been used extensively in empirical research. Although the latter objective was secondary, the results of analyses to test the validity of the three scales will be presented first, as these results are relevant to the interpretation of the analyses used in hypothesis testing. First, however, the demographic characteristics of the sample will be outlined.

## Demographic Characteristics of the Sample

The total sample comprised 120 women with a mean age of 25.5 years (SD = 5.6), and an average of 14.0 years of education (SD = 1.9). Demographic characteristics of the sample by group are shown in Table 2.

Table 2

Demographic Characteristics of the Sample by Group

| Characteristic | | Group | | | |
|---|---|---|---|---|---|
| | | Bulimic | Depressed | Dieting | Normal Control |
| Age in years | M | 25.07 | 26.73 | 27.80 | 22.17 |
| | SD | 5.77 | 4.76 | 6.24 | 4.01 |
| Education in years | M | 13.69 | 13.83 | 14.73 | 13.83 |
| | SD | 2.25 | 1.97 | 1.72 | 1.26 |
| Percent of chart weight | M | 97.54 | 102.60 | 128.67 | 94.80 |
| | SD | 15.61 | 17.91 | 11.29 | 6.88 |
| Body Mass Index | M | 21.76 | 22.45 | 28.92 | 20.66 |
| | SD | 3.75 | 4.17 | 2.86 | 1.53 |
| Weeks in therapy | M | 47.34 | 97.72 | not in | not in |
| | SD | 59.43 | 157.67 | therapy | therapy |

An ANOVA indicated that the groups differed significantly in age ($F$ (3,115) = 6.54, $p$ = .0004). Post hoc Bonferroni comparisons indicated that the normal control group was significantly younger than the other three groups with a mean age of 22.2 years ($SD$ = 4.0). The four groups did not differ significantly in years of education ($F$ (3,115) = 2.04, $p$ = .11). Groups differed significantly in weight ($F$ (3,114) = 39.04, $p$ = .0001). Results of Bonferroni comparisons indicated that these overall group differences were accounted for by the overweight dieting group, which weighed significantly more than any of the other three groups ($p$ < .05). This group was selected on the basis of being above average weight, and had a mean weight of 128.7% of expected weight ($SD$ = 11.3%), and a mean BMI of 28.9 ($SD$ = 2.9).

In addition, the following statistics are of interest: For the two groups receiving psychotherapy (the bulimic and the depressed subjects), the mean weeks in treatment differed significantly, $t$ (56) = 32.17, $p$ = .0001. The bulimic subjects reported being in treatment for an average of 47.3 weeks ($SD$ = 59.4), whereas the depressed subjects reported being in treatment over twice as long on average ($M$ = 97.7 weeks, $SD$ = 157.67). This difference was accounted for, in part, by the fact that a significant minority of bulimic subjects had been in treatment for less than 4 weeks, and/or were in time-limited group treatment programs, whereas the large majority of depressed subjects were receiving individual psychotherapy which was not time-limited.

Psychometric Characteristics of the SRS, SF, and SON Scales

The psychometric characteristics of the Soothing Receptivity Scale (SRS), the Symptoms of Fragmentation Scale (SF), and the Selfobject Needs Scale (SON) were assessed. First, internal reliability was assessed using Cronbach's alpha. Next, construct validity was assessed by examining correlations between scale scores and scores on other scales which logically or theoretically, should, or should not, be related to the scale in question. In addition, the ability of each scale to correctly predict group membership was assessed. The results of these analyses will be presented for each scale separately.

The Soothing Receptivity Scale

The SRS had an alpha of .79 and a standardized alpha of .84, suggesting adequate internal consistency. There were two items which, if removed from the scale, would increase the alpha to .86. These were item 10: "Time is the main thing that helps me feel better." and item 12: "Although it may be hard for me to talk about whatever is upsetting me, I still like having someone hold me and comfort me."

Based on the assumptions that persons who are not receptive to soothing are both more likely to experience distressing feelings such as anxiety and depression, and less likely to be able to relate to others in ways that will be comforting to them, it was anticipated that SRS scores would correlate negatively with scores on the anxiety (STAIT), depression (DPID), and object relations deficits (BORTPATH) scales. Correlational analysis indicated that SRS scores correlated

moderately with scores on STAIT ($r$ = -.71), DPID ($r$ = -.64), and BORTPATH ($r$ = -.57). These correlations suggest a negative relationship between soothing receptivity and anxiety, depression, and object relations deficits, providing some support for the convergent validity of the Soothing Receptivity Scale. Some support for the divergent validity of the scale was suggested by a low correlation of -.16 between SRS and age.

A discriminant function analysis was performed using two groups: a clinical group comprised of the bulimic and the depressed subjects, and a non-clinical group comprised of the dieting and normal control subjects. This analysis indicated that the SRS correctly classified 70% of the clinical group and 76.7% of the non-clinical group. This suggests that the instrument is moderately accurate in predicting membership in a clinical as opposed to a non-clinical population. The instrument's ability to correctly predict membership in one of the four groups, however, was much weaker, with only 40% of subjects, on average, being assigned to the correct group.

The Symptoms of Fragmentation Scale

The SF Scale had an alpha of .96 and a standardized alpha of .96. There were no items which, if removed, would increase the alpha appreciably. These results suggest that the scale has good internal consistency.

In theory, the experience of fragmentation anxiety may include feelings of anxiety, empty depression, meaninglessness, depletion,

alienation, and low self-esteem. Accordingly, scores on the SF scale should correlate positively with scores on the anxiety (STAIT), depression (DPID), and object relations deficits (BORTPATH) scales; and negatively with self-esteem (RSET) scores. Therefore, to test the convergent validity of the SF scale, the writer performed a correlational analysis using these variables. SF scores acorrelated highly with scores on STAIT ($r$ = .91), DPID ($r$ = .90), RSET ($r$ = .88), and BORTPATH ($r$ = .82).

To assess the divergent validity of the scale, the correlation between SF and age was calculated. The low correlation between these two variables ($r$ = .02) provides some support for the divergent validity of the scale.

Results of a discriminant function analysis suggest that the SF scale does relatively well in predicting group membership when the sample used in this study is divided into clinical and non-clinical groups (i.e., the bulimic and depressed groups vs. the dieting and normal control groups). Using these groups, SF correctly classified 89% of subjects in the clinical group, and 92% of subjects in the non-clinical group. When a discriminant function analysis was performed using all four groups in the study, however, only 42.5% of subjects, on average, were correctly classified.

The Selfobject Needs Scale

This scale had both an alpha and a standardized alpha of .87, suggesting adequate internal consistency. There were no items which, if removed, would increase the alpha appreciably.

The convergent validity of the SON scale was tested by correlating SON scores with the two variables in the study which seemed most closely associated with the concept of the selfobject, namely level of object relations as measured by BORTPATH, and the disclosure subscale of the SRS which measure relational aspects of soothing receptivity. The correlation between SON and BORTPATH is positive and relatively high (.77), whereas the correlation between SON and SRSD is negative and moderate (-.38). Some support for the divergent validity of the scale is suggested by a low correlation of -.14 between SON and age.

A discriminant function analysis suggested that the instrument is not highly reliable in predicting membership in the clinical as opposed to the non-clinical group. SON correctly classified 73.4% of the 60 clinical subjects, and 75% of the 60 non-clinical subjects in the sample. Using all four groups, the instrument's ability to predict membership correctly was considerably less accurate, with an average of only 38.4% of subjects being correctly classified.

Hypothesis Testing

Hypothesis 1

Hypothesis 1 states that the bulimic and depressed groups will have more severe self-regulatory deficits (as evidenced by higher scores on trait measures of anxiety, depression, and symptoms of fragmentation; and lower scores on measures of soothing receptivity and self-esteem), than the overweight dieters or the normal controls. Bulimic and depressed groups were not expected to differ from one

another on these measures; and dieting and normal control groups were not expected to differ from one another.

The initial plan was to perform a MANOVA using the five self-regulatory measures as dependent variables and group as the independent variable. However, high correlations among a number of the self-regulatory measures indicated significant multicolinearity among some of the variables (see Table 3). Accordingly, a self-regulatory summary variable was created to be used in assessing this hypothesis. This summary variable represents the total of the scores for the five scales used to measure self-regulatory deficits, namely the trait measures of soothing receptivity (SRST), anxiety (STAIT), depression (DPID), symptoms of fragmentaion (SFT), and self-esteem (RSET). To correct for directionality of scoring in the SRST and RSET scales, actual scores were subtracted from maximim scores, and the resulting values were used in calculating the summary variable. Mean scores and standard deviations for the self-regulatory summary variable (SUMT), as well as for the five self-regulatory variables which comprise the summary variable, are presented in Table 4.

To test hypothesis 1, a one-way ANOVA was performed using group as the independent variable, and the self-regulatory summary variable as the dependent variable. Results of the analysis indicated significant group differences, $F(3, 116) = 76.07$, $p < .0001$.

Results of subsequent planned comparisons to determine which groups contributed to the overall differences indicated that the

Table 3

Product-Moment Correlations Among Self-Regulatory Measures: Total Sample

| | SRST | STAIT | DPID | SFT | RSET |
|---|---|---|---|---|---|
| SRST | 1.00 | -.71 | -.64 | -.68 | .64 |
| STAIT | | 1.00 | .86 | .91 | -.86 |
| DPID | | | 1.00 | .90 | -.87 |
| SFT | | | | 1.00 | -.88 |
| RSET | | | | | 1.00 |

Note.. For all correlation coefficients $p < .0001$

Table 4

Means and Standard Deviations for Self-Regulatory Measures by Group

| Scale | Statistic | Group | | | |
|---|---|---|---|---|---|
| | | Bulimic | Depressed | Dieting | Normal Control |
| SUMT | M | 229.63 | 236.50 | 112.33 | 113.10 |
| | SD | 50.83 | 37.60 | 51.97 | 36.94 |
| SRST* | M | 57.63 | 60.60 | 75.20 | 74.80 |
| | SD | 11.04 | 10.99 | 11.29 | 7.72 |
| STAIT | M | 59.10 | 63.47 | 37.33 | 39.23 |
| | SD | 10.06 | 9.37 | 10.26 | 8.59 |
| DPID | M | 12.77 | 13.53 | 2.37 | 2.30 |
| | SD | 5.12 | 4.10 | 3.34 | 2.91 |
| SFT | M | 89.07 | 93.93 | 41.47 | 40.47 |
| | SD | 22.71 | 17.36 | 24.43 | 17.91 |

Table continues

Table 4 (continued)

Means and Standard Deviations for Self-Regulatory Measures by Group

| Scale | Statistic | Group | | | |
|---|---|---|---|---|---|
| | | Bulimic | Depressed | Dieting | Normal Control |
| RSET* | M | 30.67 | 30.83 | 50.63 | 51.10 |
| | SD | 10.58 | 9.46 | 8.60 | 7.88 |

Note. On scales marked with an asterisk, lower scores are suggestive of greater pathology. The direction of these scores was changed in creating the summary variable, SUMT.

bulimic and depressed groups combined differed significantly from the dieting and normal control groups combined, $F$ (1, 118) = 227.99, $p$ = .0001. The bulimic and depressed groups did not differ significantly from each other, $F$ (1, 58) = .20, $p$ = .66; nor did the dieting and normal control groups differ from each other, $F$ (1, 58) = .01, $p$ = .91. Group differences were in the expected direction, with the bulimic and depressed groups having higher scores on the self-regulatory summary variable than the dieting and normal control groups (see Table 4). These results support the hypothesis that bulimic and depressed subjects have more severe self-regulatory deficits than do overweight dieters or normal control subjects.

Hypothesis 2

Hypothesis 2 states that the bulimic group will have more primitive object relations and selfobject experiences than any of the other three groups. The object relations and selfobject experiences of the depressed group were expected to be more primitive than those of the dieting or normal control groups, but less primitive than those of the bulimic group. The dieting and normal control groups were not expected to differ from each other. Level of object relations was measured by the total number of pathological responses on the Bell Object Relations Test (BORTPATH), and selfobject experiences were measured by total scores on the Selfobject Needs Scale (SON).

Results of a MANOVA, using group as the independent variable and the above variables as dependent variables, indicated that

overall group differences were significant. Using Pillai's Trace as the test for multivariate significance, $F$ (6, 232) = 13.88, $p$ = .0001.

Next, a series of planned group comparisons was carried out to determine which variables and which groups contributed to the overall differences. Means and standard deviations for scores on BORTPATH and SON by group are presented in Table 5; and results of planned group comparisons using these variables are presented in Table 6, and are as follows:

For the variable BORTPATH, the bulimic and depressed groups differed from the dieting and normal control groups, $F$ (1, 118) = 108.83, $p$ = .0001, with the bulimic and depressed groups having higher scores than the dieting and normal control groups. The bulimic and depressed groups did not differ significantly from one another, $F$ (1, 58) = .12, $p$ = .73; nor did the dieting and normal control groups differ from one another, $F$ (1, 58) = .86, $p$ = .36.

For the variable SON, the bulimic and depressed groups differed from the dieting and normal control groups, $F$ (1, 118) = 58.74, $p$ = .0001, with the bulimic and depressed groups having higher scores than the dieting and normal control groups. The bulimic and depressed groups did not differ significantly from one another, $F$ (1, 58) = .40, $p$ = .53; nor did the dieting and normal control groups differ from one another, $F$ (1, 58) = .93, $p$ = .34.

An initial ANCOVA indicated that age covaried significantly with both BORTPATH, $F$ (1, 118) = 4.33, $p$ = .04, and SON, $F$ (1, 118) = 6.99, $p$ =.01, with younger age being associated with higher scores on

Table 5

Means and Standard Deviations for Measures of Object Relations and Selfobject Experiences by Group

| Scale | Statistic | Group | | | |
|---|---|---|---|---|---|
| | | Bulimic | Depressed | Dieting | Normal Control |
| BORT-PATH | M | 21.67 | 21.10 | 9.93 | 8.40 |
| | SD | 7.94 | 6.32 | 6.96 | 3.62 |
| SON | M | 96.33 | 93.70 | 70.30 | 74.33 |
| | SD | 16.79 | 16.88 | 14.39 | 16.69 |

Table 6

Group Contrasts for Scores on Measures of Object Relations and Selfobject Experiences

| Measure | Groups Compared | F | p |
|---|---|---|---|
| BORTPATH | Bulimic & Depressed vs. Dieters & Normal Controls | 108.83 | .0001 |
| | Bulimic vs. Depressed | .12 | .73 |
| | Dieters vs. Normal Controls | .86 | .36 |
| SON | Bulimic & Depressed vs. Dieters & Normal Controls | 58.74 | .0001 |
| | Bulimic vs. Depressed | .40 | .53 |
| | Dieters vs. Normal Controls | .93 | .34 |

both scales. The mean correlation between age and BORTPATH across groups was -.22, and the mean correlation between age and SON across groups was -.23. A breakdown by group of correlations between age and BORTPATH, and between age and SON is shown in Table 7.

To examine the effects of age as a covariate, a MANCOVA with group contrasts was carried out using age as a covariate. Results of these analyses indicated that, with the effects of age removed, overall group effects were still significant, $F$ (6, 228) = 14.06, $p$ = .0001, and accounted for 72% of the variance. Age effects were also significant, $F$ (2, 113) = 3.20, $p$ = .04, but accounted for only 2% of the variance. As was noted earlier, higher scores on BORTPATH and SON were associated with younger age; and, as the normal control group was significantly younger than the other three groups, the results reported above tend to lend further support to Hypothesis 2 rather than weakening it.

These results support the hypothesis in suggesting that the bulimic subjects have more primitive object relations and selfobject experiences than either the dieters or the normal controls. The results do not, however, support that part of the hypothesis that predicts more primitive object relations and selfobject experiences in bulimic subjects than in depressed subjects.

Hypothesis 3

This hypothesis predicts that, for all subjects, more severe self-regulatory deficits will be associated with more primitive object

Table 7

Product-Moment Correlations of Age with BORTPATH and Age with SON by Group

| Variables Correlated | Group | | | |
|---|---|---|---|---|
| | Bulimic | Depressed | Dieting | Normal Control |
| Age with BORTPATH | -.18 | -.18 | -.24 | -.28 |
| Age with SON | -.13 | -.07 | -.26 | -.46** |

**p <.01

relations, and more primitive selfobject experiences. To test this hypothesis, a multiple regression analysis was carried out using SUMT as the criterion variable, and BORTPATH and SON as predictor variables (although it is irrelevant to this hypothesis which variables are used as predictors and which as criteria). Results of the analysis indicate that BORTPATH and SON do predict SUMT, $F$ (2, 117) $=128.52$, $p = .0001$, accounting for 69% of the variance in total. Although age covaried significantly with BORTPATH and SON, $F$ (2, 115) $= 4.80$, $p = .03$, it accounted for only 1% of the variance. These results support the hypothesis that more severe self-regulatory deficits are associated with more primitive object relations and selfobject experiences.

Hypothesis 4

This hypothesis predicts a positive relationship in the bulimic group between severity of eating disorder symptoms on the one hand, and severity of self-regulatory deficits, and disturbances in object relations and selfobject experiences on the other hand. To test this hypothesis, a canonical correlation analysis was performed. SUMT, BORTPATH, and SON were used as measures of self-regulatory and object relations deficits, and frequency of bingeing (BINGEFRQ), frequency of self-induced vomiting (VOMITFRQ), and preoccupation with weight and shape (WTSHCONC) were used as measures of bulimic symptomatology.

The canonical correlation analysis using the identified variables was statistically significant. Using Roy's Greatest Root as the test for

significance, $F$ (3, 26) = 3.84, $p$ = .02. Two canonical variates emerged. The first had a canonical correlation of .55 and explained 31% of the variance of its own set of variables; the second had a canonical correlation of .38 and explained 14% of the variance of its own set of variables. Data on the two pairs of canonical variates is shown in Table 8. Included in the table are correlations between the variables and the canonical variates, standardized canonical variate coefficients, within-set variance accounted for by the canonical variates (Percent variance), redundancies, and canonical correlations. Total percent of variance and total redundancy indicate that both pairs of canonical variates were moderately related. However, the first self-state variate accounts for 11% of the variance in the symptom variables, and the first symptom variate accounts for 9% of the variance in the self-state variables, suggesting considerable shared variance between this pair of canonical variates.

With a cutoff correlation of .30 (see Tabachnick & Fidell, 1989, p. 217), the self-state variables which were correlated with the first canonical variate were BORTPATH (.76) and SUMT (.73). Among the symptom variables, WTSHCONC (.75) and VOMITFRQ (-.53) correlated with the first canonical variate. This first pair of canonical variates indicates that more severe self-regulatory deficits and more primitive object relations tended to be associated with greater preoccupation with weight and shape, and with less frequent use of vomiting as a method of purging.

Table 8

Results of Canonical Correlation Analysis

| | First Canonical Variate | | Second Canonical Variate | |
|---|---|---|---|---|
| | Correlation | Coefficient | Correlation | Coefficient |
| Self-State Variables | | | | |
| SUMT | .73 | .36 | .67 | .95 |
| BORTPATH | .76 | .93 | .24 | -.87 |
| SON | -.04 | -.69 | .66 | .86 |
| Percent Variance | .37 | | .31 | |
| Redundancy | .11 | | .05 | |

Table continues

Table 8 (continued)

Results of Canonical Correlation Analysis

| | First Canonical Variate | | Second Canonical Variate | |
|---|---|---|---|---|
| | Correlation | Coefficient | Correlation | Coefficient |
| Symptom Variables | | | | |
| BINGEFRQ | -.26 | .11 | .78 | 1.24 |
| VOMITFRQ | -.53 | -.73 | -.03 | -.75 |
| WTSHCONC | .75 | .86 | -.12 | -.10 |
| Percent Variance | .30 | | .21 | |
| Redundancy | .09 | | .03 | |
| Canonical Correlation | .55 | | .38 | |

Self-state variables which were correlated with the second canonical variate were SUMT (.67) and SON (.66). The only symptom variable which correlated with the second canonical variate was BINGEFRQ (.78). This second pair of canonical variates indicates that more severe self-regulatory deficits and more primitive selfobject experiences tended to be associated with more frequent bingeing.

Hypothesis 5

Hypothesis 5 states that the bulimic group will exhibit greater increases in anxiety, depression, and symptoms of fragmentation, and greater decreases in self-esteem under the condition of imagined weight gain than will the other three groups. Conversely, the bulimic group will exhibit greater decreases in anxiety, depression, and symptoms of fragmentation, and greater increases in self-esteem under the condition of imagined weight loss, than will the other three groups. The weakest relationships between affective and self-state changes and imagined weight changes were expected to be found in the depressed and normal control groups.

Three variables were used in assessing this hypothesis: (1) a summary self-regulatory variable (SUMS) comprised of the sum of scores on the trait measures of anxiety (STAIT), depression (DPID), symptoms of fragmentation (SFT), and self-esteem (RSET); (2) a summary weight gain variable (SUMG) comprising the sum of scores on the state measures of the same variables as responded to under the condition of imagined weight gain (viz., STAISG, SQDG, SFSG, and RSESG); and (3) a summary weight loss variable (SUML) comprised of

the sum of scores on the state measures of the same variables as responded to under the condition of imagined weight loss (viz., STAISL, SQDL, SFSL, and RSESL). As with the summary self-regulatory variable used in hypotheses 1, 3, and 4, the direction of scores was changed for the self-esteem variables. Mean scores and standard deviations for scores of the summary variables by group are presented in Table 9.

To test this hypothesis, first a series of paired comparisons of the means for SUMS-SUMG, and SUMS-SUML was performed to determine whether the differences in mean group scores between the trait condition and the weight gain condition, and between the trait condition and the weight loss condition, differed significantly from zero. Differences between SUMS and SUMG were significantly greater than zero in all but the depressed group. In the bulimic group, $t$ (58) = -8.31, $p$ = .0001; in the depressed group, $t$ (58) = .68, $p$ = .50; in the dieting group, $t$ (58) = -6.82, $p$ = .0001; and in the normal control group, $t$ (58) = -4.11, $p$ = .0003. Differences between SUMS and SUML were significantly greater than zero in all groups. In the bulimic group, $t$ (58) = 9.19, $p$ = .0001; in the depressed group, $t$ (58) = 8.02, $p$ = .0001; in the dieting group, $t$ (58) = 4.09, $p$ = .0003; and in the normal control group, $t$ (58) = 4.03, $p$ = .0004. In all but one case, the differences in scores were in the expected direction, with the trait scores being lower than the weight gain scores, and higher than the weight loss scores. The one exception occurred in the

Table 9

Group Means and Standard Deviations for Self-Regulatory Summary Variables Under Three Conditions

| Variable | Statistic | Group | | | |
|---|---|---|---|---|---|
| | | Bulimic | Depressed | Dieting | Normal Control |
| SUMS (trait condition) | M | 190.27 | 200.10 | 90.53 | 90.90 |
| | SD | 44.92 | 33.59 | 44.44 | 33.19 |
| SUMG (weight gain condition) | M | 227.67 | 196.06 | 131.97 | 116.07 |
| | SD | 44.61 | 49.07 | 56.49 | 45.68 |
| SUML (weight loss condition) | M | 126.03 | 156.11 | 76.00 | 74.36 |
| | SD | 45.48 | 37.23 | 34.91 | 27.21 |

depressed group, where the trait score was non-significantly higher than the weight gain score.

A series of repeated measures ANOVAS with group comparisons was then carried out to determine the relative differences across groups between SUMS and SUMG; and the relative differences across groups between SUMS and SUML. When differences between SUMS and SUMG were compared, overall group differences were significant, $F$ (3, 116) = 13.03, $p$ =.0001. Planned group comparisons indicated that the bulimic group differed significantly from the depressed group, $F$ (1, 58) = 26.50, $p$ = .0001, with the bulimic group exhibiting a greater discrepancy between SUMS and SUMG than the depressed group. The bulimic group, however, did not differ significantly from either the dieting group, $F$ (1, 58) = .25, $p$ = .62, or the normal control group, $F$ (1, 58) = 2.31, $p$ = .13 with respect to discrepancy between SUMS and SUMG. As well as differing from the bulimic group, the dieting group differed significantly from the depressed group $F$ (1, 58) = 31.90, $p$ = .0001, and from the normal control group, $F$ (1, 58) = 4.08, $p$ = .05, with the dieting group showing greater discrepancy between SUMS and SUMG than either the depressed group or the normal control group. As well as differing from the bulimic and dieting groups, the depressed group differed from the normal control group, $F$ (1, 58) =13.16, $p$ = .0004. The depressed group differed from the other three groups not only in exhibiting less discrepancy between the trait condition and the weight gain condition, but also in the direction of the

discrepancy. Unlike the other three groups, the depressed group reported feeling "better", though not significantly so, in the imagined weight gain condition than in the trait condition.

When differences between SUMS and SUML were compared, overall group differences were again found to be significant, $F$ (3, 116) = 12.75, $p$ = .0001. Planned group comparisons indicated that the bulimic group differed significantly from the depressed group, $F$ (1, 58) = 29.27, $p$ = .0001; the dieting group, $F$ (1, 58) = 16.04, $p$ = .0001; and the normal control group, $F$ (1, 58) = 27.63, $p$ = .0001, with the bulimic group showing a greater discrepancy between SUMS and SUML than any of the other groups. The depressed group did not differ significantly from either the dieting group, $F$ (1, 58) = 1.97, $p$ = .16, or the normal control group, $F$ (1, 58) = .02, $p$ = .88; nor did the dieting and normal control groups differ significantly from each other, $F$ (1, 58) = 1.56 $p$ = .21. A summary of the group means and standard deviations for differences between SUMS and SUMG, and differences between SUMS and SUML are shown in Table 10. The results of planned group comparisons are shown in Table 11.

These results support that part of the hypothesis which states that weight loss, as imigined by subjects in the bulimic group, will be associated with a greater increase in self-esteem, and greater decreases in dysphoric affects and symptoms of fragmentation, than will weight loss as imagined by subjects in the other three groups.

Table 10

Group Means and Standard Deviations for Differences Between Trait vs. Weight Gain and Trait vs. Weight Loss Summary Variables

| Variable | Statistic | Group | | | |
|---|---|---|---|---|---|
| | | Bulimic | Depressed | Dieting | Normal Control |
| SUMS-SUMG | M | -37.41 | 4.04 | -41.43 | -25.17 |
| | SD | 24.65 | 32.34 | 33.29 | 33.57 |
| SUMS-SUML | M | 64.24 | 43.99 | 14.54 | 16.54 |
| | SD | 38.28 | 30.04 | 19.48 | 22.48 |

Table 11

Group Contrasts for Differences Between Trait vs Weight Gain Condition and Trait vs Weight Loss Condition on Self-Regulatory Summary Variables

| Groups Contrasted | Trait vs. Gain | | Trait vs. Loss | |
|---|---|---|---|---|
| | F | p | F | p |
| Bulimic & Depressed vs. Dieting & Normal Control | 8.52 | .004 | 7.42 | .008 |
| Bulimic & Dieting vs. Depressed & Normal Control | 25.69 | .0001 | 22.19 | .0001 |
| Bulimic vs. Depressed | 26.50 | .0001 | 29.27 | .0001 |
| Bulimic vs. Dieting | .25 | .62 | 16.04 | .0001 |
| Bulimic vs. Normal Control | 2.31 | .13 | 27.63 | .0001 |
| Depressed vs. Dieting | 31.90 | .0001 | 1.97 | .16 |
| Depressed vs. Normal Control | 13.16 | .0004 | .02 | .88 |
| Dieting vs. Normal Control | 4.08 | .05 | 1.56 | .21 |

Contrary to expectations, however, the weakest relationships between self-state changes and imagined weight loss were found in the dieting and normal control groups rather than the depressed and normal control groups.

The results only partially support that part of the hypothesis which states that weight gain as imagined by bulimic subjects will be associated with greater decreases in self-esteem and greater increases in dysphoric affects than will weight gain as imagined by subjects in the other three groups. This relationship holds true only when the bulimic subjects are compared with the depressed subjects. As was hypothesized, however, the weakest relationships between self-state changes and imagined weight gain are found in the depressed and normal control groups.

Additional Analyses

In addition to the analyses relevant to hypothesis testing the following analyses were carried out: (1) Analyses of variance and post hoc group comparisons using Bonferroni t tests were done for each of the self-regulatory variables comprising the summary self-regulatory variable used in hypothesis 5. These analyses were performed to explore further the nature of group differences in the weight gain and weight loss conditions, and to examine the contribution of the individual self-regulatory variables to these group differences. (2) t tests were performed to compare the depressed bulimics and the non-depressed bulimics on each of the self-regulatory variables used in Hypotheses 1, 3, and 4.

(3) Product-moment correlations were performed to determine the strength and direction of the relationships between each of the self-regulatory and relational variables, and the severity of specific symptoms in the bulimic group. (4) Product-moment correlations were performed to determine the strength and direction of the relationship between length of treatment and severity of specific symptoms in the bulimic group. Results of these analyses are presented below.

ANOVAS and Bonferroni Groupings for Anxiety, Depression, Symptoms of Fragmentation, and Self-Esteem Under Trait, Weight Gain, and Weight Loss Conditions

Mean group scores, and post hoc Bonferroni comparisons of group differences on the three sets of self-regulatory measures are presented in Table 12. In all cases $t\,(116) > 2.68$, $p < .05$. On each of the trait measures, the bulimic and depressed groups did not differ from each other, and the dieting and normal control groups did not differ from each other. On each measure, the bulimic and depressed groups had scores suggestive of greater self-regulatory deficits than the dieting and normal control groups.

Under the weight gain condition, the bulimic and depressed groups did not differ significantly from each other on measures of depression, symptoms of fragmentation, and self-esteem; however, the bulimic group scored significantly higher than the depressed group on the measure of anxiety. On all measures, the bulimic and depressed groups had scores indicative of more severe self-

Table 12

Mean Scores and Group Differences on Self-Regulatory Measures Under Trait, Weight Gain, and Weight Loss Conditions

| Measure | Group | | | |
|---|---|---|---|---|
| | Bulimic | Depressed | Dieting | Normal Control |
| STAIT | 59.10$_a$ | 63.47$_a$ | 37.33$_b$ | 39.23$_b$ |
| DPID | 12.77$_a$ | 13.53$_a$ | 2.37$_b$ | 2.30$_b$ |
| SFT | 89.07$_a$ | 93.93$_a$ | 41.47$_b$ | 40.47$_b$ |
| RSET* | 30.67$_a$ | 30.83$_a$ | 50.63$_b$ | 51.10$_b$ |
| STAISG | 68.40$_a$ | 58.87$_b$ | 50.00$_c$ | 45.43$_c$ |
| SQDG | 15.14$_a$ | 13.46$_a$ | 10.73$_b$ | 9.54$_b$ |
| SFSG | 108.30$_a$ | 91.83$_a$ | 55.10$_b$ | 48.37$_b$ |
| RSESG* | 24.17$_a$ | 28.10$_a$ | 43.87$_b$ | 47.27$_b$ |

Table continues

Table 12 (continued)

Mean Scores and Group Differences on Self Regulatory Measures Under Trait, Weight Gain, and Weight Loss Conditions

| Measure | Group | | | |
|---|---|---|---|---|
| | Bulimic | Depressed | Dieting | Normal Control |
| STAISL | $41.33_a$ | $46.73_a$ | $32.83_b$ | $32.57_b$ |
| SQDL | $6.26_b$ | $9.38_a$ | $4.46_b$ | $4.43_b$ |
| SFSL | $58.50_a$ | $75.80_b$ | $31.57_c$ | $31.23_c$ |
| RSESL* | $40.07_a$ | $35.80_a$ | $52.87_b$ | $53.87_b$ |

Notes. Means with different subscripts differ significantly at $p < .05$. On scales marked with an asterisk, lower scores suggest greater pathology.

regulatory deficits than either the dieting or normal control groups. The dieting and normal control groups did not differ significantly from each other on any of the measures.

Under the weight loss condition, the picture changes slightly. On the measures of anxiety and self-esteem, the bulimic and depressed groups did not differ from each other, but did differ significantly from the dieting and normal control groups. Again, the bulimic and depressed groups showed greater self-regulatory deficits than the other two groups; and the dieting and normal control groups did not differ significantly from each other. On the SF Scale, and on the measure of depression, however, the bulimic group scored significantly lower than the depressed group. Furthermore, the depression scores for the bulimic group did not differ significantly from those of the dieting and normal control groups.

Self-Regulatory Deficits in Depressed vs. Non-Depressed Bulimics

A series of t tests was performed to compare the severity of self-regulatory deficits among depressed ($n$ = 24) vs. non-depressed ($n$ = 6) bulimics. Differences in soothing receptivity between the two groups were not significant, $t$ (28) = 1.42, $p$ > .10. Differences in anxiety between the two groups were likewise not significant, $t$ (28) = 1.94, $p$ > .10; nor were differences between the groups in level of self-esteem, $t$ (28) = 1.47, $p$ > .10. There were, however, significant differences between the depressed and the non-depressed bulimics

on measures of depression, $t$ (28) = 3.20, $p < .01$; and symptoms of fragmentation, $t$ (28) = 2.74, $p = < .02$.

Self-Regulatory Deficits, Relational Experiences, and Severity of Eating Disorder Symptoms in the Bulimic Group

A series of product-moment correlations was performed to determine whether there were relationships between scores on any of the measures of self-regulatory deficits and relational experiences, and severity of any of the symptoms of eating disorders in the bulimic group. Results of these analyses are shown in Table 13.

Length of Treatment and Severity of Eating Disorder Symptoms

Product-moment correlations were performed to determine whether there was any relationship between length of treatment and severity of six eating disorder symptoms in the bulimic group. No statistically significant relationships were found. Correlations between length of treatment and severity of the six symptoms were as follows: frequency of bingeing, $r = -.01$, $p = .96$; frequency of self-induced vomiting, $r = -.11$, $p = .58$; degree of preoccupation with weight and shape, $r = .19$, $p = .31$; importance of weight and shape in self-evaluation, $r = .01$, $p = .95$; body dissatisfaction, $r = .07$, $p = .72$; and fear of weight gain, $r = .22$, $p = .26$.

Table 13

Product-Moment Correlations Between Self-Regulatory & Relational Measures and Severity of Bulimic Symptoms in the Bulimid Group

| Bulimic Symptoms | Self-Regulatory and Relational Measures | | | | | | |
|---|---|---|---|---|---|---|---|
| | SRST | STAIT | DPID | SFT | RSET | BORT PATH | SON |
| BINGEFRQ | -.06 | .02 | .29 | .10 | .01 | -.14 | .08 |
| VOMITFRQ | .26 | -.21 | -.01 | -.18 | .13 | -.38* | -.18 |
| WTSHCONC | -.21 | .32 | .22 | .24 | -.26 | .19 | -.19 |
| WTSHEVAL | -.12 | .16 | .12 | .27 | -.32 | .27 | .10 |
| BODYDIS | -.33 | .41* | .35* | .34 | -.36* | .20 | -.03 |
| FATFEAR | -.32 | .43* | .37* | .36* | -.52** | .26 | .07 |

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

# CHAPTER IV

# DISCUSSION

## Summary of the Results

The overall results of the study support, in part, the hypotheses proposed. The bulimic and the depressed women reported greater difficulty in regulating self-esteem and dysphoric affects, less receptiveness to soothing (either from others or through their own efforts), more primitive object relations, and fewer positive selfobject experiences than either the overweight dieters or the women in the normal control group. In addition, a strong relationship was found between self-regulatory deficits and negative relational experiences across groups. A canonical correlation analysis suggested two sets of moderate relationships between self-regulatory and relational variables, and severity of three eating disorder symptoms in the bulimic group. These relationships, however, were not entirely in the direction predicted.

A statistically significant relationship was found in all groups between imagined weight loss and changes in affect, symptoms of fragmentation, and self-esteem. Statistically significant changes were found in all but the depressed group between imagined weight gain and changes in affect, symptoms of fragmentation, and self-esteem. There were, however, some differences in the nature of these changes which set the bulimic group apart from the other three

groups. Specifically, the bulimic group experienced greater decreases in dysphoric affects, and greater increases in self-esteem when they imagined losing weight than did any of the other three groups. Contrary to predictions, the depressed group was more positively affected by imagined weight loss than either the dieting or normal control groups. Also contrary to predictions, imagined weight gain affected the bulimic, dieting and normal control groups similarly, resulting in significant increases in dysphoric affects and symptoms of fragmentation, and a significant decrease in self-esteem. In contrast to the other three groups, the depressed group was not significantly affected by imagined weight gain.

Validity of the SRS, SF, and SON Scales

the Soothing Receptivity Scale

The Soothing Receptivity Scale demonstrated adequate internal consistency, and was moderately effective in predicting group membership in clinical vs. non-clinical groups in this sample. That the scale was only moderately successful in predicting group membership may suggest that low receptivity to soothing is a characteristic not necessarily associated only with psychopathology. Rather, it may be distributed more normally throughout the population, but found more consistently in certain clinical groups - perhaps particularly in those for which mood disorders are a defining characteristic.

The moderate negative correlations found between soothing receptivity and anxiety, depression, and symptoms of fragmentation;

and the moderate positive correlation found between soothing receptivity and self-esteem, seem to suggest that there may be a conceptual relationship between soothing receptivity and self-regulatory functions. In addition, the moderate negative correlations between soothing receptivity and object and selfobject relations suggest that the ability to soothe painful affects bears some relationship to the quality of one's relational experiences. Taken together, these findings are consistent with self psychology's premise that selfobject experiences (and by implication object relations) play a primary role in the development of self-regulatory functions. Although more research is needed to clarify the nature of these relationships among soothing receptivity, self-regulatory functions, and relational experiences, these preliminary findings suggest that the Soothing Receptivity Scale shows some promise as a psychometric instrument which may be useful in the empirical study of self psychology concepts.

The Symptoms of Fragmentation Scale

The Symptoms of Fragmentation Scale demonstrated good internal reliability, and was effective in differentiating clinical from non-clinical groups. It was also effective in predicting group membership in clinical as opposed to non-clinical groups in this sample.

High correlations between scores on the Symptoms of Fragmentation Scale and scores on measures of anxiety and depression indicated significant multicolinearity between these

measures. This raises the question of whether or not the scale measures a construct different from anxiety, depression, and/or general dysphoria. Although symptoms of fragmentation typically include feelings of anxiety and/or depression, they are described by self psychologists as being different from "simple" anxiety or depression in that they imply a degree of "regression of the self toward lessened cohesion, more permeable boundaries, diminished energy and vitality, and disturbed and disharmonious balance" (Wolf, 1988, p. 39). Therefore, to be useful as a psychometric scale which measures fragmentation experiences, the Symptoms of Fragmentation Scale must reflect the nature and extent of these regressive experiences, as well as the feelings of anxiety and depression which characterize the experience of fragmentation.

The findings of the present research leave this issue unresolved. While high correlations of symptoms of fragmentation with anxiety and depression do not necessarily invalidate the instrument as a measure of fragmentation experiences, neither do they support its validity. Further research is required to determine what, if anything, this scale measures in addition to anxiety and depression. Until this can be clarified, it does not seem that the scale will be particularly useful in the empirical study of self psychology.

Similarly, the moderate to high correlations between symptoms of fragmentation and object relations deficits, and between symptoms of fragmentation and more primitive selfobject experiences, suggest a relationship between vulnerability to

fragmentation and negative or primitive relational experiences. Within the context of self theory, this finding is expected, and supports the postulate that an empathic selfobject environment promotes and maintains self cohesion, while an unempathic selfobject environment leads to loss of self cohesion and fragmentation experiences. Indirectly, then, this relationship between symptoms of fragmentation and negative relational experiences supports the construct validity of the SF Scale.

The Selfobject Needs Scale

This scale demonstrated good internal reliability. It did not, however, demonstrate acceptable ability to predict membership in clinical as opposed to non-clinical groups. There are a number of possible explanations for this finding.

One possibility is that the scale measures a construct which is not exclusive to psychopathological states (or at least not to bulimia and depression). That the need for selfobjects is universal, is almost a truism among self psychologists. It would be expected, then, that selfobject needs would be evident in any of the groups in this study. It is equally true, however, that the nature of these needs, their intensity, pervasiveness, and developmental level should vary with the cohesiveness of the self structure. It seems reasonable to assume that persons with bulimic or depressive symptoms might differ significantly in terms of their self cohesion and hence in the nature of their selfobject needs, from the non-clinical groups in the study.

A second possible explanation for the finding that the SON Scale does not effectively predict clinical or non-clinical group membership is that self disorders not accompanied by symptoms of bulimia or depression were present in some form in a number of the subjects included in the non-clinical groups in this study. Alternatively, or in addition, the inability of the SON scale to accurately predict group membership may indicate that an important dimension of selfobject experience (most likely the developmental level of the experience) is not accurately reflected in the SON Scale items.

The moderately high correlation between SON and BORTPATH scores suggests that selfobject needs are experientially related to the developmental level of object relations. That is, persons with greater object relations deficits experience a greater need for, or have more primitive selfobject experiences. Although self psychology does not generally emphasize object relations per se, there is certainly an implicit recognition among self psychology theorists and practitioners (e.g. White & Weiner, 1986) that object relations affect and are affected by self states and selfobject experiences. Most selfobject experiences are, after all, provided by other people. To the extent that this interaction between objects and selfobjects is accepted, the correlation of BORTPATH with SON suggests that the SON Scale has some construct validity. Further refinement of the instrument is needed, however, before it will be useful in empirical research.

Self-Regulatory Deficits, Bulimia, and Depression

The bulimic subjects in this study had more severe self-

regulatory deficits, as evidenced by higher scores on the depression, anxiety, and symptoms of fragmentation scales, and lower scores on the self-esteem scale, than either the dieting or normal control subjects. The bulimic subjects, however, did not differ significantly from the depressed subjects in the severity of their self-regulatory deficits.

This raises questions about the relationships among self-regulatory deficits, eating disorders, and depression. The question is particularly interesting in the context of self theory, as the theory suggests that depression is a manifestations of weakened self cohesion or vulnerability to fragmentation. Wolf (1988) for example, described Kohut's three categories of depression as (1) preverbal depression, characterized by apathy, feelings of deadness, and diffuse rage, and associated with primordial trauma; (2) empty depression, characterized by depletion of self-esteem and vitality, and associated with a lack of joyful responses from a mirroring selfobject; and (3) guilty depression, characterized by heightened self-rejection and self-blame, and associated with deprivation of merger experiences with an idealized selfobject. Furthermore, Wolf (1988) states that all "major clinical diagnostic categories always imply damage to the self's structural integrity and strength, secondary to faulty selfobject responsiveness" (p. 185). He includes among these diagnostic categories, psychoses, borderline states, narcissistic disorders, and depression. This suggests that, theoretically at least, the self-regulatory deficits which are

characteristic of self disorders are inextricably linked with depression.

Although depression (including its characteristic affect) and self disorders are inextricably linked, however, a distinction should be made between the expression of affect (which does not always imply weakened self-cohesion or regression of the self) and fragmentation (which does imply a weakened or regressed self structure, but which is not necessarily accompanied by the overt expression of affect). It should be noted that, in this study, the implicit assumption is made that, in the clinical groups, it is weakened self structures that gives rise to or *cause* the dysphoric affects reported. Of course no such causal relationship can be demonstrated from the data.

Similarly, depression seems inextricably linked with bulimia. There is no shortage of research to support this association between bulimia and depression. A review by Strober and Katz of the recent literature on the topic can be found in *Diagnostic Issues in Anorexia Nervosa and Bulimia Nervosa* (Garner & Garfinkel, 1988). These authors note that the lifetime prevalence of depression found in eating disordered patients varies considerably across studies, but ranges from 20% to 100%. There is also some evidence (e.g. Piran et. al.,1985) that in a large minority of eating disorder patients, depression antedates the onset of eating disorder by at least one year. Data from longitudinal studies of course and outcome in eating disorders and depression indicate that recovery from bulimia and

recovery from affective disturbances are not related over time. That is, a decrease in level of depression is not necessarily accompanied by a reduction in bulimic episodes; nor is recovery from bulimia necessarily predictive of a corresponding decrease in depression (Strober & Katz, 1988). With respect to anorexia, studies by Hsu (1980) and Cantwell et. al. (1977) suggest that depression persists, or develops, in 20% to 45% of patients after eating disorder symptoms have resolved.

These findings can, of course, be interpreted in a number of different ways. From a self psychological perspective, both the frequent co-existence of depression and eating disorders, and the pre-existence of depression in persons who later develop eating disorders is consistent with the hypothesis that both depression and eating disorders develop in response to the failure of the self to develop sufficient cohesion. Consistent with this view is the observation by Strober and Katz (1988) that

> the connecting link [between depression and eating disorders] may be the enhanced sense of personal effectiveness associated with dietary restriction that defends the individual against the painful and ego-disruptive feelings of emergent depression. Alternatively, changes in appetite behavior and weight loss brought on by incipient depression may expedite the transition into more pathological extremes of dieting behavior by meeting certain preexisting intra-psychic needs and eliciting social reinforcement (p. 101).

This interpretation is consistent with the following findings of the present study: (1) The bulimic and the depressed groups did not differ in their self-regulatory deficits; (2) 80% of the bulimic subjects

met criteria for depression; (3) Although this was not a formal part of the study, it is interesting to note that it was extremely difficult to recruit both depressed subjects who did not report disqualifying difficulties related to their eating behaviour, and dieting subjects who were not also depressed. This difficulty lends support to the idea that there is a link not only between depression and formal eating disorders, but also between depression and atypical eating patterns of various kinds which cause distress to those who experience them.

Object and Selfobject Relations in Bulimic Women

The finding of significant object relations deficits in the bulimic subjects is consistent with earlier empirical studies (e.g. Becker, Bell, & Billington, 1987; Garfinkel, Moldofsky, & Garner, 1980) as well as with object relations theory which postulates that deficits in object relations not only accompany eating disorders, but are also important in their etiology. Many theorists, among them Masterson (1977), Shainess (1979), and Sours (1980), have suggested that developmental arrests which occur during the separation-individuation phase of development are a major source of difficulties for patients with eating disorders. According to object relations theory, these developmental arrests are responsible for difficulties such as inadequate self-other differentiation, the absence of good object representations, splitting, and ambivalent attachment, which are later expressed in the eating disordered patient's relationships with food, with her body, and with other people. Although no causal

relationship can be determined from the results of this study, it is reasonable to conclude that object relations deficits and bulimia are strongly associated with each other.

Similarly, the finding that the selfobject experiences of the bulimic subjects in this study were less self-sustaining than those of the non-clinical subjects is consistent with self psychology theory which postulates a causal relationship between early selfobject failures, deficient internalization of selfobject functions, and the subsequent development of symptoms which are an attempt to compensate for fragile self structures. Goodsitt (1985), for example, has suggested that the symptoms of eating disorders represent the attempts of the eating disordered person to regulate her self-esteem, provide her with a sense of purpose, and compensate for some of the self-sustaining relational experiences which she is unable to find in, or accept from other people. As Goodsitt states:

> She finds...some compensation and some contrived meaning for her existence. By focusing on food and weight, by turning off her need of others and turning inward to herself, by filling up her life with rituals that help her feel a sense of predictability and control, she narrows down her world to something she feels she can manage. By starving herself she feels strengthened and temporarily superior to others (p. 62).

Again, no causal relationship between selfobject experiences and bulimia can be demonstrated using the data from this study. What is demonstrated is an association between the relative absence of a sustaining selfobject environment and bulimic symptoms. The

nature of this relationship has yet to be clarified. Do relational deficits precede and/or predispose one to develop eating disorders, or are they the result of factors such as chaotic eating patterns, secrecy, shame, and isolation which arise from the eating disorder itself?

The fact that no differences were found between the bulimic and the depressed subjects with regard to either object relations deficits or selfobject experiences, raises further questions about the relationship between relational experiences, eating disorders and depression. It is consistent with self psychology theory to postulate similar deficits in early selfobject experiences which result in similar difficulties with self-regulation in both groups; however, to date there has been no empirical research in this area, and we can therefore only speculate about the nature of these causal relationships.

The Relationship Among Self-Regulatory Functions, Relational Experiences, and the Symptoms of Bulimia

A discussion of the association between self-regulatory deficits and bulimia, and between relational experiences and bulimia, leads logically to a discussion of the relationship between self-regulatory functions and relational experiences. It is really this relationship between relational experiences and the ability to regulate affects, maintain self-esteem, and prevent fragmentation anxiety that is at the heart of self psychology theory.

In this study, for all groups combined, a strong relationship was found between the ability to regulate affect and self-esteem, and vulnerability to fragmentation on the one hand, and quality of relational experiences on the other hand. This finding is consistent with self psychology theory which emphasizes the importance of a self-sustaining selfobject environment to the development of a cohesive self structure. As was discussed in detail in an earlier chapter (see pp. 10-16), two of the hallmarks of a cohesive self structure are the ability to regulate affect and self-esteem (with or without the help of appropriate selfobjects), and decreased vulnerability to fragmentation experiences.

Again, no causal relationship can be established from the data gathered in this study, and we are left with a number of questions about the nature of the relationship between self-regulation, relational experiences, and clinical symptoms: Will alleviating the symptoms of bulimia or depression allow for the development of a more positive selfobject environment, and more self-supportive interpersonal relationships? Or, conversely, will the availability of empathic selfobjects, such as those which might be found in a therapy group or a therapist, lead to the development of more robust self structures which are then better able to perform self-regulatory functions, and protect against fragmentation experiences? Finally, do these changes in self structure result in the resolution of bulimic symptoms without the necessity of treating the symptoms directly?

With respect to the relationship between self-regulatory deficits and relational experiences on the one hand, and the severity of a number of bulimic symptoms (namely, frequency of bingeing, frequency of purging by vomiting, and preoccupation with weight and shape) on the other hand, statistically significant relationships between these two sets of variables were found. The nature of these associations, however, is somewhat contradictory. As was predicted, more severe self-regulatory and object relations deficits were associated with greater preoccupation with weight and shape; and more severe self-regulatory deficits and more negative selfobject experiences were associated with more frequent bingeing. Contrary to expectations, however, more severe self-regulatory and object relations deficits were associated with less frequent use of self-induced vomiting as a method of purging.

This latter relationship is difficult to explain. It is possible that subjects with more severe self-regulatory and object relations deficits may, for some reason, favour other methods of purging such as restriction of food intake, exercising, or laxative use over self-induced vomiting, and may therefore use self-induced vomiting as a purging method less frequently than subjects with less severe self-regulatory and object relations deficits. It is also possible that many of the subjects in this study were in treatment programs which discouraged or prevented them from purging by vomiting. This factor may have artificially lowered the frequency with which these subjects used self-induced vomiting as a method of purging. In

addition, the suppression of this symptomatic behaviour may have highlighted self-regulatory and relational deficits which had previously been expressed through the symptomatic behaviour.

It is interesting to note that when the self-regulatory and relational variables were considered individually, rather than in a cononical correlation analysis, there was only one significant correlation between any of the self-regulatory and relational measures and the primary behavioral symptoms of bulimia (i.e., bingeing and vomiting). There were, however, statistically significant, moderate correlations between some of the self-regulatory variables (specifically anxiety, depression, and self-esteem), and some of the "cognitive" symptoms of bulimia, particularly body dissatisfaction, and fear of weight gain. More severe symptoms were associated with higher levels of anxiety and depression, and lower self-esteem.

It may also be relevant that no significant correlations were found between length of treatment and any of the symptoms of bulimia. Significant correlations, however, were found between length of treatment and depression, and moderate (though not statistically significant) correlations were found between length of treatment and anxiety and symptoms of fragmentation, with higher levels of depression, anxiety, and fragmentation symptoms being associated with longer treatment.

These two sets of relationships may simply reflect the fact that bulimic women tend to terminate treatment once their bingeing and

purging have been brought under control. The relationships may also indicate that the cognitive symptoms and the self-regulatory deficits (or dysphoric affects) associated with bulimia are more entrenched, and more recalcitrant to treatment than are the behavioral symptoms. In addition, the positive relationship between self-regulatory deficits and length of treatment may suggest that, as treatment progresses, and there is a decrease in the severity of bingeing and vomiting, self-regulatory deficits become more noticeable because the bulimic symptoms are no longer available to serve the self-regulatory function they once did. This latter interpretation, however, is contradicted by the finding that women in this sample of bulimics do not report a decrease in behavioral symptoms as treatment progresses.

Functions of Weight Control in Bulimic Women

It was hypothesized that weight loss serves a self-regulatory function for bulimic women. The ability to lose weight or to maintain a low body weight, in effect, compensates for their limited ability to modulate unpleasant affect, maintain a comfortable level of self-esteem, and prevent painful fragmentation experiences. Weight loss does this by providing for the bulimic woman some of the kinds of experiences a selfobject would provide such as affirmation of her value, soothing, and feelings of efficacy. Because body weight and shape are so salient to most women in this society at present, it was anticipated that imagined weight gain and loss would affect all women in a similar way to some extent; however it was predicted

that the effects of imagined weight gain and loss would be most prominent in the bulimic women.

The Effects of Imagined Weight Gain

In all but the depressed group, imagined weight gain had a statistically significant effect. An imagined weight gain of five pounds resulted in heightened feelings of depression and anxiety, greater vulnerability to fragmentation, and lowered self-esteem in the bulimic, dieting, and normal control groups. In the depressed group, the same imagined weight gain did not have a significant effect. The depressed group, in fact, reported feeling non-significantly better (i.e. they reported lower levels of depression, anxiety, and vulnerability to fragmentation, and higher self-esteem) than they felt in the trait condition.

The finding that imagined weight gain was distressing to most women was not surprising given the strong cultural value placed on thinness. What was more surprising was that the depressed group was not distressed by imagined weight gain. This difference between the depressed group and the other three groups might be explained by the fact that persons who are depressed often experience difficulties related to appetite and eating. Whereas some people tend to overeat when depressed, others experience loss of appetite, have difficulty eating, and may lose weight without wanting to do so. Because of the selection criteria for the depressed group in this study, the depressed subjects may have been more likely to experience decreased rather than increased appetite, and may

therefore have tended to be concerned about unexpected weight loss rather than about weight gain.

Differences between the typical (trait) levels of the self-regulatory summary variable, and the levels of the same variable under the imagined weight gain condition were so highly significant that no statistical distinction could be made among the bulimic, dieting, and normal control groups with regard to the relative effects of imagined weight gain on feelings of depression, anxiety, fragmentation, and self-esteem. It is interesting to note, however, that the absolute difference in means between the typical condition and the imagined weight gain condition on the self-regulatory summary variable was greater (though not significantly so) for the dieting group than it was for the bulimic group. This suggests that the bulimic group, in spite of their preoccupation with weight gain, and the extraordinary means they use to prevent weight gain, were no more distressed by the thought of unexpectedly gaining five pounds than were the dieters for whom weight gain is presumably also a very salient issue, but who do not use such extreme methods to achieve their ends. It is difficult to know how to interpret this observation. It is possible that, for the bulimic group, restriction of range is a factor affecting the scores on the self-regulatory summary variable. That is, the bulimic group's trait scores are significantly higher than those of the dieting group. This means that in reporting experiences under the imagined weight gain condition, there is a narrower range of the scale remaining above the portion already

used in reporting experiences under the typical condition. Another possible factor is that the bulimic group experiences weight fluctuations rather frequently and, as long as they have purging methods available to them, are more able to counteract the effects of weight gain than are the dieters who, presumably, are already using every acceptable means available to them to prevent weight gain. This may make imagined weight gain minimally less distressing for the bulimic group.

The Effects of Imagined Weight Loss

In all groups, imagined weight loss was associated with statistically significant decreases in anxiety, depression, and symptoms of fragmentation, and significant increases in self-esteem. This finding underlines, once again, the strength and pervasiveness of the cultural dictate that all women should be thin, and reflects the powerful effect of this dictate on the feelings and self-esteem of all the women in this sample. That the emotional effects of this cultural ideal of thinness bears little relationship to women's actual weight is demonstrated by examining data gathered from the depressed and normal control subjects in this sample. These subjects were chosen on the basis of being within a normal weight range, and were not actively trying to alter their weight. Subjects were excluded from these groups if they weighed less than 85% of expected weight for their age and height. Fully 26 of these 60 subjects weighed between 85% and 95% of expected weight - that is they would be considered to be at least slightly underweight, and in some cases of almost

anorexic weight. Only 9 of these 60 subjects were more than 10% above expected weight. Thus, the sample was skewed in the direction of women with rather low body weight. In spite of this, these women, on average, were distressed by the thought of gaining weight, and experienced increased well-being and heightened self-esteem at the thought of losing weight.

While all groups experienced significantly fewer symptoms of anxiety, depression, and fragmentation, and significant increases in self-esteem under the imagined weight loss condition than they did under the typical or trait condition, there were important differences between the bulimic group and the other three groups in this regard. The bulimic subjects were more positively affected by imagined weight loss than were subjects in any of the other three groups. This finding stands in contrast to the finding that the bulimic group differed only from the depressed group when differences in self-regulatory scores between the typical and imagined weight gain conditions were compared.

The finding that the bulimic group was relatively more positively affected by imagined weight loss than the other groups was expected. This finding might lead one to speculate that for the bulimic, losing weight not only wards off painful feelings, but perhaps more importantly provides an experience of calmness (low anxiety, low fragmentation anxiety), relative euphoria (low depression), and enhanced self-esteem which is perhaps hard to come by in any other way. This experience of heightened well-being

might be likened to a drug-induced euphoria, and just as one may become habituated to a drug, the bulimic may become habituated to the weight-loss-induced feelings of well-being, becoming increasingly dependent on weight loss to prevent a precipitous drop into a state of depression, fragmentation, and low self-esteem. If this reflects the bulimic's experience, it is not difficult to empathize with the bulimic's single-minded preoccupation with weight loss.

Because their scores on the trait measures of self-regulatory deficits did not differ significantly, it is interesting to compare the relative effects of imagined weight gain and loss on the self-regulatory scores of the bulimic and the depressed groups. As was noted in the previous section, under the imagined weight gain condition, the bulimic group scored significantly higher on this variable than the depressed group. Conversely, under the imagined weight loss condition, the bulimic group scored significantly lower than the depressed group. This indicates a greater range of affect and self-esteem in the bulimic group than in the depressed group.

When the individual scores on the variables comprising the self-regulatory summary variable are examined it becomes evident that scores on the depression scale make a particularly important contribution to this larger range of affect and self-esteem in the bulimic group. Under both the trait condition and the imagined weight gain condition, the bulimics' scores did not differ significantly from those of the depressed subjects. Under the imagined weight loss condition, however, the scores of the bulimic group were

significantly lower than those of the depressed group. Not only are the bulimic subjects less depressed than the depressed subjects; they are not significantly more depressed than the dieting and normal control subjects. This suggests that weight loss may play a particularly important role in alleviating depression in bulimic women.

Although this study establishes a relationship between imagined weight loss and increased feelings of well-being, including heightened self-esteem, in bulimic women; and although the effect of imagined weight loss is more pronounced in the bulimic women than it is in any of the other groups of women in this study, it may not be justified to make the leap of attributing this heightened well-being to the self-regulatory function of weight control. Certainly losing weight does serve the function of helping the bulimic feel "better" than she typically feels. Certainly the evidence is consistent with the idea that weight loss serves a self-regulatory function. Not enough information has been gathered about the processes involved, however, to attribute a true self-regulatory function to weight loss in the bulimic subjects. Furthermore, if weight loss serves a self-regulatory function for bulimic women, the data suggests that it does the same for the other women in the sample too. If nothing, other than the *more extreme* effect of weight loss on affect and self-esteem, sets the bulimic subjects apart from the other subjects, this seems insufficient evidence from which to conclude that weight loss serves a unique self-regulatory function in bulimic women.

Limitations of the Study

One limitation of the study relates to the samples of bulimic and depressed women selected. These samples included only women who were in treatment at the time of their participation in the study. In addition, all subjects were self-selected. It is therefore possible that the bulimic and depressed subjects in the study differ in significant ways from bulimic or depressed women who are not receiving treatment, or who chose not to participate in the study. For example, subjects in the sample may be more distressed by their symptoms, or more willing to admit to having problems than bulimic or depressed women who have not sought treatment. Therefore, caution should be exercised in generalizing the results of this study to the total population of bulimic or depressed women.

A second limitation of the study concerns the high correlations among some of the measures of self-regulatory deficits. These high correlations raise important questions about the meaning of the results. Although one would expect that persons who are depressed would also be anxious, and would also experience some lack of self cohesion and decrease in self-esteem, the strength of the relationships among these variables in this sample is greater than was anticipated. This raises the question of whether the five scales measure different constructs, or are no more than separate measures of a kind of "generic distress". The question is particularly interesting in the context of self theory, as the theory suggests that

depression, anxiety, and lowered self-esteem are manifestations of loss of self cohesion. Wolf (1988) notes, for example:

> The person whose self *regresses* from a state of cohesion to one of partial or total loss of structure experiences this as a loss of self-esteem, or as a feeling of emptiness, or depression, or worthlessness, or anxiety...Generally, when we talk about someone fragmenting, we mean a degree of regression associated with symptoms of subjective discomfort. (p. 39)

Furthermore, Wolf states that all major clinical diagnostic categories "always imply damage to the self's structural integrity and strength secondary to faulty selfobject responsiveness" (1988, p. 185). If this is the case, then perhaps these affects would be expected to co-exist to a greater degree in persons with self disorders than they would in persons who experienced these symptoms in other contexts.

It is of interest to note that, on average, the depressed subjects had higher scores on each of these measures than the bulimic subjects, although these differences were not statistically significant. This finding may be accounted for by the fact that 6 of the 30 bulimic subjects did not meet criteria for depression. A comparison of the scores of the depressed vs. the non-depressed bulimics on the self-regulatory measures indicated that the non-depressed bulimics differed from the depressed bulimics only on the measures of depression and symptoms of fragmentation. Their levels of soothing receptivity, anxiety, and self-esteem were not significantly different. These findings suggests that depression contributes to, but is not the only expression of self-regulatory deficits.

This leads to another question vis a vis the appropriateness of the scales used to measure self-regulatory deficits: Is measuring typical levels of affects and self-esteem a valid way of assessing self-regulatory deficits? Although self disorders are always associated with difficulties in regulating affect and self-esteem, it is not universally accepted that self disorders are the *only* cause of depression, anxiety or lowered self-esteem. In addition, even persons with significant vulnerability to fragmentation may, in the presence of a suitably responsive selfobject environment, experience periods of relative stability during which they feel calm, optimistic, and worthwhile. To answer this question, more qualitiative, process-oriented research is needed, using clinical groups with a variety of traditional diagnoses who have also been identified as having the self-regulatory deficits associated with self disorders.

Finally, the procedure of asking subjects to respond to certain measures under conditions of imagined weight gain and imagined weight loss may lead to some difficulties in interpreting the data collected in this manner. It is impossible to know how closely these imagined states resemble "real" states of weight gain and weight loss; and therefore it is also impossible to know how accurately the thoughts, feelings, and behaviours subjects reported under these imagined conditions, reflect the thoughts, feelings, and behaviours they would report under conditions of real weight gain or loss.

It is possible, for example, that bulimics are motivated by the fantasy or belief that losing weight will raise their self-esteem, make

them feel less distressed, or solve all their problems. However, the data suggests that this does not happen in reality. It is possible, then, that the wish for or fantasy of what weight loss will accomplish for the bulimic woman is more important than, but different from the experience of actually losing weight. If this is the case, then the data collected under the conditions of imagined weight gain and imagined weight loss may be somewhat misleading.

Directions for Future Research

Like much research, this study raises more questions than it answers. The questions related to the validity of the postulates set forth by self psychology theory are confounded by the absence of valid instruments with which to measure the relevant concepts. For example, valid measures of self-regulatory functions, self-cohesion, and selfobject experiences need to be developed before meaningful, empirically valid research in the field of self psychology can continue.

Once valid, reliable psychometric instruments have been developed, an exploration of specific questions can begin. Some of the questions raised by this study, for example, are the following:

(1) What is the nature of the relationship among self-regulatory deficits, depression, and the symptoms of bulimia? In attempting to answer this question comparisons need to be made between, for example, depressive symptoms and self-regulatory deficits in chronic and non-chronic bulimics; self-regulatory deficits and bulimic symptomatology in depressed and non-depressed

bulimics; and depression and self-regulatory deficits in symptomatic and recovered bulimics.

(2) What is the nature of the relationship between self-regulatory deficits, relational experiences, and the symptomatology of diagnostic groups other than bulimia and depression? Do these deficits manifest themselves differently in, or distinguish among different patient groups? Do they suggest different treatment foci for the various patient groups or, conversely, do these self-regulatory deficits and relational experiences provide an entirely different way of observing and categorizing which cuts across traditional diagnostic categories?

(3) The study also raises questions about the usefulness of self psychological concepts in the treatment of eating disorders. If, as this research suggests, self-regulatory deficits and relational experiences are significant features associated with eating disorders (or at least with bulimia), then it would seem important to make therapists more aware of these issues and to address them in treatment. In this regard, controlled research needs to be done to compare different modes of treatment with respect to their abilities to provide structure-building selfobject experiences. In this regard, longterm outcome studies are particularly important, as successful treatment using self psychology concepts claims to promote structural change rather than simply remove symptoms.

If this is the case, then relapse should be less common in persons successfully treated using self psychology concepts than it is in persons treated using more symptom-oriented types of treatment.

(4) Finally, the impact of socio-cultural factors in the development of eating disorders was once again corroborated by the findings of this study. Within the context of self theory, it might be useful to ask whether healthy self-esteem, and a well-integrated experience of self reduces, to some extent, the risk of committing oneself to socially popular ideals, such as thinness, at the expense of one's physical and emotional well-being.

# APPENDICES

## Graduated Mean Weights in Pounds of Women Aged 17 - 39

| Height in Feet and Inches | Age in Years | | | |
|---|---|---|---|---|
| | 17 - 19 | 20 - 24 | 25 - 29 | 30 - 39 |
| 4' 10" | 103 | 105 | 110 | 113 |
| 4' 11" | 108 | 110 | 112 | 115 |
| 5' 0" | 111 | 112 | 114 | 118 |
| 5' 1" | 115 | 118 | 119 | 121 |
| 5' 2" | 119 | 120 | 121 | 124 |
| 5' 3" | 123 | 124 | 125 | 128 |
| 5' 4" | 126 | 127 | 128 | 131 |
| 5' 5" | 129 | 130 | 132 | 134 |
| 5' 6" | 132 | 133 | 134 | 137 |
| 5' 7" | 136 | 137 | 138 | 141 |
| 5' 8" | 140 | 141 | 142 | 145 |
| 5' 9" | 145 | 146 | 148 | 150 |
| 5' 10" | 148 | 149 | 150 | 153 |
| 5' 11" | 150 | 155 | 156 | 159 |
| 6' 0" | 154 | 157 | 159 | 164 |

Source: Ad Hoc Committee of the New Build and Blood Pressure Study, Association of Life Insurance Medical Directors of America and Society of Actuaries, 1979.

# APPENDIX B

159 Kingsmount Park Rd.
Toronto, Ontario, M4L 3L7
date

inside address

Dear _____:

I am a Ph.D. student in the Clinical Psychology Program at the University of Windsor, Windsor, Ontario. I am currently doing my dissertation research on self-regulatory deficits and the functions of weight control in bulimic women. To complete my research, I need to find 30 [bulimic/depressed] women who would be willing to respond to a confidential questionnaire which takes approximately one hour to complete, and which can be returned to me by mail. I am providing remuneration of $10.00 to respondents who qualify and who return a completed questionnaire to me.

I am writing to you because I understand that you work with [eating-disordered/depressed] women, and I would be interested in discussing with you the possibility of involving some of the [bulimic/depressed] women who are in treatment with you as subjects in my research study.

I would be glad to provide you with a copy of the questionnaire and/or the research proposal which has been approved by the Ethics Committee at the University of Windsor. If you think it would be appropriate, I would also be more than happy to meet with any interested women to tell them about the study and answer any questions they might have about it.

Thank you in advance for any help you are able to give me. I will give you a call in the next couple of weeks so that we can discuss this matter in more detail. I look forward to talking with you.

Sincerely,

Carole Vipond
(416) 690-7789

# APPENDIX C

## Newspaper Advertiements for Subject Recruitment

### 1. Advertisement for Depressed Women

Depressed Women
Needed to complete a questionnaire by mail. Must be 18 - 35, currently depressed, receiving treatment for depression, and not dieting. Thesis research. Confidential. Remuneration provided. Leave a message for Carole 690-7789.

### 2. Advertisement for Overweight Dieters

Research Study
Women aged 18 - 35 needed to complete a questionnaire by mail. Must be 30 - 70 lbs. overweight and dieting but not depressed. Dissertation research. Confidential. Remuneration provided. Leave a message for Carole 690-7789.

# APPENDIX D

## SCREENING INTERVIEW FOR TELEPHONE INQUIRIES

Which study are you calling about? depression study [ ]
dieting study [ ]

How old are you? ____ _ (If not between 18 and 35 years, end interview.)

What is your present height? weight? _____ (check inclusion/exclusion criteria)

Are you currently dieting to lose weight? If yes, how long? How many days in the last month?

If dieting, how much weight, if any, have you lost in the last month? _____

If dieting, what methods of weight control do you use almost every day?_____

Do you ever eat large quantities of food in a short time? (If yes, inquire about frequency, loss of
control, specific example of type and quantities of food consumed.)

I need to ask you a few questions about your mood to determine your eligibility for this study. Please respond to the following statements, indicating whether or not you have experienced these feelings NEARLY EVERY DAY FOR AT LEAST THE PAST TWO WEEKS.

| Nearly every day for the last two weeks..... | TRUE | FALSE |
|---|---|---|
| 1. I've been feeling sad. | [ ] | [ ] |
| 2. I don't feel hopeful about my life. | [ ] | [ ] |
| 3. I seem to worry all the time. | [ ] | [ ] |
| 4. I've been feeling irritable. | [ ] | [ ] |
| 5. I'm often afraid. | [ ] | [ ] |
| 6. I don't have much interest in my activities. | [ ] | [ ] |
| 7. I don't sleep well at all. | [ ] | [ ] |
| 8. I sleep excessively (missing appointments, sleeping for most of the day, or going to bed very early). | [ ] | [ ] |
| 9. I don't have a very good appetite. | [ ] | [ ] |
| 10. My appetite has increased significantly. | [ ] | [ ] |
| 11. I feel agitated (pressure toward excessive movement or speech). | [ ] | [ ] |
| 12. I feel like I move, think, or react more slowly than usual. | [ ] | [ ] |
| 13. I don't have as much interest in sex as usual. | [ ] | [ ] |
| 14. I don't have as much energy as usual. | [ ] | [ ] |
| 15. I feel tired most of the time. | [ ] | [ ] |

| | | |
|---|---|---|
| 16. I feel guilty a good deal of the time. | [ ] | [ ] |
| 17. I don't think I'm as good a person as others are. | [ ] | [ ] |
| 18. I have trouble thinking clearly. | [ ] | [ ] |
| 19. I have trouble concentrating. | [ ] | [ ] |
| 20. I often think about death and dying. | [ ] | [ ] |

INCLUSION CRITERIA FOR DEPRESSION

A. AT LEAT 2 OF THE FIRST 6 ITEMS MUST BE TRUE
B. 1 ITEM IN AT LEAST 4 OF THE FOLLOWING ITEM-PAIRS MUST BE TRUE:
7 or 8; 9 or 10; 11 or 12; 6 or 13; 14 or 15; 16 or 17; 18 or 19; 20.

Are you presently receiving treatment for depression? an eating disorder? other difficulties?

RESPONDENT MEETS CRITERIA FOR:

| | |
|---|---|
| Bulimic group | [ ] |
| Depressed group | [ ] |
| Dieting group | [ ] |
| None of the above | [ ] |

Name _____

Address _____

_____

_____

# APPENDIX E

Date

Dear Research Participant,

First, let me thank you for agreeing to take part in this study!

I am a graduate student in Clinical Psychology at the University of Windsor, and am conducting a research study on various aspects of personality as they relate to eating behaviours, and attitudes about weight and shape. I will be making comparisons among four groups of women (depressed women, overweight dieters, bulimic women, and normal-weight, non-dieting women who are not depressed). I do not want to tell you exactly what I am trying to find out at this time, because it could affect the way you respond to the questionnaire; however, if you are interested in finding out about the results of the study, please complete the request form on the last page of the questionnaire (or give your name to your therapist) and I will be glad to send you a summary of my findings. Please be patient though - I don't expect to complete the study for about a year!

You will find enclosed 2 copies of a Consent Form, and a questionnaire with a number on it. Please read the Consent Form and sign both copies if you agree to take part in the study. One copy of the Consent Form is for you to keep. The other copy should be returned with your questionnaire.

I think you will find that the questionnaire is fairly straightforward. It takes an average of about an hour to complete. Just be sure to follow the instructions at the beginning of each section exactly. Otherwise the information you give may not be accurate, and the results of the study might not be valid. Your responses will be kept confidential and will not be identified with you in any way, even if you choose to include your name on the questionnaire.

After you have completed the questionnaire, please return it to me in the enclosed stamped envelope. When I receive your questionnaire you will be paid $10.00. I will mail a cheque to you directly if I have your name and address, or forward it to your therapist to give to you if I do not have your name and address.

Once again, thank you for participating in this study. I hope that through this research your time, effort, and experience will contribute to an increased understanding of eating disorders, and to their successful treatment and prevention.

Sincerely,

Carole Vipond
University of Windsor
(416) 690-7789

# APPENDIX F

## CONSENT FORM

### Research Study on Personality, Eating Behaviour, and Attitudes Toward Weight and Shape

I am a Ph.D. student at the University of Windsor. As part of my degree requirements, I am conducting a study on the relationships between certain aspects of personality and attitudes about weight, shape, and eating.

Participation in this study is completely voluntary. If you agree to participate, you will be asked to complete a questionnaire in which you will answer questions and rate statements related to your attitudes about weight, shape, and eating. You will also be asked questions about your feelings and attitudes toward yourself and your life.

The questionnaire will take approximately 60-90 minutes to complete.

You may receive feedback on the results of the study by indicating your wish to do so in the space provided at the end of the questionnaire.

If you agree to participate in this research project, your rights will be protected in the following ways:

1. The information you provide will remain confidential and will not be identified with you in any way.

2. The information you provide will be used for research purposes only.

3. You will not be asked to do or to reveal anything that will be harmful to you in any way.

4. You may discontinue your participation in the study at any time without suffering any consequences.

5. This study has been reviewed and approved by the Ethics Committee of the University of Windsor's Psychology Department.

6. You may report any complaint you have, regarding any procedure that you believe violates your welfare, to the University of Windsor, Office of Research Services ([519] 253-4232, ext. 3916) for referral to the Ethics Committee.

### AGREEMENT TO PARTICIPATE

I have read the above information, understand it, and agree to participate in this study.

Signature _____

Date _____

PLEASE RETURN THIS COPY WITH YOUR QUESTIONNAIRE

# APPENDIX G

## EATING ATTITUDES QUESTIONNAIRE

### INTRODUCTION

This questionnaire consists of three parts:

PART I includes some general information questions, some questions about your mood, and questions about your attitudes toward food and weight.

PART II includes a number of scales which ask you about your general attitudes and feelings about yourself and your life.

PART III includes questions about the feelings you have in two different situations related to weight.

You may notice that some of the statements or questions you will be asked to respond to in different parts of the questionnaire are similar or exactly alike. Don't look back to see what your earlier responses were. There is no need for your answers to be consistent. Just respond honestly to each question as you come to it.

PLEASE READ THE INSTRUCTIONS AT THE BEGINNING OF EACH SECTION CAREFULLY BEFORE ANSWERING THE QUESTIONS. When you are sure that you understand the instructions, go ahead. Please try to ANSWER EVERY QUESTION. Your answers will be kept confidential, and will not be identified with you in any way.

Now, go on to Part I.

## PART I

### GENERAL INFORMATION, EATING ATTITUDES AND MOOD

You will be using several different rating scales to answer the questions in this section. PLEASE BE SURE TO READ EACH RATING SCALE CAREFULLY, AND USE THE APPROPRIATE RATING SCALE FOR EACH SET OF QUESTIONS.

## GENERAL INFORMATION

Name (please print) _____

Address (please print)_____

_____

_____

Phone (_____) _____
area code

Age _____

Height _____

Present weight _____

Education (last grade completed) _____

Father's occupation _____

Mother's occupation _____

Father's education _____

Mother's education _____

Are you presently receiving psychotherapy or attending a support/ self-help group? yes [ ]
no [ ]

If yes, what type of therapy?
individual therapy [ ]
group therapy [ ]
self-help/support group [ ]
other (please specify) _____

If yes, what is/are the main problem(s) for which you sought help? (Check as many as are applicable.)
depression [ ]
eating disorder [ ]
obesity [ ]
other (please specify _____
_____

If you are in therapy or attending a self-help/support group, how long have you been attending? _____

## EATING PATTERNS AND ATTITUDES

This group of questions asks you about some of your eating patterns and attitudes over the last 4 WEEKS. For each question, please use the rating scale below, and CIRCLE THE NUMBER below each question that indicates the NUMBER OF DAYS IN THE LAST 4 WEEKS that you have done what is asked in each question.

### RATING SCALE

0 - NEVER (0 days in the last 4 weeks)
1 - RARELY (1-5 days in the last 4 weeks)
2 - SOMETIMES (6-12 days in the last 4 weeks)
3 - ABOUT HALF THE TIME (13-15 days in the last 4 weeks)
4 - FREQUENTLY (16-22 days in the last 4 weeks)
5 - ALMOST EVERY DAY (23-27 days in the last 4 weeks)
6 - EVERY DAY (28 days in the last 4 weeks)

1. How often in the last 4 weeks did you eat the following meals or snacks?

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| breakfast | 0 | 1 | 2 | 3 | 4 | 5 | 6 |
| mid-morning snack | 0 | 1 | 2 | 3 | 4 | 5 | 6 |
| lunch | 0 | 1 | 2 | 3 | 4 | 5 | 6 |
| mid-afternoon snack | 0 | 1 | 2 | 3 | 4 | 5 | 6 |
| dinner | 0 | 1 | 2 | 3 | 4 | 5 | 6 |
| evening snack | 0 | 1 | 2 | 3 | 4 | 5 | 6 |
| middle-of-the-night snack | 0 | 1 | 2 | 3 | 4 | 5 | 6 |

2. In the last 4 weeks, how much of the time have you been consciously trying to limit the amount of food you ate so that you could lose weight or look better?
0 1 2 3 4 5 6

3. In the last 4 weeks, how often have you gone for periods of 8 or more waking hours without eating anything so that you could lose weight or change you body shape?
0 1 2 3 4 5 6

4. How often in the last 4 weeks have you tried to keep your calorie intake below a certain limit?
0 1 2 3 4 5 6

5. If you circled 4, 5, or 6 in question 4., what was your calorie limit for those days?
_____ calories per day.

6. How often over the last 4 weeks have you been so preoccupied with thoughts about your weight or shape that those thoughts have interfered with your ability to concentrate on other things?
0 1 2 3 4 5 6

7. On average over the last 4 weeks, how dissatisfied have you been with the shape of your body?

| 1 | 2 | 3 | 4 |
|---|---|---|---|
| not at all | slightly | moderately | extremely |

Now I would like to know about some of your attitudes and behaviours related to eating and weight over the last 3 MONTHS. To make it easier for you to recall that period of time, please ask yourself the following questions: (You don't need to write down your answers.)

What was the date 3 months ago today?
What were some of the events in your life around that time? Since that time?
Did you make any decisions or changes in your life around that time?
What feelings do you remember having about yourself or your life around that time?

When you are able to identify and remember that period of your life fairly clearly, please answer the following questions as accurately as you can.

8. What is your present weight? _____ lbs.

9. What has your average weight been over the last 3 months? _____

10. How long have you been within 10 lbs. of this average weight?

| | | | |
|---|---|---|---|
| less than 6 months | [ ] | 2 - 5 years | [ ] |
| 6 months to 1 year | [ ] | over 5 years | [ ] |
| 1 - 2 years | [ ] | | |

11. Over the last 3 months, have you been making an effort to stay at your average weight or to lose weight?

yes [ ] no [ ]

12. What weight would you like to be? _____

13. If you imagine the ways in which you evaluate your worth or success in life (based on things like your performance at work or school, your relationships, your skills and talents etc.), how important have your weight and shape been, over the last 3 months, in the way you evaluate yourself? (Check one box in the 'weight' column, and one box in the 'shape' column.)

| | weight | shape |
|---|---|---|
| not at all important | [ ] | [ ] |
| slightly important | [ ] | [ ] |
| moderately important | [ ] | [ ] |
| very important | [ ] | [ ] |
| nothing is more important | [ ] | [ ] |

Please use the rating scale below to answer the following questions, unless otherwise indicated. (This rating scale is similar to the one you used in the earlier questions, but covers a 3 MONTH period rather than a 4 week period.)

RATING SCALE

0 - NEVER (0 days in the last 3 months)
1 - RARELY (1-14 days in the last 3 months)
2 - SOMETIMES (15-34 days in the last 3 months)
3 - ABOUT HALF THE TIME (35-49 days in the last 3 months)
4 - FREQUENTLY (50-77 days in the last 3 months)
5 - ALMOST EVERY DAY (78-89 days in the last 3 months
6 - EVERY DAY (90- days in the last 3 months)

14. How often in the last 3 months have you felt that you are too fat?
0 1 2 3 4 5 6

15. How often in the last 3 months have you been afraid that you might gain weight or get too fat?
0 1 2 3 4 5 6

16. How often in the last 3 months have you felt that any particular part of you body is too fat?
0 1 2 3 4 5 6

17. How often in the last 3 months have you tried to follow certain rigid rules regarding your eating (e.g. a calorie limit, pre-set quantities of food, or rules about what or when you should eat)?
0 1 2 3 4 5 6

18. If you circled 4, 5, or 6 in question 17, what were the rules you followed?

_____
_____
_____

19. If you circled 4, 5, or 6 in question 17, how upset did you feel if you broke any of your dietary rules?

not at all upset [ ]
slightly upset [ ]
moderately upset [ ]
extremely upset [ ]
I never broke any of my rules [ ]

20. How often, over the last 3 months have you experienced a feeling of loss of control over your eating (i.e. a feeling that you could not resist eating even if you wanted to, or a feeling that you could not stop eating once you started)?
0 1 2 3 4 5 6

RATING SCALE

0 - NEVER (0 days in the last 3 months)
1 - RARELY (1-14 days in the last 3 months)
2 - SOMETIMES (15-34 days in the last 3 months)
3 - ABOUT HALF THE TIME (35-49 days in the last 3 months)
4 - FREQUENTLY (50-77 days in the last 3 months)
5 - ALMOST EVERY DAY (78-89 days in the last 3 months
6 - EVERY DAY (90+ days in the last 3 months)

21. How often in the last 3 months have you eaten what most people would consider a very large amount of food in a very short time?

never [ ]
less than once a week [ ]
more than once a week but less than twice a week [ ]
2 - 5 times a week [ ]
almost daily [ ]
more than once a day [ ]

22. If you had any episodes of bingeing, creating large quantities of food in a short time in the last 3 months, what did you typically eat during a single one of these episodes? (Please list all items with quantities. (e.g. 1 large bag chips, 3 chocolate bars, etc.)

_____

_____

_____

_____

23. Do you think that you could have resisted these episodes of eating (i.e. prevented them from occurring or stopped them once they started?

yes [ ] no [ ] I had no such episodes [ ]

24. Over the last 3 months how often have you done each of the following things as a means of controlling your weight or shape, or to counteract the effects of eating? (Use the scale at the top of p. 4 for this question.)

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| (a) used laxatives | 0 | 1 | 2 | 3 | 4 | 5 | 6 |
| (b) used diuretics ('water pills', special teas etc.) | 0 | 1 | 2 | 3 | 4 | 5 | 6 |
| (c) made yourself vomit | 0 | 1 | 2 | 3 | 4 | 5 | 6 |
| (d) followed strict dietary rules | 0 | 1 | 2 | 3 | 4 | 5 | 6 |
| (e) exercised vigorously | 0 | 1 | 2 | 3 | 4 | 5 | 6 |

25. For each item in question 24 that you circled 3, 4, 5, or 6, has there been a period of 2 weeks or more in the last 3 months that you have NOT engaged in this behaviour?

| | yes | no | not applicable |
|---|---|---|---|
| (a) using laxatives | [ ] | [ ] | [ ] |
| (b) using diuretics | [ ] | [ ] | [ ] |
| (c) inducing vomiting | [ ] | [ ] | [ ] |
| (d) strict dieting | [ ] | [ ] | [ ] |
| (e) vigorous exercising | [ ] | [ ] | [ ] |

26. How many menstrual periods have you had in the last 3 months? _____

27. Have you used oral contraceptives or any other hormone preparation in the last 3 months?

yes [ ] no [ ]

MDI

Please respond to the following statements indicating whether you have experienced these feelings NEARLY EVERY DAY FOR AT LEAST THE PAST TWO WEEKS.

| Nearly every day for the last two weeks..... | TRUE | FALSE |
|---|---|---|
| 1. I've been feeling sad. | [ ] | [ ] |
| 2. I don't feel hopeful about my life. | [ ] | [ ] |
| 3. I seem to worry all the time. | [ ] | [ ] |
| 4. I've been feeling irritable. | [ ] | [ ] |
| 5. I'm often afraid. | [ ] | [ ] |
| 6. I don't have much interest in my activities. | [ ] | [ ] |
| 7. I don't sleep well at all. | [ ] | [ ] |
| 8. I sleep excessively (missing appointments, sleeping for most of the day, or going to bed very early). | [ ] | [ ] |
| 9. I don't have a very good appetite. | [ ] | [ ] |
| 10. My appetite has increased significantly. | [ ] | [ ] |
| 11. I feel agitated (pressure toward excessive movement or speech). | [ ] | [ ] |
| 12. I feel like I move, think, or react more slowly than usual. | [ ] | [ ] |
| 13. I don't have as much interest in sex as usual. | [ ] | [ ] |
| 14. I don't have as much energy as usual. | [ ] | [ ] |
| 15. I feel tired most of the time. | [ ] | [ ] |
| 16. I feel guilty a good deal of the time. | [ ] | [ ] |
| 17. I don't think I'm as good a person as others are. | [ ] | [ ] |
| 18. I have trouble thinking clearly. | [ ] | [ ] |
| 19. I have trouble concentrating. | [ ] | [ ] |
| 20. I often think about death and dying. | [ ] | [ ] |

## PART II

### GENERAL ATTITUDES ABOUT YOURSELF AND YOUR LIFE

Please rate the following statements according to how you GENERALLY FEEL. Follow the instructions at the beginning of each set of statements, being sure to USE THE APPROPRIATE RATING SCALE for each set of statements.

## SRS

This questionnaire is used to determine the different ways people respond to being emotionally upset. Using the scale below, please rate how much you agree or disagree with each of the following statements by circling the number that best describes you own feelings. When making your ratings, imagine that each statement begins with "Generally when I am upset..." You can think about "upset" as meaning, for example, sad, or depressed or anxious, or unhappy, or nervous etc., whichever is easiest for you to imagine when rating the statements.

### RATING SCALE

1 - STRONGLY AGREE
2 - MODERATELY AGREE
3 - NEITHER AGREE NOR DISAGREE
4 - MODERATELY DISAGREE
5 - STRONGLY DISAGREE

GENERALLY, WHEN I AM UPSET.....

| | | | | | | |
|---|---|---|---|---|---|---|
| 1. | People find it hard to cheer me up. | 1 | 2 | 3 | 4 | 5 |
| 2. | I can recall a pleasant memory that will have a soothing effect on me if I want to. | 1 | 2 | 3 | 4 | 5 |
| 3. | Going to see a friend will pick me up. | 1 | 2 | 3 | 4 | 5 |
| 4. | A warm bath can be a soothing experience for me. | 1 | 2 | 3 | 4 | 5 |
| 5. | Being held and cuddled by someone close to me will soothe me. | 1 | 2 | 3 | 4 | 5 |
| 6. | I find that even if I talk about it a lot with others, I really don't feel much better afterwards. | 1 | 2 | 3 | 4 | 5 |
| 7. | Just spending time with someone close to me will help me to feel better. | 1 | 2 | 3 | 4 | 5 |
| 8. | I rebound quickly from whatever is upsetting me. | 1 | 2 | 3 | 4 | 5 |
| 9. | I actively try to find someone to be with who can cheer me up. | 1 | 2 | 3 | 4 | 5 |
| 10. | Time is the main thing that helps me to feel better. | 1 | 2 | 3 | 4 | 5 |
| 11. | I keep my feelings to myself so others won't try to comfort me. | 1 | 2 | 3 | 4 | 5 |
| 12. | Although it may be hard for me to talk about whatever is upsetting me, I still like having someone hold me and comfort me. | 1 | 2 | 3 | 4 | 5 |

RATING SCALE

1 - STRONGLY AGREE
2 - MODERATELY AGREE
3 - NEITHER AGREE NOR DISAGREE
4 - MODERATELY DISAGREE
5 - STRONGLY DISAGREE

GENERALLY, WHEN I AM UPSET.....

| | | | | | | |
|---|---|---|---|---|---|---|
| 13. | Talking things over with a friend provides only momentary comfort. | 1 | 2 | 3 | 4 | 5 |
| 14. | Listening to music (or reading a book, watching a movie, or a similar activity) will soothe me. | 1 | 2 | 3 | 4 | 5 |
| 15. | I find it hard to cheer myself up. | 1 | 2 | 3 | 4 | 5 |
| 16. | The experience of nestling in the arms of someone close to me is a soothing one. | 1 | 2 | 3 | 4 | 5 |
| 17. | I respond well when someone tries to cheer me up. | 1 | 2 | 3 | 4 | 5 |
| 18. | Having someone hold and cuddle me may not help me to feel any better. | 1 | 2 | 3 | 4 | 5 |
| 19. | Meditation or relaxation exercises can have a soothing effect on me. | 1 | 2 | 3 | 4 | 5 |
| 20. | I rarely ask other people for help with whatever is troubling me. | 1 | 2 | 3 | 4 | 5 |

## STAI-T

Below are a number of statements which people have used to describe themselves. Using the rating scale below, read each statement and then circle the number at the right of the statement that best describes how you GENERALLY feel.

### RATING SCALE

1 - ALMOST ALWAYS
2 - OFTEN
3 - SOMETIMES
4 - ALMOST NEVER

| | | |
|---|---|---|
| 1. | I feel pleasant. | 1 2 3 4 |
| 2. | I feel nervous and restless. | 1 2 3 4 |
| 3. | I feel satisfied with myself. | 1 2 3 4 |
| 4. | I wish I could be as happy as others seem to be. | 1 2 3 4 |
| 5. | I feel like a failure. | 1 2 3 4 |
| 6. | I feel rested. | 1 2 3 4 |
| 7. | I am "calm, cool, and collected". | 1 2 3 4 |
| 8. | I feel that difficulties are piling up so that I cannot overcome them. | 1 2 3 4 |
| 9. | I worry too much over something that doesn't really matter. | 1 2 3 4 |
| 10. | I am happy. | 1 2 3 4 |
| 11. | I have disturbing thoughts. | 1 2 3 4 |
| 12. | I lack self-confidence. | 1 2 3 4 |
| 13. | I feel secure. | 1 2 3 4 |
| 14. | I make decisions easily. | 1 2 3 4 |
| 15. | I feel inadequate. | 1 2 3 4 |
| 16. | I am content. | 1 2 3 4 |
| 17. | Some unimportant thought runs through my mind and bothers me. | 1 2 3 4 |
| 18. | I take disappointments so keenly that I can't put them out of my mind. | 1 2 3 4 |
| 19. | I am a steady person. | 1 2 3 4 |
| 20. | I get in a state of tension or turmoil as I think over my recent concerns. | 1 2 3 4 |

DPI - D

This questionnaire consists of a number of statements that people have used to describe themselves. Read each statement and check either the 'true' or the 'false' box beside each statement depending on whether or not you think the statement GENERALLY describes your

... ...u feel at the present moment.

| | | TRUE | FALSE |
|---|---|---|---|
| 1. | I feel that I have a number of accomplishments in my life of which I am justly proud. | [ ] | [ ] |
| 2. | My friends seem to have more fun than I do. | [ ] | [ ] |
| 3. | I have rarely, if ever, felt that my life was worthless. | [ ] | [ ] |
| 4. | I don't believe that I can live up to what is expected of me. | [ ] | [ ] |
| 5. | I am as happy as my friends. | [ ] | [ ] |
| 6. | I never seem to be really happy. | [ ] | [ ] |
| 7. | I feel that I can be as successful as others at most things | [ ] | [ ] |
| 8. | I do not think that I am good enough to succeed at many of my undertakings. | [ ] | [ ] |
| 9. | I am confident that I will do well in most things that I try. | [ ] | [ ] |
| 10. | Others always seem to enjoy life more than I. | [ ] | [ ] |
| 11. | I believe that life is very interesting. | [ ] | [ ] |
| 12. | I always feel insignificant. | [ ] | [ ] |
| 13. | My future is bright. | [ ] | [ ] |
| 14. | I usually think that other people are better than I. | [ ] | [ ] |
| 15. | I usually trust in my ability to do a good job. | [ ] | [ ] |
| 16. | I am in a rut. | [ ] | [ ] |
| 17. | I put much faith in my ability to overcome seemingly hopeless situations. | [ ] | [ ] |
| 18. | I sometimes become saddened and consider committing suicide. | [ ] | [ ] |
| 19. | I have as much confidence in my ability as most people have. | [ ] | [ ] |
| 20. | I often think that my life has been wasted. | [ ] | [ ] |

SE - T

This questionnaire consists of a number of statements with which you may or may not agree. Please read each statement and, using the rating scale below, indicate how much you agree or disagree with each statement by circling the number beside it that most closely corresponds to your opinion or experience. There are no right or wrong answers.

RATING SCALE

1 - AGREE STRONGLY
2 - AGREE MODERATELY
3 - AGREE SLIGHTLY
4 - DISAGREE SLIGHTLY
5 - DISAGREE MODERATELY
6 - DISAGREE STRONGLY

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| 1. | I have very clear goals in life. | 1 | 2 | 3 | 4 | 5 | 6 |
| 2. | Criticism or scolding makes me very uncomfortable. | 1 | 2 | 3 | 4 | 5 | 6 |
| 3. | I tend to be restless and irritable. | 1 | 2 | 3 | 4 | 5 | 6 |
| 4. | I feel quite content even when I am doing ordinary everyday things. | 1 | 2 | 3 | 4 | 5 | 6 |
| 5. | I am optimistic that things will generally turn out well. | 1 | 2 | 3 | 4 | 5 | 6 |
| 6. | I feel that nobody really cares about me. | 1 | 2 | 3 | 4 | 5 | 6 |
| 7. | I find it hard to make even simple decisions. | 1 | 2 | 3 | 4 | 5 | 6 |
| 8. | I am easily discouraged. | 1 | 2 | 3 | 4 | 5 | 6 |
| 9. | Life is interesting and exciting. | 1 | 2 | 3 | 4 | 5 | 6 |
| 10. | I find it hard to concentrate on a task or job. | 1 | 2 | 3 | 4 | 5 | 6 |
| 11. | Facing my daily tasks is a source of pleasure and satisfaction. | 1 | 2 | 3 | 4 | 5 | 6 |
| 12. | I often wonder what the meaning of life really is. | 1 | 2 | 3 | 4 | 5 | 6 |
| 13. | My feelings are easily hurt. | 1 | 2 | 3 | 4 | 5 | 6 |
| 14. | I spend a lot of time aimlessly. | 1 | 2 | 3 | 4 | 5 | 6 |
| 15. | At times I feel so panicky that I don t know what to do to calm myself down. | 1 | 2 | 3 | 4 | 5 | 6 |
| 16. | It is often hard not to give up hope of amounting to something. | 1 | 2 | 3 | 4 | 5 | 6 |
| 17. | Life is worthwhile. | 1 | 2 | 3 | 4 | 5 | 6 |

RATING SCALE

1 - AGREE STRONGLY
2 - AGREE MODERATELY
3 - AGREE SLIGHTLY
4 - DISAGREE SLIGHTLY
5 - DISAGREE MODERATELY
6 - DISAGREE STRONGLY

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| 18. | Others seem to respect and care about me. | 1 | 2 | 3 | 4 | 5 | 6 |
| 19. | I feel bored much of the time. | 1 | 2 | 3 | 4 | 5 | 6 |
| 20. | The future looks pretty bleak. | 1 | 2 | 3 | 4 | 5 | 6 |
| 21. | I am usually full of energy. | 1 | 2 | 3 | 4 | 5 | 6 |
| 22. | I often feel restless and unable to concentrate. | 1 | 2 | 3 | 4 | 5 | 6 |
| 23. | I am likely to fly into a rage when something goes wrong. | 1 | 2 | 3 | 4 | 5 | 6 |
| 24. | Every day is new and different. | 1 | 2 | 3 | 4 | 5 | 6 |
| 25. | I often spend time thinking of ways I could get back at people who have treated me badly in the past. | 1 | 2 | 3 | 4 | 5 | 6 |
| 26. | Sometimes I feel as if I am really falling apart. | 1 | 2 | 3 | 4 | 5 | 6 |
| 27. | I don't like to be alone because it makes me feel so empty inside. | 1 | 2 | 3 | 4 | 5 | 6 |
| 28. | I usually expect to succeed in the things I do. | 1 | 2 | 3 | 4 | 5 | 6 |
| 29. | I don't seem to care whether I get anywhere in life or not. | 1 | 2 | 3 | 4 | 5 | 6 |
| 30. | I don't feel very involved in the things I do. | 1 | 2 | 3 | 4 | 5 | 6 |

RSE-T

Please use the rating scale below to indicate how much you GENERALLY agree or disagree with the following statements, that is how much or how little each statement describes how you GENERALLY feel about yourself and your life.

RATING SCALE

1 - AGREE STRONGLY
2 - AGREE MODERATELY
3 - AGREE SLIGHTLY
4 - DISAGREE SLIGHTLY
5 - DISAGREE MODERATELY
6 - DISAGREE STRONGLY

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| 1. | On the whole I am satisfied with myself. | 1 | 2 | 3 | 4 | 5 | 6 |
| 2. | At times I think I am no good at all. | 1 | 2 | 3 | 4 | 5 | 6 |
| 3. | I feel that I have a number of good qualities. | 1 | 2 | 3 | 4 | 5 | 6 |
| 4. | I am able to do things as well as most other people. | 1 | 2 | 3 | 4 | 5 | 6 |
| 5. | I feel I do not have much to be proud of. | 1 | 2 | 3 | 4 | 5 | 6 |
| 6. | I certainly feel useless at times. | 1 | 2 | 3 | 4 | 5 | 6 |
| 7. | I feel that I am a person of worth, at least on an equal plane with others. | 1 | 2 | 3 | 4 | 5 | 6 |
| 8. | I wish I could have more respect for myself. | 1 | 2 | 3 | 4 | 5 | 6 |
| 9. | All in all I am inclined to feel that I am a failure. | 1 | 2 | 3 | 4 | 5 | 6 |
| 10. | I have a positive attitude toward myself. | 1 | 2 | 3 | 4 | 5 | 6 |

SON

This questionnaire consists of a number of statements with which you may or may not agree. Please read each statement and, using the rating scale below, indicate how much you agree or disagree with each statement by circling the number beside it that most closely corresponds to your opinion or experience. There are no right or wrong answers.

RATING SCALE

1 - AGREE STRONGLY
2 - AGREE MODERATELY
3 - AGREE SLIGHTLY
4 - DISAGREE SLIGHTLY
5 - DISAGREE MODERATELY
6 - DISAGREE STRONGLY

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| 1. | To be understood by others is more important to me than almost anything else. | 1 | 2 | 3 | 4 | 5 | 6 |
| 2. | One of the main problems in the world today is that most people don't believe in anything. | 1 | 2 | 3 | 4 | 5 | 6 |
| 3. | I like to let others know if I think they have done something well. | 1 | 2 | 3 | 4 | 5 | 6 |
| 4. | Sometimes I feel all alone in the world. | 1 | 2 | 3 | 4 | 5 | 6 |
| 5. | People often disappoint me. | 1 | 2 | 3 | 4 | 5 | 6 |
| 6. | Unfortunately, an individual's worth often goes unrecognized no matter how hard he or she tries. | 1 | 2 | 3 | 4 | 5 | 6 |
| 7. | Most people seem to understand how I feel about things. | 1 | 2 | 3 | 4 | 5 | 6 |
| 8. | It doesn't bother me much if people laugh at my ideas. | 1 | 2 | 3 | 4 | 5 | 6 |
| 9. | I can't help feeling envious of people who are more successful in life than I am. | 1 | 2 | 3 | 4 | 5 | 6 |
| 10. | It makes me feel good about myself to belong to a group whose members and leaders I admire. | 1 | 2 | 3 | 4 | 5 | 6 |
| 11. | It is almost impossible for one person to understand the feelings of another. | 1 | 2 | 3 | 4 | 5 | 6 |
| 12. | It is better not to expect too much; that way you are rarely disappointed. | 1 | 2 | 3 | 4 | 5 | 6 |
| 13. | I feel more self-confident when I know others are behind me in what I am doing. | 1 | 2 | 3 | 4 | 5 | 6 |
| 14. | What the world needs is more leaders that people can trust and respect. | 1 | 2 | 3 | 4 | 5 | 6 |

RATING SCALE

1 - AGREE STRONGLY
2 - AGREE MODERATELY
3 - AGREE SLIGHTLY
4 - DISAGREE SLIGHTLY
5 - DISAGREE MODERATELY
6 - DISAGREE STRONGLY

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| 15. | I get all the sympathy and understanding I should. | 1 | 2 | 3 | 4 | 5 | 6 |
| 16. | People do not really fulfill their human potential unless they involve themselves deeply with a group whose values they share. | 1 | 2 | 3 | 4 | 5 | 6 |
| 17. | I am apt to give up doing something I want to do if others think it is not worth doing. | 1 | 2 | 3 | 4 | 5 | 6 |
| 18. | Being admired by others makes me feel fantastic. | 1 | 2 | 3 | 4 | 5 | 6 |
| 19. | I feel that there is nothing much that I can depend on. | 1 | 2 | 3 | 4 | 5 | 6 |
| 20. | I tend to put people "on pedestals" and then find out later that they are not all I had imagined them to be. | 1 | 2 | 3 | 4 | 5 | 6 |
| 21. | It is very important to me that people give me the recognition I deserve. | 1 | 2 | 3 | 4 | 5 | 6 |
| 22. | Before I make important decisions about things, I like to try to imagine what someone I admire would decide. | 1 | 2 | 3 | 4 | 5 | 6 |
| 23. | To have people accept me is more important to me than it is to most people. | 1 | 2 | 3 | 4 | 5 | 6 |
| 24. | It is sometimes hard for me to go on with my work if I am not encouraged by my friends or colleagues. | 1 | 2 | 3 | 4 | 5 | 6 |
| 25. | It is exciting to be around people who devote themselves wholeheartedly to worthwhile causes. | 1 | 2 | 3 | 4 | 5 | 6 |
| 26. | Even when I think I have made up my mind on something, I will easily change it if someone I respect disagrees with me. | 1 | 2 | 3 | 4 | 5 | 6 |
| 27. | When I feel understood, I am more hopeful that I will be able to accomplish the things I would like to. | 1 | 2 | 3 | 4 | 5 | 6 |
| 28 | It is very disappointing to me when I find out about the weaknesses of people I respect and admire. | 1 | 2 | 3 | 4 | 5 | 6 |
| 29. | Hardly anyone seems to really understand me. | 1 | 2 | 3 | 4 | 5 | 6 |
| 30. | I can understand how people might get great comfort from religion. | 1 | 2 | 3 | 4 | 5 | 6 |

BORT

Please rate each of the following statements, indicating whether each statement is more likely to be true or false for you. There are no right or wrong answers. Just try to answer every question as honestly as you can. Do not leave any blanks.

| | | TRUE | FALSE |
|---|---|---|---|
| 1. | I have at least one stable and satisfying relationship. | [ ] | [ ] |
| 2. | If someone dislikes me, I will always try harder to be nice to that person. | [ ] | [ ] |
| 3. | I would like to be a hermit forever. | [ ] | [ ] |
| 4. | I may withdraw and not speak to anyone for weeks at a time. | [ ] | [ ] |
| 5. | I usually end up hurting those closest to me. | [ ] | [ ] |
| 6. | My people treat me more like a child than an adult. | [ ] | [ ] |
| 7. | If someone whom I have known well goes away, I may miss that person. | [ ] | [ ] |
| 8. | I can deal with disagreements at home without disturbing family relationships | [ ] | [ ] |
| 9. | I am extremely sensitive to criticism. | [ ] | [ ] |
| 10. | Exercising power over other people is a secret pleasure of mine. | [ ] | [ ] |
| 11. | At times I will do almost anything to get my way | [ ] | [ ] |
| 12. | When a person close to me is not giving me his or her full attention, I often feel hurt and rejected. | [ ] | [ ] |
| 13. | If I become close with someone and he or she proves untrustworthy, I may hate myself for the way things turned out. | [ ] | [ ] |
| 14. | It is hard for me to get close to anyone. | [ ] | [ ] |
| 15. | My sex life is satisfactory. | [ ] | [ ] |
| 16. | I tend to be what others expect me to be. | [ ] | [ ] |
| 17. | No matter how bad a relationship may get, I will hold on to it. | [ ] | [ ] |
| 18. | I have no influence on anyone around me. | [ ] | [ ] |
| 19. | People do not exist when I do not see them. | [ ] | [ ] |
| 20. | I've been hurt a lot in life. | [ ] | [ ] |
| 21. | I have someone with whom I can share my innermost feelings and who shares such feelings with me. | [ ] | [ ] |

| | TRUE | FALSE |
|---|---|---|
| 22. No matter how hard I try to avoid them, the same difficulties crop up in most of my important relationships. | [ ] | [ ] |
| 23. I yearn to be completely "at one" with someone else. | [ ] | [ ] |
| 24. In relationships, I am not satisfied unless I am with the other person all the time. | [ ] | [ ] |
| 25. I am a very good judge of other people. | [ ] | [ ] |
| 26. Relationships with men always turn out the same way with me. | [ ] | [ ] |
| 27. Others frequently try to humiliate me. | [ ] | [ ] |
| 28. I generally rely on others to make my decisions for me. | [ ] | [ ] |
| 29. I am usually sorry that I trusted someone. | [ ] | [ ] |
| 30. When I am angry with someone close to me, I am able to talk it through. | [ ] | [ ] |
| 31. Manipulating others is the best way to get what I want. | [ ] | [ ] |
| 32. I often feel nervous when I am around men. | [ ] | [ ] |
| 33. I often worry that I will be left out of things. | [ ] | [ ] |
| 34. I feel that I have to please everyone or else they might reject me. | [ ] | [ ] |
| 35. I shut myself up and don't see anyone for months at a time. | [ ] | [ ] |
| 36. I am sensitive to possible rejection by important people in my life. | [ ] | [ ] |
| 37. Making friends is not a problem for me. | [ ] | [ ] |
| 38. I do not know how to meet or talk with men. | [ ] | [ ] |
| 39. When I can not make someone close to me do what I want, I feel hurt or angry. | [ ] | [ ] |
| 40. It is my fate to lead a lonely life. | [ ] | [ ] |
| 41. People are never honest with each other. | [ ] | [ ] |
| 42. I put a lot into relationships and get a lot back. | [ ] | [ ] |
| 43. I feel shy about meeting or talking with men. | [ ] | [ ] |
| 44. The most important thing to me in a relationship is to exercise power over the other person. | [ ] | [ ] |
| 45. I believe that a good mother should always please her children. | [ ] | [ ] |

## PART III

## ATTITUDES AND FEELINGS IN TWO SITUATIONS RELATED TO WEIGHT

In this section you will be asked to remember how you felt, or to imagine how you would feel in two different situations: (1) if you unexpectedly GAINED 5 POUNDS; and (2) if you unexpectedly LOST 5 POUNDS. You will then be asked to rate some statements, indicating HOW YOU WOULD FEEL IN THAT SITUATION.

Before you begin to rate the statements for each situation, take a minute or two to really try to recall or imagine yourself in that situation. Try to get a clear picture of what you would be thinking, feeling, and doing if you were in that situation now.

SQD: G/L

This questionnaire consists of a number of statements about moods and feelings that most people have at one time or another. Please rate each statements according to HOW YOU FEE'. WHEN YOU ARE IN THE SITUATIONS YOU HAVE BEEN ASKED TO IMAGINE. First, using the rating scale below, and the set of ratings under the heading "FEELINGS AFTER GAINING 5 lbs.", read each statement, and circle the number that indicates how you would feel after finding that you had GAINED 5 LBS. UNEXPECTEDLY. Then, using the same rating scale, and the set of ratings under the heading "FEELINGS AFTER LOSING 5lbs.", read each statement again and circle the number that indicates how you would feel after finding that you had just LOST 5 LBS. UNEXPECTEDLY. Your feelings may be the same in both situations, or they may be different. It doesn't matter.

RATING SCALE
1 - VERY TRUE
2 - FAIRLY TRUE
3 - FAIRLY FALSE
4 - VERY FALSE

| | | FEELINGS AFTER GAINING 5 lbs. | FEELINGS AFTER LOSING 5 lbs. |
|---|---|---|---|
| 1. | I'm in really high spirits. | 1 2 3 4 | 1 2 3 4 |
| 2. | The way I feel now, I wouldn t depend too much on the kindness of people I know. | 1 2 3 4 | 1 2 3 4 |
| 3. | At this moment I'm not as optimistic about things as I usually am. | 1 2 3 4 | 1 2 3 4 |
| 4. | I'm in the mood to enjoy some kind of game or sport with friends. | 1 2 3 4 | 1 2 3 4 |
| 5. | I've gotten a lot of enjoyment out of doing things for myself today. | 1 2 3 4 | 1 2 3 4 |
| 6. | Right now I find loud noises and loud voices hard to take. | 1 2 3 4 | 1 2 3 4 |
| 7. | At the moment I'm not as happy as others around me seem to be. | 1 2 3 4 | 1 2 3 4 |
| 8. | In my present state I have trouble keeping my mind on anything worthwhile. | 1 2 3 4 | 1 2 3 4 |
| 9. | Right now I feel that everything in life is working out the way I want. | 1 2 3 4 | 1 2 3 4 |
| 10. | Whatever I'd have to do right now, I think I'd do it better than usual. | 1 2 3 4 | 1 2 3 4 |
| 11. | I feel so "down" I wonder if I can make it through today. | 1 2 3 4 | 1 2 3 4 |
| 12. | I'm in a playful, joyful mood. | 1 2 3 4 | 1 2 3 4 |

STAIS-G/L

Below are a number of statements which people have used to describe themselves. FIRST, IMAGINE HOW YOU WOULD FEEL AFTER GAINING 5 LBS. Read each statement and, using the rating scale below, circle the number to the right of the statement that best describes how you would feel after finding that you had gained 5 lbs. unexpectedly. THEN, GO THROUGH THE STATEMENTS AGAIN, this time imagining how you would feel if you had just lost 5 lbs. unexpectedly. This time use the rating scale on the far right of the page to indicate how you would feel after losing 5 lbs. unexpectedly. Give the answer that seems to best describe your feelings AT THAT MOMENT.

RATING SCALE

1 - NOT AT ALL
2 - SOMEWHAT
3 - MODERATELY SO
4 - VERY MUCH SO

| | | FEELINGS AFTER GAINING 5 lbs. | FEELINGS AFTER LOSING 5 lbs. |
|---|---|---|---|
| 1. | I feel calm. | 1 2 3 4 | 1 2 3 4 |
| 2. | I feel secure. | 1 2 3 4 | 1 2 3 4 |
| 3. | I am tense. | 1 2 3 4 | 1 2 3 4 |
| 4. | I feel strained. | 1 2 3 4 | 1 2 3 4 |
| 5. | I feel at ease. | 1 2 3 4 | 1 2 3 4 |
| 6. | I feel upset. | 1 2 3 4 | 1 2 3 4 |
| 7. | I am presently worrying over possible misfortunes. | 1 2 3 4 | 1 2 3 4 |
| 8. | I feel satisfied. | 1 2 3 4 | 1 2 3 4 |
| 9. | I feel frightened. | 1 2 3 4 | 1 2 3 4 |
| 10. | I feel comfortable. | 1 2 3 4 | 1 2 3 4 |
| 11. | I feel self-confident. | 1 2 3 4 | 1 2 3 4 |
| 12. | I feel nervous. | 1 2 3 4 | 1 2 3 4 |
| 13. | I am jittery. | 1 2 3 4 | 1 2 3 4 |
| 14. | I feel indecisive. | 1 2 3 4 | 1 2 3 4 |
| 15. | I am relaxed. | 1 2 3 4 | 1 2 3 4 |
| 16. | I feel content. | 1 2 3 4 | 1 2 3 4 |

RATING SCALE

1 - NOT AT ALL
2 - SOMEWHAT
3 - MODERATELY SO
4 - VERY MUCH SO

| | FEELINGS AFTER GAINING 5 lbs. | FEELINGS AFTER LOSING 5 lbs. |
|---|---|---|
| 17. I am worried. | 1 2 3 4 | 1 2 3 4 |
| 18. I feel confused. | 1 2 3 4 | 1 2 3 4 |
| 19. I feel steady. | 1 2 3 4 | 1 2 3 4 |
| 20. I feel pleasant. | 1 2 3 4 | 1 2 3 4 |

SES-G/L

Now, continuing to think of yourself in the same situations that you were imagining in the last set of questions, use the rating scale below to indicate how much you would agree or disagree with each of these statements IF YOU WERE IN THE SITUATIONS THAT YOU HAVE BEEN ASKED TO IMAGINE. Circle the number in each set of ratings that best describes how you would feel IF YOU WERE IN THE SITUATION INDICATED ABOVE EACH SET OF RATINGS.

RATING SCALE

1 - AGREE STRONGLY
2 - AGREE MODERATELY
3 - AGREE SLIGHTLY
4 - DISAGREE SLIGHTLY
5 - DISAGREE MODERATELY
6 - DISAGREE STRONGLY

| | FEELINGS AFTER GAINING 5 lbs. | FEELINGS AFTER LOSING 5 lbs. |
|---|---|---|
| 1. I have very clear goals. | 1 2 3 4 5 6 | 1 2 3 4 5 6 |
| 2. Criticism or scolding would make me very uncomfortable now. | 1 2 3 4 5 6 | 1 2 3 4 5 6 |
| 3. I feel restless and irritable. | 1 2 3 4 5 6 | 1 2 3 4 5 6 |
| 4. I would feel quite content to do ordinary everyday things right now. | 1 2 3 4 5 6 | 1 2 3 4 5 6 |
| 5. I am optimistic that things will generally turn out well. | 1 2 3 4 5 6 | 1 2 3 4 5 6 |
| 6. I feel that nobody really cares about me. | 1 2 3 4 5 6 | 1 2 3 4 5 6 |
| 7. I find it hard to make even a simple decision now. | 1 2 3 4 5 6 | 1 2 3 4 5 6 |
| 8. I am easily discouraged. | 1 2 3 4 5 6 | 1 2 3 4 5 6 |
| 9. Life is interesting and exciting. | 1 2 3 4 5 6 | 1 2 3 4 5 6 |
| 10. I find it hard to concentrate on a task or job. | 1 2 3 4 5 6 | 1 2 3 4 5 6 |
| 11. Facing my daily tasks is a source of pleasure and satisfaction. | 1 2 3 4 5 6 | 1 2 3 4 5 6 |
| 12. I wonder what the meaning of life really is. | 1 2 3 4 5 6 | 1 2 3 4 5 6 |
| 13. My feelings are easily hurt. | 1 2 3 4 5 6 | 1 2 3 4 5 6 |
| 14. I feel aimless and without direction. | 1 2 3 4 5 6 | 1 2 3 4 5 6 |

RATING SCALE

1 - AGREE STRONGLY
2 - AGREE MODERATELY
3 - AGREE SLIGHTLY
4 - DISAGREE SLIGHTLY
5 - DISAGREE MODERATELY
6 - DISAGREE STRONGLY

| | FEELINGS AFTER GAINING 5 lbs. | FEELINGS AFTER LOSING 5 lbs. |
|---|---|---|
| 15. I feel so panicky that I don't know what to do to calm myself down. | 1 2 3 4 5 6 | 1 2 3 4 5 6 |
| 16. It is hard not to give up hope of amounting to something. | 1 2 3 4 5 6 | 1 2 3 4 5 6 |
| 17. Life is worthwhile. | 1 2 3 4 5 6 | 1 2 3 4 5 6 |
| 18. Others seem to respect and care about me. | 1 2 3 4 5 6 | 1 2 3 4 5 6 |
| 19. I feel bored right now. | 1 2 3 4 5 6 | 1 2 3 4 5 6 |
| 20. The future looks pretty bleak. | 1 2 3 4 5 6 | 1 2 3 4 5 6 |
| 21. I am full of energy. | 1 2 3 4 5 6 | 1 2 3 4 5 6 |
| 22. I feel restless and unable to concentrate. | 1 2 3 4 5 6 | 1 2 3 4 5 6 |
| 23. I would likely fly into a rage if something went wrong right now. | 1 2 3 4 5 6 | 1 2 3 4 5 6 |
| 24. Every day is new and different. | 1 2 3 4 5 6 | 1 2 3 4 5 6 |
| 25. I find myself thinking of ways I could get back at people who have treated me badly in the past. | 1 2 3 4 5 6 | 1 2 3 4 5 6 |
| 26. I feel as if I am really falling apart. | 1 2 3 4 5 6 | 1 2 3 4 5 6 |
| 27. I don't like to be alone because it makes me feel so empty inside. | 1 2 3 4 5 6 | 1 2 3 4 5 6 |
| 28. I expect that I will succeed in most things I do. | 1 2 3 4 5 6 | 1 2 3 4 5 6 |
| 29. I don't seem to care whether I get anywhere in life or not. | 1 2 3 4 5 6 | 1 2 3 4 5 6 |
| 30. I don't feel very involved in what I am doing right now. | 1 2 3 4 5 6 | 1 2 3 4 5 6 |

RSES-G/L

As with the last set of questions, please rate each of these statements to indicate how you would feel in the two situations indicated below. For these statements, however, please use the following rating scale:

RATING SCALE

1 - AGREE STRONGLY
2 - AGREE MODERATELY
3 - AGREE SLIGHTLY
4 - DISAGREE SLIGHTLY
5 - DISAGREE MODERATELY
6 - DISAGREE STRONGLY

| | | FEELINGS AFTER GAINING 5lbs. | FEELINGS AFTER LOSING 5lbs. |
|---|---|---|---|
| 1. | On the whole I am satisfied with myself. | 1 2 3 4 5 6 | 1 2 3 4 5 6 |
| 2. | Right now I think I am no good at all. | 1 2 3 4 5 6 | 1 2 3 4 5 6 |
| 3. | I feel that I have a number of good qualities. | 1 2 3 4 5 6 | 1 2 3 4 5 6 |
| 4. | I am able to do things as well as most other people. | 1 2 3 4 5 6 | 1 2 3 4 5 6 |
| 5. | I feel I do not have much to be proud of. | 1 2 3 4 5 6 | 1 2 3 4 5 6 |
| 6. | I certainly feel useless right now. | 1 2 3 4 5 6 | 1 2 3 4 5 6 |
| 7. | I feel that I am a person of worth, at least on an equal plane with others. | 1 2 3 4 5 6 | 1 2 3 4 5 6 |
| 8. | I wish I could have more respect for myself. | 1 2 3 4 5 6 | 1 2 3 4 5 6 |
| 9. | All in all I am inclined to feel that I am a failure. | 1 2 3 4 5 6 | 1 2 3 4 5 6 |
| 10. | I have a positive attitude toward myself. | 1 2 3 4 5 6 | 1 2 3 4 5 6 |

You have now completed the questionnaire.

THANK YOU VERY MUCH FOR YOUR PARTICIPATION!!

Carole Vipond, M.A.
Psychology Department
University of Windsor
(416) 690-7789

If you would like further information about this study, please complete the form below.

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[ ] I would like to be informed of the results of this study.

Name (please print) _____

Address _____

_____

_____

Phone (_____) _____
area code

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# VITA AUCTORIS

Carole Vipond was born in Halifx, Nova Scotia on September 3, 1942. At the age of 5 she moved to Toronto with her family to begin her academic pursuits. She earned a B.A., with majors in Psychology and Sociology, from the University of Toronto in 1965, an M.Ed. in Adult Education and Counselling from the Ontario Institute for Studies in Education in 1975, and an M.A. in Clinical Psychology from the University of Windsor in 1988.

Between academic pursuits, Carole has been employed as a child care worker, a research assistant, a life skills coach, and a vocational counsellor. She is currently employed as a Psychometrist at Queens Street Mental Health Centre in Toronto where she lives with her partner and two psychologically-minded Siamese cats.