THE RELATIONSHIP OF ATTACHMENT AND SHAME TO ANOREXIA: A CASE STUDY COMPARING RESTRICTIVE AND NORMAL EATERS

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Research has described and many clinicians have reported the anorectic patient as socially disconnected, having a disembodied sense of self, perfectionist expectations, and inadequate and shameful feelings. The more intense the internal war, the more food-focused and self-defeating behavior ensues, thwarting one's ability to receive value, self-acceptance, and love. Addressing the anorexia phenomenon, this study considered, from a sociological perspective, the dynamics of attachment and shame.

On the basis of 4 propositions and using a multi-method, case-replication design, attachment and shame patterns for 5 restrictive and 5 normal eaters were compared, as determined by scores from the Parental Bonding Instrument, Inventory of Parental and Peer Attachment, Internalized Shame Scale, and personal interviews. Analysis was progressive, as propositions were tested by pattern-matching steps of rating, comparing, and interpreting recurring responses to self-report and interview questions.

All anorectics reported a dominant mother, with whom 4 were over attached and struggled ambivalently for autonomy, and a quiet, inexpressive father, whom 4 considered frequently absent or unavailable. As compared to normal eaters, anorectics' trust and communication scores were lower for both parents and peers. Generally, anorectics showed markedly higher internalized shame. Findings indicated that non-optimal parental bonding patterns were related to shame. The maternal bonding pattern of

affectionless control (high protection, low care) showed the highest shame score, although affectionate constraint (high protection, high care), the most frequently found pattern, also showed a high shame level. There were polarized differences between restrictive and normal eaters, especially in regards to self-hatred, low self-esteem, and suicide ideation. Anorectics also reported more inferiority and peer alienation. Other emergent findings were noted. A modification of a self-definition/relatedness illustration was suggested, as well as a model for the development of anorexia. Social implications, treatment suggestions, and future research recommendations were also presented.

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TABLE OF CONTENTS

LIST OF TABLES

LIST OF ILLUSTRATIONS

CHAPTER I

INTRODUCTION

The question of why people would engage in a variety of life-threatening behaviors, such as starvation, bingeing and purging, has challenged clinicians for over two centuries. Anorexia nervosa (self-starvation) was first reported by Richard Morton in 1694 and by 1873 was recognized as a pathological eating disorder syndrome (Nagel and Jones, 1992). But reportedly, within the past twenty years, incidence has increased so rapidly that it has been termed a social epidemic (Gordon, 1990). Gordon further noted that although the highest incidence remains in Western societies, anorexia is increasingly being found in Western Europe, Japan, and to a lesser degree, in Eastern Europe and the Soviet Union.

Society's rigid and narrow definition of beauty is reinforced by 90% U.S. girls owning a Barbie doll, with a figure realistically unattainable (Phillips, 2000). Weight dissatisfaction has become such a pervasive U.S. phenomenon that for many women, chronic dieting, often including excessive exercising, is considered a normal experience (Polivy and Herman, 1985). A "social physique anxiety" is revealed in several studies, such as one by Jacoby (1990), in which 78% of U.S. women saw themselves as overweight. This is more than three times what health charts indicate actually exists.

Bloom, Gitter, Gutwell, Kogel, and Zaphiropoulos (1994) have described the pursuit and adoration of thinness as a desperately-held imperative, with status, like that of a god, and potentially fatal consequences. Although no formal research has examined the

actual dollar cost, the ultimate price is staggering. Often, prolonged hospitalizations, along with individual, family, and group therapy are required at enormous personal and systemic costs. In a 12-year follow-up study, Herzog, Schelberg, and Deter (1997) found that 50% of the anorectics did not improve until 6 years after the first inpatient treatment. Aside from the possibility of starving to death, there are health consequences to being underweight for an extended time. The prognosis is serious, with possible death from an accompanying disease, or even suicide, whether premeditated or resulting from starvation or misuse of drugs (Battegay, 1991).

According to Duffy (1999), only one-third of eating disordered people completely recover; another third learn to function at a very high level, but still have some food issues; while the remaining third continue to struggle with active eating disorders for many years. In an eight-year follow-up outcome study of adolescent and adult anorectics, Casper and Jabine (1996) found that all with chronic anorexia, and even one third of those who had physically recovered from anorexia, qualified for one or more psychiatric diagnoses. The syndrome affects all facets of an individual's life, ranging from physical health to the ability to function at school or work, to the quality of all her relationships. Compared to a well-nourished individual, the starving human displays various behavioral differences, such as food preoccupation and hoarding (Keys,Brozak, Herschel, Mickelson, and Taylor, 1950). The anorectic, having paranoia that others will become thinner than she, is constantly comparing her body to that of other women, while deluded in viewing herself as heavier.

Sunday and Halmi (1996) found the following differences in restricting anorectics

from the control subjects: a longer meal duration, a slower overall rate of eating, more frequent pauses during the meal, and more short bouts of eating. Furthermore, they showed more abnormalities in hunger and satiety ratings, generally indicating less hunger, having less urge to eat, and being more full than controls or bulimics.

Thurstin (1992) has described how anoreectic behavior becomes riddled with devices to minimize and forestall eating by certain rituals. According to Thurstin (1992), the anorectic may spend most of her mealtime simply moving food around on a plate. Eating far less than a weight-loss diet permits, she might cut food into tiny portions or take small bites, while chewing slowly and drinking non-caloric, non-nutritive liquids. Furthermore, if confronted with the low nutritional intake, she will likely claim to have eaten earlier and to feel stuffed. Rather than looking forward to dining with others, she will generally find excuses to eat alone, gradually withdrawing from all social contact. Yet, inconsistently, meal planning becomes a major preoccupation throughout the day. She may have exaggerated interest in recipes and cooking for others, perhaps believing that managing everyone's eating agenda will guarantee control over her own (Thurstin, 1992).

Weiss (1995) has suggested that explanations for such behavior remain multi-faceted, contradictory and paradoxical. Anorexia has been described as a social, psychological, biological, and even philosophical phenomenon, which penetrates the innermost recesses of the self (Kaplan & Garfinkle, 1993; Grostein, 1990; Strober, 1991; Johnson, 1991). The anorectic does not know how to have an identity apart from non-eating. Although flirting with death, she is simultaneously engaged in an unending

struggle to exist.

While many clinicians have stressed the role of family dynamics in the development of eating disorders, only recently has there been objective evidence for characteristic styles in families of eating disorder patients. Research has indicated that two major contributing and interrelated factors, which may be linked to anorexia, are attachment and shame.

Attachment is an enduring affectional bond, of substantial intensity, with the mother, father and/or some other caregiver, beginning at infancy. According to Ainsworth (1991), this initial bond (attachment) is never wholly interchangeable or replaceable by another relationship. Bowlby (1988) reported a direct linkage between early caregiving quality and later personality and behavioral problems of children, adolescents and adults. Crittenden (1995) has suggested that aggressive or covert attempts of a child to force attachment compliance may result in behavioral disorders, which draw attention to oneself, and thought disorders which deflect responsibility from oneself. For example, extreme risk-taking behavior, such as refusal to eat, may be used to elicit "protective" attention.

Shame is a disturbed or painful feeling of dishonor or disgrace, common to all. However, there is a vast difference between a person's having a shameful experience and a shame-prone identity. **Internalized shame**, as defined in this study, is an innate "affect" within the core sense of oneself, related primarily to a feeling of inferiority. "Affect" is defined by Reid and Wise (1989) as "the outward, often facial, manifestation of subjective feelings or emotions" (p.243). Shame experiences appear to embody the

word's root meaning--to uncover, expose, or wound (Lynd, 1958). A shame-type experience seriously jeopardizes or destroys trust in oneself and/or another. Kaufman (1992) has theorized shame to be most frequently triggered by a breaking of the "interpersonal bridge," that is a familial or social connection with another.

Various theories of anorexia have been proposed and feminist literature has well described women's painful adaptations to the slimness culture. However, despite increasing interest in the anorexia phenomena, there have been very few, if any studies, that have examined its relationship to the socio-cultural environment, in general, and attachment and shame, more specifically. The proposed study addresses this research void.

Using a case design, the underlying question of this research is: "What is the relationship between attachment, shame and restrictive eating behavior?" The purpose is to refine understanding of the anorexia phenomena, as related to attachment and shame from a sociological perspective. In Chapter II there follows a review of relevant literature. Chapter III entails a description of the multi-case, multi-method, replication design, as well as specific methodology used in this study. An analysis of data, as regarding the relationship between attachment and anorexia and that between shame and anorexia is found in Chapters IV and V, respectively. Chapter VI is a report of other findings that emerged from the data and a suggested model for the development of anorexia. Finally, Chapter VII concludes with a general discussion of important findings, implications, limitations, and recommendations for further research.

CHAPTER II

REVIEW OF LITERATURE

Introduction

Caught in a world split between the public and private, the modern individual creates a reservoir of frustrated desires (Bloom et al. (1994). Therefore, anorexia nervosa may be explained as a problem of how an individual struggles to preserve unity of self and social relationships, under the impact of cultural expectations and developmental changes, seemingly placing oneself at odds with her basic nature. Killian (1994) concluded that person who loathes fat and worships thinness experiences dynamic tension between body and will: the body's need for nourishment and the will to be thin. Thus, anorexia and bulimia facilitate a woman's attempts to meet society's standard of attractiveness. Bruch (1978) suggested that the eating disordered woman attempts to androgynize her appearance to avoid both the maturity demands of womanhood and the conflicting issues of what it means to be a woman today. Buffeted by ambiguous cultural forces and a contradictory message of "Eat, but don't eat," she learns to distrust hunger and satiation signals and to develop a fat body image, regardless of her shrinking size. For some, the primary relationship becomes that with food. Paradoxically, the need and desire for social connection is translated to the physical realm, with the body becoming a stand-in for "real" people. As noted by Bloom et al. (1994):

Food represents relationship; hope for it, experience in it, fear of it. In this way,

> relationship to food parallels deep needs and fears about both attachment--the ability to connect, to make contact--and individuation--the need to be recognized in one's uniqueness (p. 35).

The progression of starvation and withdrawal from others increases the intensity of vibrant needs, inward tension and self-hatred. In response, the anorectic seemingly feels compelled to maintain an eating ritual, waging a self-exhausting struggle to master these distorted inner and outer experiences (Grostein, 1990). Furthermore, according to Kaufman (1992), an individual suffering from anorexia typically experiences him/herself as intrinsically deficient and worthless. Seemingly, the more intense the war rages within, the more food-focused and self-defeating one's behavior becomes, thwarting his/her ability to receive the very acceptance, value, and love so desperately needed.

Therefore, insight into the anorexia phenomenon would seemingly require tapping her unconscious, internal world within its social context. Thomas and Zaniecki (1918-20/1996) who implemented this subjective measure of social behavior and personality research, considered the personal life record as the 'perfect type' in sociology. Thus, understanding the dynamics of attachment and shame from a sociological perspective, as they relate to restrictive eating behavior, may help explain this phenomenon of an anorectic's fractured sense of self, disconnected feelings and paradoxical behavior. A number of studies have suggested a link between attachment and anorexia and between shame and anorexia. A review of related research follows.

Attachment

Attachment, as defined by Bowlby (1977), is an affectional tie between the infant

and mother, or some other caregiver, perceived to be stronger and wiser. Attachment behavior is any form of conduct that results in attaining or maintaining protection and care, with close proximity to an attachment figure. For example, when a relationship is established with the mother, an infant tends to want to be around her a lot. The function of attachment is to protect the child from emotional or physical danger. If there is a secure sense of attachment, that relationship becomes a safe and stable base from which the child can explore the environment and develop a core sense of self (Ainsworth, 1982).

Attachment Theory

Rather than being a general theory of relationships, attachment is specific to those relationships most important to one's feelings of security. The underlying assumption of attachment theory is that human beings are innately programmed and naturally driven to seek and form attachments, or enduring affectional bonds, with others. Thus, an individual is handicapped without a loving, secure base from which to operate. A child must have secure attachment to survive, whereas an adult must have it to thrive (Scarf, 1995).

According to Bowlby (1980) perceived attachment is reconciled by a behavioral routine, which early in development becomes goal-directed. The goal is maintaining proximity to or communication with the attachment figure(s). The issue is not separation or differentiating as a distinct individual, since this process naturally occurs in the infant's maturational makeup. However, when there is not a sense that the attachment figure is connected and/or attuned to the child's felt needs, various compensative behaviors are activated.

The quality of attachment over time forms an internal working model for building future socialization. This is a compilation of expectations, emotional responses, and action patterns occurring in attachment relationships. The child internalizes representations of the relationship(s) with the attachment figure(s). To the extent that such representations are adequate (i.e. parent is internalized as soothing and caring), the child can then depend upon his/her own internalized soothing functions in times of distance from the attachment figure(s) (Bowlby, 1982). This model is the principal determinant, throughout the life span, of whether attachment relationships are normal or disturbed. It is becoming a widely accepted theoretical view that the personality emerges within this special emotional context. Within the infant's first crucial relationship, the brain is being structured. One's capacities, ways of responding emotionally, and patterns of perceiving the world, as well as a philosophy of human nature are being slowly developed. A person's own sense of goodness, worthiness, self-love and ability to love are grounded in the early developmental experiences with attachment figures. The all-important "other" is being woven into the very tapestry of the self (Scarf, 1995). So, it can be seen that when a child's attachment needs are not met, various problems result. However, Colin (1996) suggests that rather than determining the individual's psychological future, such experiences set the child on a developmental trajectory, which can be modified or even radically altered by life's many experiences and opportunities.

According to attachment theory, proximity seeking in childhood is a means of establishing security with the caregiver. The underlying common dynamic is feared loss of the attachment figure. In secure attachment, the individual views him/herself as

relatively undistressed and others as supportive. The secure child can readily separate from mother and engage in exploratory behavior in situations of minimum stress. S/he seeks contact in stressful situations, but can return to play once comforted. Bowlby (1980) distinguished between secure and problematic or "anxious" attachments, describing the various ways by which an "anxiously attached child" may edit out of awareness certain perceptions or feelings about the attachment(s) in order to sustain the relationship(s), and his/her own security within it.

Typically, anxious attachment behavior manifests in stressful situations, when an anxiously-attached child suffers a major separation or loss, and proximity of attachment object(s) become important. In such a case, exposing the fault lines of prior anxious bonding may reveal, as suggested by Salzman (1988), the following patterns of insecure attachment:

> 1) anxious-*ambivalent dependence*--characterized by a combination of longing, fear, and anger; may be clingy and fearful, but also rage at caregiver(s) who try to comfort them and appear inconsolable;
>
> 2) *false self-sufficiency*--characterized by avoidance of caregivers and existence upon an exaggerated, independent stance;
>
> 3*) compulsive caregiving*--characterized by the child's insistence upon taking care of a fragile, bereaved parent and denying his/her own wishes for care (p. 54).

Empirical studies by Ainsworth (1972), and Main, Tomasini, and Tolan (1979) used the "strange situation" paradigm as a means of examining the nature of attachment, both as a set of proximity-seeking behaviors and as enduring bonding styles. Using a

carefully regulated pattern of separation and reunion episodes between infant and caregiver, the strange situation revealed the following insecure response types:

1) avoidant--indicating false self-sufficiency by gaze aversion, apparent detachment from mother, and little evident distress over separation;

2) disorganized--displaying disoriented behaviors in parent's presence (i.e. may freeze with a trance-like expression, hands in air, rise and then fall prone at parent's entrance, or cling, while leaning away)

3) *resistant-ambivalent*, appearing actively angry and preoccupied by parent (i.e. may alternately seek and resist parent or exhibit passivity and/or fail to settle or return to exploration upon reunion).

West and Sheldon, (1989) have proposed that attachment can be useful in defining disturbances in interpersonal relationships and differentiating attributes, which characterize many psychiatric disorders. The authors have theoretically defined four pathological patterns of adult attachment in a self-report scaled instrument. This does not mean that all so-called "anxious attachments" invariably produce psychopathological conditions. They only create psychological vulnerabilities, which may, under stressful circumstances, yield pathology. Therefore, one cannot assume a direct relationship between "anxious attachment" and pathology.

Bowlby (1973) identified two key features of the internal attachment model:

1) whether the *attachment figure* is judged to be the sort of person who, in general, responds to calls for support and protection;
2) whether the *self* is judged to be the sort of person towards whom anyone,

and the attachment figure in particular, is likely to respond in a helpful manner. The first concerns the child's image of other people; the second concerns the child's image of the self. Bartholomew and Horowitz (1991) have proposed a 4-group model of adult attachment styles. Four prototypic attachment patterns were defined, using combinations of a person's self-image (positive or negative) and his/her image of others (positive or negative).

Relevant to assessing parental attachment, Parker, Tupling, and Brown (1979) identified two dimensions. These include **care** (perceived nurturance) and **protection** (perceived control). Intersecting the two scales at their means results in four possible types of parental bonding: *neglectful* (low care, low protection), *affectionless control* (low care, high protection), *affectionate constraint* (high care, high protection), and *optimal* (high care, low protection).

Although attachment theory may appear psychological in many ways, it also cuts across sociocultural lines. According to Holmes (1993), there was a strong moral and social vision running through the life and work of Bowlby. The “attachment theory” father considered emotional deprivation of children as a degrading social ill, destroying the fabric of social life. Bowlby associated the kind of responsiveness and attunement that good parents provide for their children with those social factors which he saw as most likely to produce flourishing citizens.

According to Touliatos, Perlmutter, and Strauss (1990), results from a number of studies indicate that parent attachment scores are related to subscales from several other measures of family environment and coping strategies. Armsden and Greenberg (1987)

found adolescents' perceived quality of attachment in both parent and peer relationships to be positively correlated with psychological well-being. Lapsley, Rice, & Fitzgerald (1990) discovered that both parent and peer attachment were significant predictors of identity and college adjustment in both first-year and advanced students, supporting the assumption that attachment continues to contribute to some aspects of identity development and adjustment throughout adolescence and the college years.

Brandes (1991) has suggested that the coping styles of eating-disordered families might be better understood by linking eating disorders research to attachment research. Activation of the attachment system through the perception, accurate or inaccurate, of denied access to a bonded other, elicits anger, irritability and hyperactivity. On the otherhand, such perception, in some cases, results in a complete deactivation of the attachment system, so that normal attachment behavior is inhibited. This may lead to affective coolness, object withdrawal, emotional distancing and rationalization. Consequently, any new attachments become insecure and are dealt with in either an anxious, clingy way or an avoidant, cool fashion.

Probably most connections between adult psychopathological symptoms (including anorexia) and early experiences with attachment figures go unacknowledged, being neither well demonstrated nor understood. Despite voluminous attachment literature, further exploration is needed of attachment theory's clinical applicability and the utility of therapeutic interventions, with which to apply it.

Social Influences on Attachment and Anorexia

Bowlby (1982) has argued that healthy attachment leads to the sensory experience

of warmth, nourishment and protection, with a decrease in arousal level. As a consequence, it promotes healthful detachment, socialization and exploration. A sense of identity is best fostered within a family climate that balances “connectedness” with “individuality.” Therefore, anorexia may be considered as a response to experiences that makes it possible for the individual to deal with psychosocial events in his/her everyday world (Marcus and Wiener, 1989). Viewing it as socially constructed behavior, Stierlin and Weber, (1989) have described how anorexia sends an underlying paradoxical message.

> Whatever may have started the daughter on her hunger trip, whatever additional motivations may be involved, the daughter's behavior has become a dramatization of the cry: "I'm starving, I need nourishment!" At the same time, however, her refusal to eat and her vomiting are saying: "This food that you're giving me is not what I need, not what I'm craving. I need approval, love for my own sake, affection, independent of my achievements (pp. 47-48).

But being unable to decode this message, parents react by intensifying their efforts to provide their child with food and care for his/her physical welfare, which s/he in turn continues to refuse.

Thus, **parental care** appears to be a key developmental risk factor to anorexia, whether insufficient care reflects a personal style in the parents or is a consequence of parental separation, marital discord, socioeconomic privation or other factors. A lack of appropriate parental care (responsiveness and acceptance) apparently fixates the individual to a sense of helplessness, engenders feelings of inferiority and self-

disparagement, and makes the recipient more vulnerable to frustration or deprivation by subsequent relationships. Bowlby (1977) suggested that such parental deprivation engenders "anxious attachment", with the child being insecure, overly dependent under stress, depressed and disposed to develop neurotic symptoms. Specifically, deficient care may result in a child's being vulnerable as a consequence of a low intrinsic level of self-esteem and self-worth (Parker, Barrett, and Hickie, 1992).

Overprotection or **control** is another risk factor, which encompasses many of the characteristic descriptions of anorectic families. For example, Minuchin, Rosman, & Baker (1978) argued for the relevance of *overprotectiveness*, enmeshment, rigidity, and lack of conflict resolution in the parents of diabetics, asthmatics and *anorectics*. Parker (1983) positioned *overprotection*, a construct of several components, at the opposite pole from promoting independence and autonomy. McCormick and Kennedy (1994) found that college students, who classified their parental attachment as secure, rated their parents as high in encouraging independence (low protection) and acceptance (high care).

Aside from excessive psychological control over a child, *overprotection* may reflect such characteristics as intrusion, infantilization, and/or encouraged dependency. Less common dimensions may include excessive contact, prevention of independent behavior, strictness, and parental obsessiveness. The main pathogenic influence exerted by *overprotection* is slowing down or restricting the child's necessary socialization. In contemporary society, where malignant parental influences may not be diffused or counteracted by an effective, immediate and supportive group, *overprotection* may be more readily a risk factor to poor self-image and resultant neurotic dysfunction (Parker,

1983).

Trust, **communication**, and **alienation** have been shown to be important components of attachment toward both parents and peers (Armsden and Greensberg, 1987). **Trust** refers to felt security in the knowledge that the attachment figure(s) understand, respect, and are sensitive and responsive to the individual's emotional needs and desires. Chassler (1993) found that anorectics, relative to controls, experienced their early attachment figures as significantly more unresponsive, unavailable, and *untrustworthy.* **Communication** refers to the extent and quality of verbal communication with attachment figures. Kog and Vandercyken (1989) found that eating disordered families demonstrated less openness in discussing disagreements between parents and children than control-group families. **Alienation** refers to anger toward or emotional detachment from attachment figures. Armsden and Greenberg (1987) found that the quality of attachment to parents (the sum of trust and communications scores minus the alienation score) to be positively correlated with measures of self-concept, self-esteem, life satisfaction and healthy family environment.

A sense of security with both parents and peers during adolescence is important. By developing strong connectedness with significant others along with autonomy, adolescents seem to feel better about themselves in a variety of areas. O'Koon (1997) found that older adolescents' attachment to Mother and Father was significantly related to global aspects of well being, while *peer attachment* was significantly correlated with body image, social relationships and sexuality attitudes, areas which gain prominence during this developmental period. Except for gross parental deprivations, there appears to

be considerable scope for modification of early attachment patterns through subsequent interpersonal relationships. Parental and peer relations are different social systems, the parent-child relationship being the most influential, with the potential of providing a secure base, from which the individual can explore the wider social world without distress. But exploratory activity promotes contact with peers, and such interactions extend competencies, resulting in the acquisition of attitudes and affects that are central to social adaptation. As loyalties toward one's family lose their importance, associations with friends outside the family take on a new significance and resilience. *Peer attachment* is positively related to social self-concept on the Tennessee Self-Concept Scale and is negatively associated with loneliness (Touliatos et al., 1990).

Shame

Shame, perhaps "the master emotion," is an unseen regulator of feelings generated by social interactions (Karen, 1994). As the child internalizes the world's negative judgments, some part of him/her cringes in shame, setting off a whole series of defenses and compensatory behaviors. Shame, in itself, may not be bad or destructive. Goffman (1967) has viewed it as a normal and necessary part of human social organization. Abell and Gecas (1997) suggest that different styles of parental control (love withdrawal, power assertive behavior, and inductive responses) elicit feelings of guilt or shame. The way shame is managed, clearly, may be critical to the person’s well-being. When individuals are connected through self-control, they tend to reflect on how they think about themselves in relation to their social and moral responsibilities and status. But parental control by withdrawal of positive regard is more likely to pose a threat to the child-parent

bond than to call attention to norm violation.

Shame Theory

According to Underland-Rosow (1992), shame is not just a feeling, but also a learned behavior. It is a diversion taught to infants by their parents, which serves to distract, destroy, and deny the infant's or small child's feelings, which are deemed undesirable by parents or caregivers. This diversion functions to restrain infants from trusting their own goals, thoughts, feelings, perceptions, impressions, etc. As the diversion (shame) continues, it becomes internalized, so that many individuals go through life without clear connection to what they actually feel. Rather, they experience shame whenever a "non-acceptable feeling" begins to emerge. Furthermore, this lack of connection with their true feelings results in a sense of disconnection in relating to other people. Thus, unacknowledged shame is a pathogen. It is a crippling, irrational sense of deficiency. Fossom and Mason (1986) have defined shame as an inner sense of being defective, completely diminished, fundamentally bad, inadequate, or not fully valid as a person. This parallels the detailed account by Strober (1991) of the anorectic's inner world: the omnipresent fear of seeming weak, inadequate and average; the inability to take pleasure in leisure; a reluctance to confront risks and novelty, to engage in uninhibited spontaneous action, or to assert feelings.

Lynd (1958) has described shame as an isolating, alienating, incommunicable experience. Even so, addictive or co-addictive attempts to deal with pain, caused by the shame of feeling unlovable, are rooted in a pervasive sense of *alienation* and emptiness. According to Hofler and Kooyman (1996), addiction is a delayed maladaptive attachment

transition in young adults, resulting in a shift of the painful urge for physical closeness toward a drug, a "neutral object," which is adopted to serve as a secure base. Defining addiction as the compelling use of a substance or process, in order to avoid, distort (enhance or decrease) or deny feelings, Shaef (1987) considered addiction an act of social disconnection. Similarly, shame has also been associated with social disconnection (Underland-Rosow, 1992). Shame has been shown to be an intervening variable between attachment and psychological stress (Akashi, 1994), which may lead to addictive behaviors such as anorexia. According to Huebner (1993), addiction is a process in which the use of a certain substance leads to a compelling habit of increasing use, resulting in successive changes in mind and body. Further, he has suggested that just as addictive drugs alter brain functioning, not eating can produce endorphins in the brain, which physiologically give an elevated mood.

Shame has been increasingly seen to be hidden behind many forms of psychopathology and to represent major disturbances of the self (Broucek, 1991; Kaufman, 1992). Social psychologists have linked such experiences as shame, shyness, embarrassment, and social anxiety to various forms of public self-consciousness, impression management, and fear of others' negative evaluation (Crozier (1990). Sociologists, such as Goffman (1968), have conceptualized shame as a social stigma.

According to Lewis (1992), the stimuli that elicit the shame state can best be understood by considering shame from a phenomenological point of view. For a person's responses to events and situations are specific to their unique histories of experiences, expectations, desires, and needs. Lewis proposes four phenomenological features of

shame:

1) the desire to hide or to disappear;
2) intense pain, discomfort, and anger;
3) the feeling that one is no good, inadequate, unworthy;
4) the fusion of subject and object.

The fourth feature enables one to differentiate between shame and guilt. As Lewis (1992) explained, shame is the complete closure of the self-object circle, disrupting ongoing activity, with the focus completely upon the self. Confusion results, with inability to think clearly, talk, or act. Thus, shame's function is to signal the avoidance of behaviors likely to cause it. In contrast, the focus of the self in guilt is upon the behavior that caused the interruption, the inadequacy to meet certain standards, and upon the object, the one who suffers from that failure. It directs behavior toward alternative action patterns that repair the inappropriate behavior.

Miller (1985) concluded that the core of shame depends upon the presence of characteristic self-images, images of the other, and body imagery. As Bordo (1993) contended, "The size and shape of the body have come to operate as a market of personal, internal order (or disorder)—as a symbol of the emotional, moral, or spiritual state of the individual." But according to Martin (2000), members of Overeaters Anonymous viewed body size as secondary shame, developed as a result of some earlier primary shame experiences during early childhood in which they failed to live up to adult expectations.

Gilbert, Pehl, & Allan (1994) suggested that shame is "related to rank and status judgments; of feeling inferior, powerless, or bad in comparison with others" (p. 25). In

this "ranking theory of shame," the authors have delineated two major pathways in social ranking. One is based upon threat and coercion, while the other is based upon social attractiveness. In shame one sees self as inferior, unattractive, falling below a standard, and/or invoking unacceptable impressions in others. This, in turn, may activate automatic submissive responses or aggressive retaliation. Gilbert et al. (1994) reported strong support for the phenomena in the model by Lewis (1987) being related to shame. These included feelings of helplessness, anger at others, anger at self, self-consciousness, and feelings of inferiority. Furthermore, they found submissive behavior to be involved in both shame and depression.

Tangney (1992) noted that a clear concern with others' evaluations of the self was almost exclusively associated with shame. The specific types of situations more likely to elicit shame than guilt were failure experiences, embarrassing situations, socially inappropriate behavior or dress, and sex. There can be little doubt that shameful feelings about the self are an important component of relational security. As described by Lewis, 1987, the anxious child inevitably feels that there is something wrong when the immense love that flows out from him/her toward his/her caretakers is not accepted. This results in self-hatred and an effort to keep secret his/her defectiveness. Schore (1991) has argued that shame arises from early child-parent interactions in which the child experiences a failure in parental attunement. In achievement, the child may feel deflated by the parent, who, rather than reflecting his/her joy, may ignore or put the child down. As suggested by Miller (1985), an individual who feels that s/he is not permitted to express anger may instead, become self-critical and feel ashamed.

Lewis (1987) has grounded the shame concept in attachment theory. Defining shame as the vicarious experience of rejection, she has reported that it is always accompanied by what she has called "humiliated fury" (p.32). For Lewis (1990), this helps account for the angry resistance of the ambivalent child. The avoidant child, however, may be showing a reaction pattern that involves bypassing the shame of being rejected. As explained by Retzinger (1995), in bypassed shame, with little or no bodily arousal, persons are unaware of being in a shame state. Bypassed shame is seen mainly in self-conscious content, with thoughts of what should have been said, how the self is inferior to others: less beautiful, strong, intelligent, sufficient, etc. Thoughts, speech, or perception may be overly rigid. Rather than directly expressing humiliated fury, s/he may behave, as if turning the tables on the rejecting parent, by rejecting him/her. In the "relentless pursuit of thinness", the anorectic engages in a desperate struggle for a "self-respecting identity" (Bruch, 1973). According to Slade (1992), an eating disordered person may seek power and control through food, perhaps because that offers the possibility of inducing shame in the other person, so as to displace it from oneself.

Karen (1994) has described how people differ in the degree to which they defend against shame. By restricting their lives and narrowing their consciousness, some obsessively avoid it, sometimes even to the point of depression. Others are more aware of and tormented by their shame. According to Karen (1994),

> Findings about parental attitudes toward negative emotion give us not only a better understanding of shame formation, but are suggestive of some of the critical factors that may be at work in the continuation--and creation--of secure

> attachment in later childhood. To be understood, instead of punished; to express anger, and not be rejected; to complain, and not be taken seriously; to be frightened, and not have one's fear trivialized; to be depressed or unhappy, and feel taken care of; to express a self-doubt, and feel listened to and not judged--such experiences may be for later childhood what sensitive responsiveness is to the baby's cries (pp. 246-247).

Research findings suggest that mothers of secure children seem much less threatened by the child's negativity. Their early sensitivity to the infant's signals manifests in later years by their ability to spot negative emotions, even when unspoken, and to help the child voice them. Marvin and Stewart (1991) found that mothers of secure three-and four-year olds were much more likely, as part of their display of concern upon their return from having left the room, to ask about the child's anger at them for leaving. Whereas, Grossmann (1989) found that the returning mothers of avoidantly attached infants tended to ignore the negative feelings their children expressed during play, only giving them friendly attention when they were in a positive mood. Furthermore, parents of anxiously attached (predominantly avoidant) children rarely reported getting directly angry toward their children or being likely to describe negative feelings to the children in negotiating conflicts. Yet, these were also the mothers who experienced their children as most aggressive and prone to bite and hit them (Slade and Aber, 1987).

Although there have been no studies isolating the relationship of shame to anorexia, research has indicated shame to be a significant problem in eating disordered women. A study by Casper, Offers, & Ostrov (1981) found that 70% of the anorectic

adolescents endorsed the statement, "Sometimes I feel so ashamed of myself that I just want to hide in a corner," versus 28% of the control subjects without an eating disorder.

Tschida (1990) found that the perception of acceptance and rejection from mothers and fathers of daughters with eating disorders and chemical dependency was strongly associated with levels of internalized shame. Data showed that the impact of parental rejection appeared to be greater for mothers than for fathers. Although the level of self-reported parental rejection was about the same, it was also found that eating disordered women had significantly higher internalized shame than chemically dependent women.

In research reported by Cook (1994), women scoring high on internalized shame were occupied with thinness and had a high level of body dissatisfaction. Frank (1991) studied 94 college students, finding that women with eating disorders experienced more shame and guilt in relation to eating than did either normal or depressed women, and that such shame and guilt differentiated the eating disorders from other psychopathology. She further suggested that shame, felt in relation to food, hunger and appetite, may symbolize the guilt felt about needs for nurturance.

Reynolds (1991), who studied 28 females, diagnosed as either bulimic or anorectic, found a significant relationship between the severity of eating disorders and degree of internalized shame. McCreery (1993) concluded that elevated shame levels reported by 20 bulimic women, was directly related to their lack of acceptance of normal interpersonal needs and rooted in connectedness to others. The study demonstrated that the conflict over autonomy versus interdependence induced shame in women who

experienced strong needs for dependence on others. By comparing internalized shame scores, it was shown that eating disordered subjects scored higher than all others, including non-clinical, alcohol/drug, affective disorders and Post Traumatic Stress Disorder (Cook, 1994).

Thus, research has indicated several possible linkages between shame and anorexia. This suggests that an investigation of disturbed relationships between the anorectic and attachment figures and the degree of the individual's internalized shame could contribute to predicting onset, as well as determining prognosis and treatment modality of the disorder.

Social Influences on Shame and Anorexia

Parents can use a variety of socializing techniques that result in **low self-esteem**, **alienation** (social disconnection), and a sense of **inferiority**. Lewis (1992) has suggested some factors relevant to the socialization of shame. He explained that individual differences in shame come about through the differential socialization of standards, rules, and goals. Differences in individuals' standards will lead to dissimilarities in situations likely to generate shame. For example, some families may value athletic performance, while others value academics, finances, beauty, etc. The important feature may not be the imposition of high standards, but rather the response to their violation. Lewis (1992) also asserted that many parental factors direct the child's focus onto the self, rather than the action. An example would be saying, "You are bad", instead of "What you did and the way you did it was wrong." Furthermore, the parent's tone of socialization and use of shame and humiliation as devices for conformity may lead to a global focus. Moreover,

traumatic events, such as abuse, death, or even serious illness of a parent may lead to this type of attribution.

According to Lewis (1992), setting standards, rules and goals is one aspect of the attribution system involving the self, which leads to shame. The second aspect has to do with the subject's evaluation of the self. Shame results only when one makes an internal judgment, that is, when s/he sees him/herself as responsible for the particular failure. Lewis (1992) explained that some parents tend to attribute the child's success or failure to forces outside, rather than the child's inability or lack of effort. This lessens the possibility of a shame self-evaluation. Disgust, contempt and humiliation which a child receives, occurring around events such as crying, toilet training, genital play, sports, academic achievement and/or eating rules, may contribute to shame attributions and lead to restrictive eating. According to Lewis (1992), power assertion, which may be an antidote for parental shame, forces the child away from thinking about the content of the message, due to the intensity of the stimulus. The author further reasoned that love withdrawal is a precipitant of shame, since it is difficult for the child to attend to the cause of love being withdrawn. It leads to internal attributions of self-blame and to a very powerful global attribution of failure, thus, provoking shame, which then leads to poor interpersonal relationships. Lewis (1992) concluded that the result might be self-hatred and an effort to keep secret his/her defectiveness. Thus, events around such issues as attractiveness demands can be prototypical; that is, there would be no choice but to make an internal and global attribution of self-failure.

Sanford and Donovan (1987) have made a distinction between self-esteem and

self-image. Self-image is defined as a set of beliefs and images one has and holds to be true of him/herself. In contrast, **self-esteem** (self-respect, self-love, or self-worth) is the measure of how much one likes or approves of his/her self-image. Simply put, **self-esteem** is the reputation one has with him/herself. And one's feeling of self-worthlessness can quickly lead to self-hatred and then, hatred of others. According to Sanford and Donovan (1987), many of the basic ideas about the self, acquired prior to adulthood, appear to have come from two main sources: how one was treated and what others communicated about oneself. It is possible to have a positive self-image and still lack **self-esteem**. There are two types of **self-esteem**—global and specific. Sanford and Donovan (1987) define g*lobal **self-esteem*** as the measure of how much, as a whole, one likes and approves of his/her perceived self. In contrast, *specific self-esteem* is the measure of how much one likes and approves of a certain part of his/herself. Sanford and Donovan (1987) found that most women they interviewed had negative body images because they saw themselves inaccurately.

> The relationship between **self-esteem** and body image is a complicated one, and the specific dynamics will vary from person to person. For some women, **low self-esteem** follows in part from a negative body image. But for other women it is **the low self-esteem** that comes first and a negative body image that follows from it. For them, abstract negative feelings about the self become manifested as concrete body hatred. Instead of saying, "I'm worthless" or "I'm unhappy," a woman says, "I'm fat" or "I'm ugly." In this way, her pain or self-hatred becomes less nebulous and free-floating, and she obtains a perverse sense of solace and,

more important, a sense of control. She knows exactly what is wrong with her. Her body is what is wrong with her, and if only she had a better body, she would have a much better life (p. 370).

According to Lewis (1992), the impressionable impact of **alienation** is greater in early life, when parents are the child's whole world and when the self is beginning to actualize and to form a way of relating to others. An unempathic rupture between parent and child brings a separation (disconnection) in their interrelationship. For example, when a mother fails to respect the child's refusal to eat, does not cuddle him/her to sleep or makes fun of him/her, there is a momentary split in the attunement. The more often these moments occur, the larger the split and the deeper the sense of detachment of the self. When the demands of others impinge and overtake one's identity, s/he learns to hide the true self, "to cover it over" (the root meaning of shame). In shame, the other is experienced in some way as unlike the self – **alienated**. Thus, as Lewis (1992) has suggested, many have shut out much of their inner core because of fears based on the childhood reality that they would be laughed at, shunned, ignored or hated. According to (Peele, 1989), this subsequently may lead to an eating disorder or other addiction, which is often rooted in a pervasive feeling of **alienation**. Sanford and Donovan (1987) reported that many of the women interviewed felt to some extent **alienated** or estranged from their bodies. The authors considered this inevitable, in light of the fact that in western society one is taught to regard the mind as separate from the body, and to think of oneself not as a body, but as an intellect having, or owning, a body. Some express this visually, seeing themselves as heads with no bodies, or headless bodies.

Shame-prone behavioral patterns, including nonverbal indications, interpersonal behaviors, and individual behavior, as described by Harper and Hoopes (1990), common to anorectics, indicate a cognitive evaluation of **low self-esteem** and an internalized sense of **inferiority**. According to Broucek (1991), shame occurs when an individual is tempted to abandon one's authentic subjectivity and become an object. Originally, object meant "something thrown in the way." This self-perception leads to a reactive and mechanical style of behavior, with a loss of spontaneity and autonomy.

Wurmser (1981) viewed the shame experience as bipolar. The object pole is the person in front of whom one is ashamed, while the subject pole is that aspect of oneself of which s/he feels ashamed. McFarland and Baker-Baumann (1990) have suggested that the disordered eater experiences a reciprocal interchange between body-shame and self-shame. Thus, her shame vacillates between being ashamed of her body, which can be seen by the world (object pole), and what her "fatness" represents (lack of control/weakness) and says about her inner self (subject pole). By internalizing the view of society that says, "What is fat is bad," feeling fat becomes synonymous with feeling bad. Thus, when some women encounter a disappointment or failure in a non-weight-related domain, they suddenly feel fat. In other words, as explained by Silberstein, Striegel-Moore, and Roden (1987), "feeling fat" encapsulates their thoughts, perhaps even blocking out other bad feelings about the self. It may lead women to feel like a failure with regard to femininity. As fat and badness, so thinness and happiness become nearly synonymous. Silberstein et al. (1987) have concluded that rather than being dissipated by dieting efforts, the experience of shame is amplified by the sense of

personal failure when these efforts do not prove successful in attaining and maintaining a target weight. Not only that, but since efforts to lose weight by diet and/or exercise heighten a woman's attentiveness to her weight and shape, perceived imperfections may result in even further self-criticism and shame. Furthermore, women may become ashamed of being ashamed, as feeling ashamed of one's weight is evidence that weight does matter. Finally, the self-inflicted starvation that others assume about one's eating behavior affirms and amplifies her sense of self as faulty, unworthy and inadequate.

According to Harper and Hoopes (1990), families with healthy identities interact with friends, neighbors, and others in community settings. Individuals belong or feel estranged according to the quality of friendships developed and the outcomes of services delivered or received. Thus, the quality of **peer relations** is another important component of shame. According to Harper and Hoopes (1990), healthy **peer relations** may be dependent upon the following family characteristics:

1) They are good neighbors, by offering support and help when neighbors need it.
2) Friends are valued and their home is open to them.
3) The respect they show each other is reflected in how they interact with friends, work relationships, and other individuals in the community.
4) The children are taught to be friendly and to respect people and their property.
5) Parents participate in their children's activities in the community, neighborhood, school, church, and other contexts.
6) Neither family members nor the family, as a whole, has difficulty in

interpersonal relationships and in other social contexts, including work (p 69).

Harper and Hoopes (1990) have suggested that individuals from families who do not relate well with friends, neighbors, and the community tend to be shame-prone. This shaming occurs through a combination of the way the individual is treated and talked about by his/her parents, role models, and peers; the attitudes and expectations they convey toward him/her; and the way they handle his/her feelings, drives and needs. Believing that people cannot be trusted or that one must always perfectly perform to be worthy of respect can impede peer relationships and result in defensive behavior, such as restrictive eating. On the other hand, a greater receptivity for new values, new objectives, and/or new information from peers encourages a rethinking of attitudes toward the family creed or separation from the parents' mindset. Consequently, cultural slimness demands may be modeled and enforced by peers. As concluded by (Gordon, 1990), much disordered eating is socially learned through peer relationships.

As previously described, anorexia is a dangerous condition that can provoke horror and invite coercion, which is vehemently resisted. It curtails rationality, distorts one's worldview, and hinders healthy relationships. Thus, shame, with its many layers associated with weight and eating, becomes such a powerful, painful, and overwhelming experience that a woman is tempted to deny its presence. As expressed in Dying to Be Perfect, a television film depicting the life of Ellen Hart Pena, "It's easier not to feel."

Summary

Research has suggested that from an attachment perspective, anorexia may be viewed as resulting from disrupted parental bonding. *Parental car*e and *protection*

(control) have been identified as key developmental risk factors, leading to four possible types of parental bonding: weak or neglectful (low care, low protection), affectionless control (low care, high protection), affectionate constraint (high care, high protection),and optimal (high care, low protection). An attachment pattern typically manifests in stressful situations, especially when there is threat of separation from or loss of the attachment figure(s). The over-controlling or under-nurturing parent may lead the anorectic to engage in care-eliciting behaviors, evoking a comforting parental response. Anorectics may experience a low sense of *trust* and *communication* (attunement) with either or both parents and peers, as well as an impression of *alienation.*

Shame has been basically defined as an irrational sense of being defective, bad or inadequate, characterizing the anorectic, engaged in a desperate struggle for a self-respecting identity. Reportedly, shameful feelings about the self occur with relational insecurity. Failure to measure up to parental expectations can lead to social disconnection, a lack of identification of one's true feelings, and a sense of inability or ambivalence in relating to others. This may activate automatic submissive responses or aggressive retaliation. Thus, *low self-esteem* (an estimate of self-worthlessness), as well as an internalized sense of *inferiority* toward others, and perceived *alienation* from others are components of shame, which the literature suggests may be related to anorexia. Furthermore, *peer influence* may either reinforce or lessen the shame experience.

CHAPTER III

METHODS AND PROCEDURES

A Multi-Case, Multi-Method, Replication Design

To explain this phenomenon of a fractured sense of self, disconnected feelings and paradoxical behavior, this study considered the dynamics of attachment and shame from a sociological perspective, as related to eating behavior. To do this, a multi-case, multi-method, replication design (Yin, 1994; Yeatts and Hyten, 1997), comparing restrictive and normal eaters, was selected. Rather than the "sampling" logic used in multiple respondent survey research, this design used "replication" logic to predict what should be found for each case (or experiment). Cases either supported or refuted the propositions being tested. This methodology works best with dichotomous cases, such as restrictive versus normal eaters. Characteristics were identified to clarify the conditions under which restrictive eating behavior was to be found, as well as those conditions where the opposite was expected to occur (e.g., normal eating behavior). Thus, cases could be carefully selected, so that one was known to demonstrate the phenomenon, while the comparative one did not. Information was then collected on the individuals to determine whether they supported findings in the literature regarding the relationship between attachment and restrictive eating, as well as shame and restrictive eating. If the cases did not support one or more of these propositions derived from the literature, then, revised and/or new propositions were suggested.

Criteria for Judging Quality of Research Design

Yin (1994) has identified a variety of case-study tactics for increasing construct validity, internal validity, external validity and reliability (Table 1). Descriptions follow for using these tactics in each of the case studies.

Construct validity, according to Yin (1994), refers to establishing correct operational measures for the concepts being studied. Many case studies have been criticized for using "subjective" judgments to collect data, rather than developing an operational set of measures. In order to increase construct validity in this study, at least two sources of evidence were used to measure each concept, encouraging a process of triangulation or convergent lines of inquiry. Incorporating self-administered instruments, personal interviews composed of both focused and open-ended questions, as well as direct observations enabled a broader investigation, and addressed a range of attitudinal, behavioral and experiential issues.

Internal validity refers to establishing causal relationships, whereby certain conditions are shown to lead to other conditions, as distinguished from spurious relationships (Yin, 1994; Campbell and Stanley, 1966). When a case investigator "infers" a causal relationship between two variables without realizing the influence of some third factor, there is a threat to internal validity. According to Yin (1994), pattern matching can increase internal validity. This requires examining the case to determine whether the causal relationships proposed by the proposition(s) match the characteristics of the case. Therefore, this study employed pattern-matching techniques by deriving initial propositions to predict an overall pattern of a restrictive versus a normal eater.

Table 1. Case study tactics for four design tests

Tests	Case-Study Tactic	Occurrence of Research
Construct Validity	use multiple sources of evidence	data collection
	establish chain of evidence	data collection
	have key people review draft of case study report	composition
Internal Validity	do pattern matching	data analysis
	do explanation-building	data analysis
External Validity	use replication logic in multiple-case studies	research design
Reliability	use case study protocol	data collection
	develop case study data base	data collection
	establish chain of evidence	data collection

SOURCE: Modified from Yin (1994, p. 33)

Working toward theoretical replication, each case was compared with other cases of restrictive eaters, as well as cases of normal eaters. Propositions were supported, adjusted, or refined accordingly, after each restrictive versus normal eater set of cases were examined.

External validity, that is, whether a study's findings may be generalized beyond the immediate study, has been a major barrier in case study research. Critics generally contrast case study research with survey research, where a "sample" (if carefully selected) readily generalizes to a larger universe. However, according to Yin (1994):

> *This analogy to samples and universes is incorrect when dealing with case studies*. This is because survey research relies on *statistical* generalization, whereas case studies (as with experiments) rely on *analytical* generalizations (p. 36).

In analytical generalization, the researcher generalizes a particular set of results to some broader theory. But as Yin (1994) has noted, the generalization is not automatic. A theory must be tested through replications of the findings in subsequent studies. This **replication logic** is the same that underlies the use of experiments, allowing scientists to generalize from one experiment to another. This method was used in conducting case studies of 5 pairs of restrictive and normal eaters. According to Yin (1994), "...when external conditions are not thought to produce much variation in the phenomenon being studied, a smaller number of theoretical replications is needed" (p. 50).

Reliability is determined by whether a researcher clearly documents all the research procedures followed, so that another researcher could duplicate the research

procedure exactly. The goal of reliability is to minimize the errors and biases in the study. This can be achieved by implementing tactics for accurately documenting the procedures followed. Therefore, this study used a case study protocol and case study database. The protocol contained the data collection instruments, as well as the procedures and general rules followed in employing the instruments. The case study database included all the data collected for the case studies. Independent of the case study report, which presents findings and draws conclusions from the data, the database in this study included all responses from those screened and interviewed, self-administered inventories, as well as observations, other notes, and miscellaneous materials.

In keeping with this multi-method, multi-case replication design, the following steps were executed:

1. Identification of propositions
2. Case selection
3. Development of the data collection protocol
4. Conducting a pilot study
5. Conducting comparative case studies
6. Data analysis
7. Writing of case reports
8. Drawing cross-case conclusions

Explanation of how each step was carried out is presented below.

Identificatoin of Appropriate Propostions

The first essential step in the multi-case, multi-method, replication design is

identification of existing propositions. As presented in the literature review, shame and attachment propositions may be considered "mid-range" theory, which focuses on merely part of a larger framework. In summary, these propositions are described as follows:

1. Insecure attachment with primary caregiver(s), whether parent(s) or guardian(s), is associated with increased restrictive eating behavior.

a) A perceived lack of protection from the primary caregiver(s) leads to insecure attachment.

b) A perceived lack of care from the primary caregiver(s) leads to insecure attachment.

c) A lack of trust in the primary caregiver(s) leads to insecure attachment.

d) A lack of communication with the primary caregiver(s) leads to insecure attachment.

2. A perceived sense of overprotection (over attachment) from primary caregiver(s) is associated with increased restrictive eating behavior.

3. Insecure attachment with peer(s) is associated with increased restrictive eating behavior.

a) A lack of peer trust leads to insecure attachment with peer(s).

b) A lack of communication with peers leads to insecure attachment with peer(s).

4. Internalized shame is associated with increased restrictive eating behavior.

a) Inferiority is related to increased internalized shame.

b) Alienation is related to increased internalized shame.

c) Low self-esteem is related to increased internalized shame.

d) Negative peer influence is related to increased internalized shame.

Case Selection

The research was examined and approved by the Institutional Review Board for the Protection of Human Subjects in Research. Confidentiality was maintained for all participants. Following a trail of leads, a study sample of 5 anorectic participants was obtained from eating disorder professionals in the Dallas Metroplex. Although the trend may be changing (Harris, 2001), most anorectics reportedly have been young white females. Thus, I sought to maintain this homogeneity for the purpose of comparisons. Controlling for race, age and sex, I selected young adult (18-36), Caucasian, female restrictive eaters, both single and married. A matched sample (by age, sex, race, and marital status) consisted of normal eaters, who never had experienced pathological eating problems. For the purposes of this study, a 'normal eater' was defined as an individual experiencing an 'undisturbed eating pattern'. This meant eating was in response to hunger, taste, and nutrition. Weight was not an issue, nor was body image a barrier to normal lifestyle. Screened and willing normal eaters, retrieved through a large metro church bulletin, a Texas Woman's University Research Methods class, and referrals from anorectic participants, as well as word of mouth, were pooled and utilized as anorectic candidates became available for matching.

All participants were screened by a self-report "Are You Dying to Be Thin" Questionnaire (Reiff and Lampson, 1992). Although not a critical diagnostic tool, this instrument measures unhealthy eating attitudes and behaviors. Thus, it reflects tendencies toward anorexia, bulimia, compulsive eating, or obesity. The DTBT instrument (Exhibit

3) served as a second screening for anorectics already professionally diagnosed, as well as a means to select normal eaters.

Demographics

The participants' ages ranged from 19–36 (Table 2). Except for one instance in which there was a 2 years age difference, all other pairs were either the same age or 1year apart. Both groups of participants were highly educated, with only 1 having no college and 2 some college. Two were college graduates; 2 had almost completed graduate studies; and 3 had graduate degrees. Although little difference between the two groups was noted in this study, Condit (1990) has suggested that anorexia may be related to level of education. "Women receive double-bind messages with regard to education, such as 'do well, but not too well.' These messages create a conflict, …[which may be resolved]… by denying the femininity at odds with the educational achievement through a pursuit of a 'masculine' body (Lawrence, 1987)" (p. 404). Likewise, Silberstein, Peterson, and Perdue (1986) concluded, "Eating disorders appear to develop when the level of bias against women has decreased enough to encourage females to strive for educational and professional achievement, but has not decreased enough to eliminate the supposed association between femininity and lack of competence (p. 915). This may be related to a common anorectic theme: growing up, believing that absolute standards for achievement and appearance were conditions that must be met in order to secure the acceptance, approval, and love of significant others (Way, 1993).

Table 2. Demographics of anorectics and normal eaters

Demographic Factor	Anorectics	Normal Eaters
Age		
Range	19 – 35	19 - 36
Average	29	30
Education		
Some training	--	1
Some college	2	--
College graduate	--	2
Some graduate work	1	1
Graduate degree	2	1
Religion*		
None	-- 1©	1® --
Baptist	2 ® 1©	1® 1©
Roman Catholic	1® --	1® --
Methodist	1® --	-- --
Lutheran	1® 1©	1® 1©
Church of Christ	-- --	1® 2©
Non-denominational	-- 2©	-- 1©
Satanic	1® --	-- --
Occupation		
Leasing consultant	--	1
Formerly in nursing	1	1
Occupational therapist	--	1
Pre-school teacher	1	--
Real estate	1	--
Speech therapist	1	--
Student counselor	--	1
None	1	1
Annual Household Income		
$15,000 or less	3	1
$15,000 – 25,000	--	1
$25,000 – 40,000	--	1
$40,000 – 60,000	1	2
Over $60,000	1	--

*Religion
Childhood ®
Current ©

Respondents were asked to report their childhood and current religions. One anorectic, currently in a non-denominational church, recalled being raised in Catholic, Protestant, and satanic churches, while 1 claimed no childhood or current religion. Only 1 normal eater reported no church upbringing, although she was a Protestant at the time of data collection. There were, at the time of interviews, 1 anorectic and 3 normal eater Protestants, 1 Catholic normal eater, and 2 anorectics and 1 normal eater of non-denominational persuasion. Interestingly, most participants were either working or studying in a helping field, including counseling, teaching, nursing, and speech/occupational therapy. The only exceptions were an anorectic in real estate and a and a leasing consultant normal eater. As for household income, 3 anorectics and 1 normal eater reported $15,000 or less. The other 2 anorectics reported income over leasing consultant normal eater. As for household income, 3 anorectics and 1 normal eater reported $15,000 or less. The other 2 anorectics reported income over $40,000, with one being over $60,000. There was 1 normal eater in each of the first three income categories and 2 reporting $40,000–60,000. This agrees with findings of Gard and Freeman (1996), failing to support the stereotype that, as a whole, there is an increased prevalence of anorexia in high socioeconomic groups.

Barber (1998) has interpreted eating disorders as "one nonfunctional manifestation, in modern environments of evolved psychological mechanisms which modulate the standard of feminine bodily attractiveness as a response to economic conditions…. When economic opportunities for women are good, a slender standard is preferred and marriage is put off, or de-emphasized, in favor of developing a career and

relative economic independence" (p. 295, 305). Thus, thinness is not only presented as attractive, but associated with success, power, and other highly valued attributes. Bemporad, O'Driscoll, and Daehler (1988) described anorexia as a representation of the "clash between normal female development and the contradictory demands of an unhealthy and pathogenic female social ideal…and certain kinds of familial constellations…. [It is] the hyperbole of the self-controlled, autonomous superwoman, valued by American culture today, …that betrays limited, contradictory, [and crippling] social roles" (pp.96-97).

Data Collection Protocol

A clear and specific data collection protocol was used in carrying out each case study. The protocol included the procedures, schedule, study themes, self-administered instruments, and interview questions. Also, to increase reliability, a case study database was created and a chain record of evidences was maintained. Thus, rather than being limited to written reports, other investigators can review specific steps of the research process, as well as the specific data collected. The database included interview transcripts, summaries, observations, and evaluations, as well as results from self-administered instruments. There were also comparisons of findings by matching emergent patterns within and across cases, conjectures about the data, and possible relevance of findings to propositions. Material was classified to the categories of eating behavior, attachment and shame, as well as to emerging social factors. As each entry was filed, it was compared with previous ones in that category. Thus, an external observer could follow the research to the conclusion of the case study.

Field Procedures and Schedule

Although every avenue was pursued to find them, anorectic participants were very difficult to obtain. Due to confidentiality and the severity of the disorder, professionals were hesitant to recommend patients. Also, seeking restricting anorectics further narrowed eligibility requirements, as about half of anorectics are also bulimic (Barber, 1998). To interface with professionals of eating disorders and seek candidates, I attended meetings of the Dallas Association of Eating Disorder Professionals and 3 eating disorder workshops. Initially, I contacted 6 national eating disorder associations, 5 major eating disorder treatment centers, 12 university counseling centers (during and after Eating Disorders Week), 20 local "eating problem" support group leaders, 7 metro hospitals, 7 psychiatric clinics, 12 Md.'s, 6 nurses, 8 dietitians, 10 counseling centers, 8 church counseling centers, and 54 therapists. Later in Oklahoma, 6 university counseling centers, 2 hospitals, 2 treatment centers, 12 counseling centers, and 30 therapists were also contacted by phone or in person. In addition, a letter to professionals describing the research was distributed at the American Association of Christian Counselors World Conference and the Texas Marriage and Family Therapists State Conference, both held in Dallas. The letter (Appendix A) was also mailed to selected eating disorder professionals, requesting young adult, Caucasian, female volunteers, who met the Diagnostic and Statistical Manual of Mental Disorders IV (American Psychiatric Association, 1994) criteria for restricting anorexia. (Appendix B). From all these contacts, only 7 therapists were willing to participate in the study and refer clients. Ultimately, only 4 of those provided qualified participants who followed through with the study.

Referrals were contacted by phone, given further explanation of the research requirements, read a participant agreement statement, which they would be later requested to sign, and asked whether they would be willing to participate. If willing, relevant demographic information was recorded and filed for future sample selection. For final selection, the "Are You Dying to be Thin" instrument (Appendix C) was administered. Qualified volunteers, selected for participation, were matched from a pool of normal eaters. Each participant was requested to sign a participant agreement form Appendix D), carefully read a letter of instructions, and to construct a Lifeline, as described below. The questionnaire (Appendix E), including the self-administered attachment and shame instruments, demographics, and instructional cover letter, was mailed the following week. Participants were requested to bring completed questionnaire to the in-person interview. Of the 7 anorectics, who qualified and agreed to participate, scheduled an interview, and received the questionnaire by mail, 2 did not show up and were not responsive to subsequent phone calls to reschedule. Each of the 5 anorectic participants was matched from the pool of normal eaters.

Respondents were asked for their height and current weight, the least and most they had ever weighed, along with their ideal weight. A standard table of height and age was used to determine 15% below health weight, a criterion for diagnosing anorexia. Having been in recovery, participants were above that standard at the time of interview. However, the criterion was met by their reported least weight during the height of their illness, and in three cases, their conceived ideal weight at the time of interview (Table 3). According to Steiger and Houle (1991), it may be questionable in such populations (of

severity) whether selection factors or the effects of chronic illnesses and malnutrition confound specific psychological traits associated with eating disturbance and nonspecific traits linked to character and other psychopathologies. Thus, women in recovery may be less likely to be experiencing effects of malnutrition or the other sequelae of long-standing and severe eating problems that, presumably, could be affecting their mental status and ability to accurately respond to questions.

After a pilot study (described on p.61), a schedule was developed for carrying out the in-person interviews and observations. An interview of approximately 75 minutes was conducted with a restrictive and then a normal eater, occasionally alternating the order.

Triangulated Methods.

Qualitative case study approach was highly personal, in-depth research. Each case studied was instrumental in learning about the differences in attachment and shame criteria between anorectics and normal eaters. Although dealing with many complex phenomena and issues, triangulated methods were expected to minimize misinterpretation and misunderstanding of how the participants viewed and explained their eating behavior.

Table 3: Height and weight criteria for anorectics and normal eaters

	Anorectics				
	Married		Single		
Age	35	35	32	19	25
Height	5'6"	5'7"	5'11-1/2"	5'7-1/2"	5'3-1/2"
Frame	med.	med.	med.	med.	sm.
Current Weight	128	128	146	137	102
Ideal Weight	125	<100	115	120	80's
Most Weighed	138	255	151	138	102
Least Weighed	72	104	116	110	69
Health Weight*	124-139	128-143	146-161	130-145	109-117
15% below HW	105	109	124	110	93

	Normal Eaters				
	Married		Single		
Age	36	36	34	19	24
Height	5'2-1/2"	5'	5'8"	5'7"	5'9"
Frame	med.	med.	med.	med.	sm.
Current Weight	135	110	145	135	125
Ideal Weight	125	110	140	med.	125
Most Weighed	135	180**	150	150	134
Least Weighed	110	105	122	130	116***
Health Weight*	111-123	103-115	132-147	128-143	130-140
15% below HW H W	94	88	112	109	116

*Based on table prepared by Metropollitan Life Insurance Co. Source of basic data.
Build and Blood Pressure Study, Society of Actuaries
**Excessive weight gain due to cortisone treatment for illness
***Weight loss due to breaking off marriage engagement

Greene, Caracelli, & Graham (1989) have advanced five purposes, also sought in this study, for combining methods:

1) Convergence of results
2) Complimentary emergence of overlapping facets
3) Development of sequential information
4) Initiation of contradictions and fresh perspectives
5) Expansion of scope and breadth

Thus, through triangulation, a substantial collection of data was generated. Comprehensive and accurate description was sought. By choosing three co-observers for four interviews of anorectics and three of normal eaters, there was **investigative triangulation**. Through employing multiple self-report instruments, observations, and focused, open-ended interviews, **methodological triangulation** and **data triangulation** were utilized, with expectation that variance would be reflected within the trait, and not the method.

Specific Methods and Procedures

At least two research methods were used to measure the social factors of both parental/peer attachment and shame, which included parental care, protection, overprotection, trust, communication, alienation, inferiority, and peer influence. Employed research methods included self-administered instruments, an in-person interview, observations recorded during the in-person interview, and a thought-provoking exercise of constructing a Lifeline. (See Table 4 for a data collection protocol interview.)

Table 4. Data collection protocol

	DMS IV	DTBT	PBI	IPPA	ISS	Interview	Observation
Eating Behavior	X	X				X	
Parental Attachment							
Protection			X			X	
Care			X			X	
Trust				X		X	
Communication				X		X	
Peer Attachment							
Trust				X		X	
Communication				X		X	
Internalized Shame							
Self-esteem					X	X	X
Inferiority					X	X	X
Alienation				X	X	X	
Peer Influence				X		X	

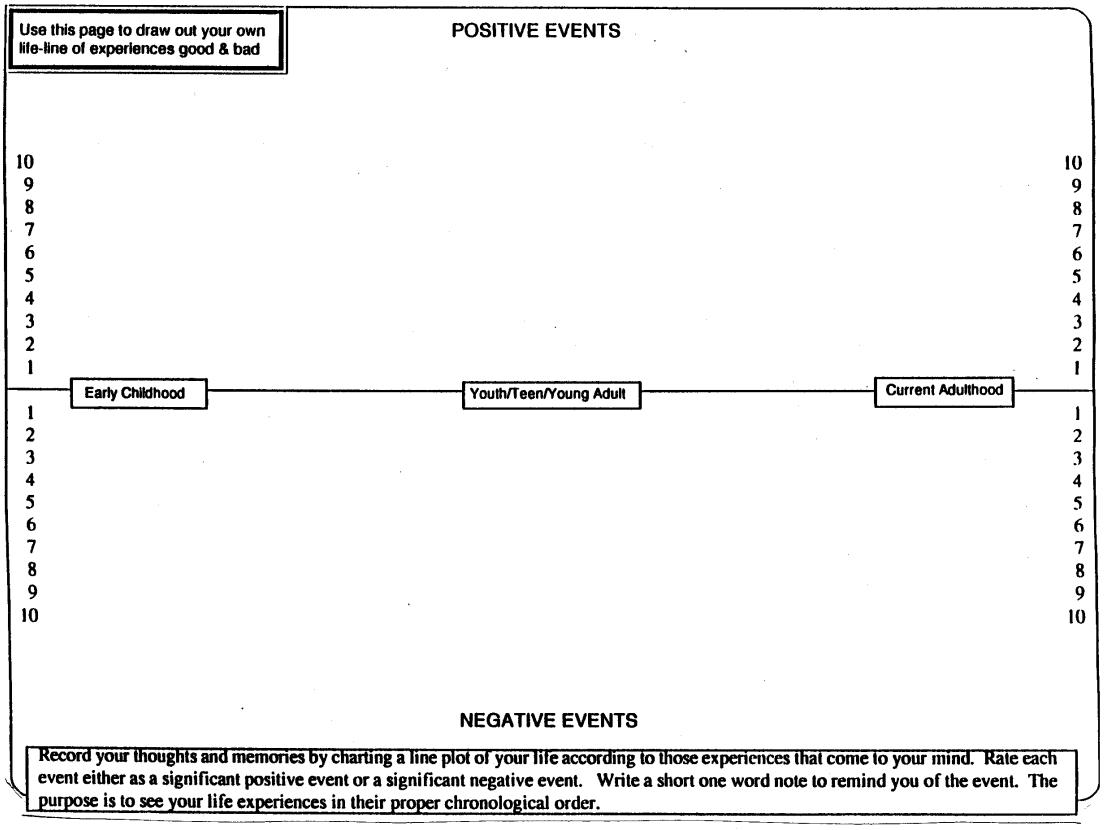
DSM IV -- Diagnostic and Statistical Manual of Mental Disorders
DTBT -- Dying to Be Thin Questionnaire
PBI -- Parental Bonding Instrument
IPPA -- Inventory of Parent and Peer Attachment
ISS -- Internalized Shame Scale

Using a Lifeline form (Figure 1), subjects were requested to trace positive and negative life experiences, considering how they may be related to eating behavior patterns. Lifelines were used primarily to stimulate thinking prior to the interview, so as to more readily recall life experiences, which may be related to attachment, shame, and restrictive eating behavior. The Lifeline is a life history chart, used very successfully by Hope Net since 1988, helping people break through denial of problems in their past and deal with emotional wounds, such as sexual abuse and/or other entry point(s) of shame.

Self-administered instruments included the Parental Bonding Instrument (Parker et al., 1979), Inventory of Parent and Peer Attachment (Armsden and Greenberg, 1987) and the Internalized Shame Scale (Cook, 1994). A description of each instrument follows.

The Parental Bonding Instrument (PBI), designed by Parker et al. (1979), is a self-report questionnaire, which measures parental *care* and *protection* as constructs of parent-child attachment. The *care* dimension involves, at one end, affection, emotional warmth, empathy, and closeness, and on the other, emotional coldness, indifference, and neglect. One end of the *protection* marks the dimension of control, overprotection, intrusion, excessive contact, infantilization, and prevention of independent behavior. The other end is delineated by allowance of independence and autonomy. The PBI is designed not to measure *protection* in terms of safety, but rather as the degree of control or rigidity. The safety dimension is actually incorporated into the neglect end of the *care* scale.

Figure 1. Lifeline of positive and negative events



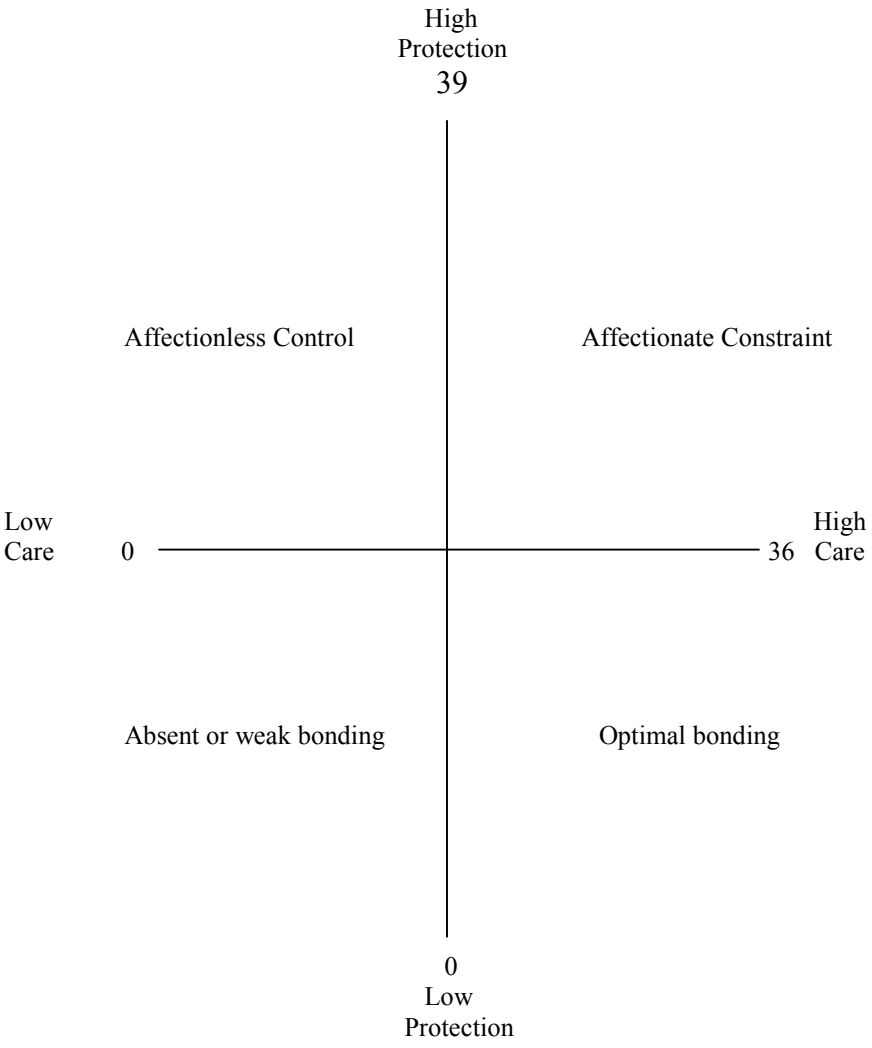
Taken from Hope Net material. Used by permission of Ken Freeman, Last Harvest, Marshall, TX.

Lopez and Gover (1993), have explained that in their review of theoretical and empirical bonding literature, Parker et al. (1979) observed the predominance of two primary, bipolar parenting dimensions. They noted that *care* was clearly concerned with general levels of parental warmth versus indifference or neglect, while over*protection* seemed related to levels of parental control versus encouragement of the child's autonomy. Therefore, the PBI was designed to "examine the parental contribution to a parent-child bond," (Parker et al., 1979, p. 1) through the measurement of these factors.

The PBI consists of 25 items, which direct adult respondents to recall their first 16 years, answering each question as it related to their biological parents or parental figures. Using a 4-point Likert scale, participants indicate whether each statement was very like, moderately like, moderately unlike, or very unlike the parent in question. Of the 25 items, 12 relate to care and 13 relate to protection of the child by the parent(s).

The PBI had codes for scoring with Arabic numerals for the care items and Roman numerals for those measuring protection. For each parent, a care score and a protection (control) score were obtained. The higher the score, the higher the care or the control exercised by the parent. Following Parker et al., (1979), participants were classified into four bonding pattern quadrants, according to the way they related to parents on the basis of the PBI. These included: optimal bonding—high care, low control; weak bonding—low care, low control; affectionate constraint—high care, high control; affectionless control—low care, high control (Figure 2). The cutoff points for "low" and "high" were the mean scores in the scales of care and control.

Figure 2. Parental bonding patterns from care and protection scales*



*The two scales of the Parental Bonding Instrument (Parker et al., 1979) are shown with the conceptualized parental bonding possibilities.

*Key:
Optimal – low protection, high care
Weak – low protection, low care
Affectionless control – high protection, low care
Affectionate constraint – high protection, high care

Test-retest reliability for the full current version is more than .90, the PBI having been proven highly reliable at test-retest periods of up to 10 years (Wilhelm & Parker, 1990). Validity has been assessed in several studies, including investigations with siblings, comparisons of scores given by adult children with those obtained on self-ratings by their parents, and corroborative interviews, indicating that PBI scores would reflect actual, rather than imaginary, parental behaviors. Canetti et al. (1997) assessed the internal reliability of the PBI sub-scales by computing the Cronbach alpha coeficients. All four scales were found to be reliable: Maternal care, alpha=0.75, maternal protection, alpha=0.82, paternal care, alpha=0.80 and paternal protection, alpha=0.83. The PBI (Appendix E, Part I) was used to examine Propositions 1a, 1b, and 2.

The Inventory of Parent and Peer Attachment (IPPA), developed by Armsden and Greenberg (1987), measures the degree of *trust*, quality of *communication*, and extent of anger and *alienation* in relationships with mother/father and peers. The IPPA was derived from attachment theory's assumption that as cognitive development proceeds, internalized, versus actual, parental attachment figures play an increasingly important role as a source of continuing emotional stability and well-being (Bowlby, 1969/1982). At the same time, by virtue of peers' ability to provide the adolescent with a measure of needed support and encouragement, especially during adolescence (Weiss, 1982), emotionally significant peers may also come to serve as important attachment figures in their own right. Therefore, the IPPA attempts to measure the relative importance of parental and peer attachment in adolescence and young adulthood by assessing the effective-cognitive expectancies associated with internalized representations of each

attachment.

The revised IPPA (Armsden and Greenburg, 1989), used in this study, yields separate ratings for mother and father. Responses are given on a 5-point Likert scale, with each of the three sections containing 25 items and comprising separate Trust, Communication, and Alienation scales. Specifically, trust items reflect the degree of mutual understanding and respect ("My mother/father/friends respected my feelings") communication items assess the extent of spoken communication (I told my mother/father/friends about my problems; while alienation items tap feelings of anger and interpersonal isolation ("My mother/father/friends didn't seem to understand what I was going through). With permission of the authors, items in this study were converted to past tense, asking for recall of the first 16 years of a respondent's life, rather than current experience. This was more compatible for comparison with PBI scores. The IPPA score was derived by reverse scoring negatively worded items, and then summing the response values in each section. A summary score for each scale was computed by adding raw scores for Trust and Communication and subtracting the Alienation raw score. The lower the score, the more disturbed the attachment.

Based on summary scores for 27 18-20 year-olds, 3-week test-retest reliability coefficients were .93 for the Parent Attachment scale and .86 for the Peer Attachment scale. Using only the Mother/Father sub-scales from the revised IPPA, Papini, Loggman, & Anderson (1991) reported Cronbach alphas of .89 and .88 for Mother and Father, respectively. Armsden and Greenberg (1987) further reported Cronbach's coefficient alphas for the Parent scale to be .91 for the Trust factor, .91 for the Communication

factor, and .86 for the Alienation factor. With respect to validity, Armsden and Greenberg (1987) found IPPA parent attachment scores to correlate significantly with reported levels of family support, conflict, and cohesiveness, and with the tendency to seek out parents in times of need. IPPA parent and peer attachment scores were also significant predictors of self-esteem, life satisfaction, depression, anxiety, resentment, and alienation. Less secure parental attachment, as indexed by the IPPA, has been related to depression, suicidal ideation, separation anxiety, and hopelessness within a young adolescent sample (Armsden, McCauley, Greenberg, Burke, & Mitchell, 1990). Several studies have also assessed the relationship between IPPA scores and various personality variables. According to Filewood (1993), there were extremely high correlations between the IPPA and the PBI attachment instruments. The author found that between 70 and 78% of the variation in the IPPA could be attributed to the PBI scales. The IPPA (Appendix E, Part II) was used to examine Propositions 1c, 1d, 3a, 3b, and 4d.

Cook (1989) developed the *Internalized Shame Scale* (ISS), specifically to measure enduring, chronic shame that has become an internalized part of one's identity. Cook (1990) described the ISS as a measure of the extent (via frequency of painful feeling) to which the self-structure (i.e. working model of the self) is dominated by feelings of shame directed toward the self, or internalized. The ISS consists of 30 Likert-scaled items that yield two basic scale scores. The two scales include a 24-item shame scale and a 6-item self-esteem scale. The 24-item shame scale comprises two sub-scales, an inferiority scale (15 items) and an alienation scale (9 items). Since 1984, the scale has been administered to over 3,000 subjects, both clinical and non-clinical (Cook, 1990).

Extensive reliability and validity studies have resulted in four revisions of the scale, the latest of which was used for this study. Validity studies have focused on concurrent correlation with related variables and differences between clinical and non-clinical samples. According to Cook (1994), with two large reliability samples representing non-clinical subjects (N=645 college students) and clinical subjects (N=370), the scale had alpha reliabilities of .95 and .96, respectively. Alpha reliability coefficients for the current version range from .94 for the Shame scale and .88 for the Self-esteem scale, and test-retest reliability coefficients range from .71 to .84, indicating that the ISS has good reliability.

A series of studies, comparing the results of the ISS with three different self-concept/self-esteem measures, led to the conclusion that the ISS was measuring "a trait that contributed more to the development of emotional problems than did low self-esteem alone" (Cook, 1988, p.18). Further, the author observed that items on the Shame sub-scale and the six Self-esteem items on the ISS did not load on the same factor, but loaded respectively on two different factors. Ursu (1984) argued that internalized shame and low self-esteem are conceptually different. Shame being an affect, a shame-prone identity describes the affective experience of a person with such an identity. Self-esteem is not an affect, but rather a cognitive evaluation about the self. The ISS (Exhibit E, Part III) was used to examine Propositions 2 a, b and c.

An *in-person interview* was developed with questions to explore further the four attachment and four shame variables, as well as to collect information about behavior and attitudes associated with weight, food intake, the individual's attitudes toward her own

physical appearance, family dynamics around eating, and peer relations. The semi-structured interview (Appendix F), designed around the four theoretical propositions, was based on literature review and counseling experience with the population under investigation. The format may have some similarity to the Adult Attachment Instrument (AAI), which enables researchers to assess attachment representations in adulthood. The AAI, as described by Main and Goldwyn (1994), is a semi-structured interview, which probes alternatively for general accounts to specific memories and current descriptions of relationships with parents. In the interview respondents reflect on their childhood attachment experiences and evaluate possible impacts of these experiences on their own personality and behavior. Verbal transcriptions are rated for security of attachment. Much of the analysis is searching for overall coherency in the representation of attachment-related issues (e.g., do memories support, fail to support, or contradict general evaluations of the current state of mind and feelings). However, the AAI, apparently constructed to derive psychological material, while this study was sociological in design, eliciting attachment, as well as shame and eating behavior criteria. An M.D., specializing in eating disorders, critiqued the initial draft of the in-person interview. After being refined through the pilot study, it was evaluated by a Ph.D. and an M.S., as well as scrutinized for continual revision throughout the research process. Interviews were tape-recorded and transcribed verbatim, noting usage of particular words, which may identify attachment or shame criteria. One of three observers, a pastoral counselor, a psychology graduate student, and a licensed counselor of alcohol and drugs, observed all but one case pair of interviews, noting attachment and shame criteria. Although familiar to the subject

matter, observers were blind to the study's propositions and questionnaire results. Two of the observers were selected to review case report drafts.

Observations of respondents' behavior, mannerisms, interactions, non-verbal cues, avoidance tactics, conflicting accounts etc. were also recorded. Since some eating disordered patients tend to deny their behavior, while others may exaggerate it, an effort was made to take all information obtained during the interview, including gestures, facial expressions, and intonations. The interactive process of reviewing interview and observation data expanded and enriched the analysis. Information was filtered and rated objectively, based on definitions, descriptions and propositions of attachment and shame. Following each interview, detailed comments were immediately recorded

The Pilot Case Study

In final preparation, I conducted a pilot study. Consisting of one pair of cases, I used the preliminary research to refine the protocol, including the sampling criteria, data collection strategy, and timing. I assessed the wording of in-person questions for clarification, determined the best order for completing the various methods of data collection, and designed the interview evaluation form (Appendix G). Since data from the pilot study appeared to be valuable, I incorporated into the final study.

Conducting the Case Studies

A case study of a restrictive eater, paired with one of a normal eater, was completed and compared for patterns of shame, attachment and comprising social factors. As studies were conducted, a case study database, including interview notes and observations, was created. Propositions were examined for accuracy, as found necessary

to reflect the data collected, and considered for any needed adjustment or replacement. Following a comparative analysis, two additional cases, alternating interview order of normal/restrictive subjects, were studied and analyzed in similar fashion. Yin (1994) has suggested up to five or six replications may be necessary to reflect adequately what actually exists. Thus, five pairs of restrictive and normal eaters were included in this study, as that seemed sufficient to confirm matching patterns of the two groups.

Data Analysis

Propositions guided data analysis, clarifying the focus of data and contributing to the organization of the case study. According to Yin (1994), one of the most desirable strategies for case-study analysis is the use of a pattern-matching logic, by which an empirically based pattern is compared with a predicted one (or with alternative predictions). Internal validity, the establishment of a causal relationship, is strengthened when cases exhibit coinciding patterns. Pattern matching enhances the examination of cases, allowing the opposite to be predicted (e.g., propositions concerning restrictive versus normal eating). When results from a particular case study did not coincide as predicted, the proposition in question was re-examined and considered for removal or modification.

Transcripts were subsequently analyzed individually and examined for contradictions and omissions. Commonalties and differences in familial, behavioral, cognitive, and affective patterns of restrictive and normal eaters emerged. Specific similarities in answers were noted and compared, searching for attachment and shame criteria. Reported experiences, which triggered parental and/or peer alienation and/or

social disconnection, as well as overt and subtle markers of shame and attachment, were noted. To assure internal reliability, two of the interview observers were asked to review a draft of the case study report, checking for accuracy of the facts. Analysis was progressive, beginning on the first day with rating, comparing, and interpreting recurring responses to in-person interview and self-report questions. There was continual search for consistencies and discrepancies. Collection and analysis went hand in hand, as matching and contrasting patterns emerged.

At the interview, respondents were asked to rate each parent for care, protection, trust, and communication, as well as peers for trust and communication on a 10-point scale. In order to compare these scores more congruently with those from PBI and IPPA instruments, an assigned value was used to multiply each step of the scale, so as to synchronize the interview and instrument scales. (For example, peer communication, ranging 9-45 on IPPA, was assigned 9 for the first step and 4 for each of the remaining 9 steps.) Instrument, adjusted interview, and average combined scores were recorded and compared (Table 5). Eight of the averaged instrument and combined averaged scores were either the same or had only 1 point difference, while most others showed only 2-4 points difference. The greatest difference of 5 and 7 points respectively, in instrument and interview scores occurred for both father protection and care for anorectics and father protection for normal eaters. However, both instrument and interview averages showed higher protection from both mother and father for anorectics than that for normal eaters, with the same differences for mother and only 2 points difference between PBI and combined scores for father.

Table 5. Raw and average scores for attachment criteria by instrument and interview

	Anorectics																				
	Married								Single										Combined		
Data Source & Average	A*		A AV	B**		C***		AV	A			A AV	B			C			AV	C AV	AV
Respondent	N=2								N=3												
Age	35	35	**35**					**35**	32	19	25	**25**							**25**		**29**
Attachment w/ Mother																					
Protection (0-39)	26	30	**28**	34	39	30	35	**32**	35	13	30	**26**	39	13	34	37	13	32	**27**	**29**	**26**
Care (0-36)	23	3	**13**	20	0	22	2	**12**	34	23	25	**27**	20	36	20	27	30	23	**25**	**21**	**22**
Attachment Pattern****	3	2	**21**	3	2	3	2	--	3	4	3	--	3	4	3	3	4	3	--	--	--
Trust (10-50)	32	10	**21**	32	10	32	10	**21**	27	23	33	**28**	14	19	45	21	21	39	**27**	**24**	**25**
Communication (9-45)	22	13	**18**	25	9	24	11	**17**	30	20	24	**25**	21	17	37	26	19	31	**25**	**22**	**22**
Alienation (6-30	22	29	**26**	--	--	--	--	**26**	14	24	13	**17**	--	--	--	--	--	--	**17**	--	**20**
Attachment Score (Trust+Communication +Reverse Scored Alienation)	68	30	**49**	--	--	--	--	**49**	79	55	80	**71**	--	--	--	--	--	--	**71**	--	**62**
Attachment w/ Father																					
Protection (0-39)	21	19	**20**	22	34	22	27	**24**	21	14	14	**16**	30	13	39	26	14	27	**22**	**23**	**18**
Care (0-36)	28	15	**22**	28	0	28	8	**18**	8	21	21	**17**	4	8	4	6	15	13	**11**	**14**	**19**
Attachment Pattern****	3	2	--	3	2	3	2	--	2	4-	4-	--	2	1	2	2	1	2	--	--	--
Trust (10-50)	37	15	**26**	36	10	37	13	**26**	17	23	25	**22**	10	50	19	14	37	22	**24**	**25**	**23**
Communication (9-45)	30	13	**22**	33	9	32	11	**21**	13	20	19	**17**	13	33	13	13	27	16	**20**	**21**	**19**
Alienation (6-30)	16	24	--	--	--	--	--	**20**	19	18	23	--	--	--	--	--	--	--	**20**	--	**20**
Attachment Score (Trust+Communication+Reverse Scored Alienation)	87	40	--	--	--	--	--	**64**	47	8	57	--	--	--	--	--	--	--	**62**	--	**63**
Attachment w/ Peers																					
Trust (10-50)	34	36	**35**	37	28	36	32	**34**	31	37	34	**34**	24	10	24	28	24	29	**27**	**30**	**34**
Communication (8-40)	23	25	**24**	26	19	25	22	**23**	26	30	19	**25**	22	33	33	24	32	26	**27**	**26**	**25**
Alienation (7-35)	22	27	**25**	--	--	--	--	**25**	25	24	28	**26**	--	--	--	--	--	--	**26**	--	**25**
Attachment Score (Trust+Communication+Reverse Scored Alienation)	77	78	**78**	--	--	--	--	**78**	74	85	79	**79**	--	--	--	--	--	--	**79**	**--**	**79**

*A – score from self-administered questionnaire
**B – score from interview, adjusted to A scale
***C – Combined average score
**** -- 1=weak bonding; 2=affectionless control; 3=affectionate constraint; 4=optimal bonding

Scores were determined separately for married and single participants by instrument (A) and then interview (B). Averages (C) were recorded for each individual and each group.. Overall averages for anorectics by instrument and interview (C), as well as by instrument only (A) were then recorded.

Note: There is a greater degree of the attachment variable with increasing score.
The lower the attachment score, the more insecure the attachment.

Table 5. Raw and average scores for attachment criteria (Cont.)

	Normal Eaters																								
	Married									Single											Combned				
			A									A											C	A
Data Source & Average	A*		AV	B**		C***		AV		A		AV	B		C			AV			AV	AV	AV	
Respondent	N=2									N=3															
Age	36	36						**36**		34	19	24									**26**	--	**30**		
Attachment w/ Mother																									
Protection (0-39)	25	5	**15**	30	17	28	11	**19**		7	15	12	**11**	21	13	17	15	14	15	**14**	**16**	**13**			
Care (0-36)	7	36	**22**	8	36	8	36	**22**		31	21	36	**29**	36	28	36	34	25	36	**31**	**28**	**26**			
Attachment Pattern****	2	4	--	2	4	2	4	--		4	4	4	--	4	4	4	4	4	--	--	--	--			
Trust (10-50)	22	49	**36**	19	50	21	50	**35**		45	22	48	**38**	45	41	50	45	32	49	**42**	**39**	**37**			
Communication (9-45)	16	45	**31**	17	45	17	45	**31**		32	25	43	**33**	45	21	45	39	23	44	**35**	**32**	**32**			
Alienation (6-30)	23	7	**15**	--	--	--	--	**15**		12	22	8	**14**	--	--	--	--	--	--	**14**	--	**14**			
Attachment Score	51	123	**87**	--	--	--	--	**87**		101	61	119	**94**	--	--	--	--	--	--	**94**	--	**91**			
(Trust+Communication+Reverse Scored Alienation)																									
Attachment w/ Father																									
Protection (0-39)	15	6	**11**	21	21	18	14	**16**		7	19	12	**13**	21	21	26	14	20	19	**20**	**19**	**12**			
Care (0-36)	25	33	**29**	22	36	24	35	**29**		32	17	36	**28**	36	32	36	34	25	36	**32**	**28**	**29**			
Attachment Pattern****	4	4	--	4-	4-	4	4	--		4	4	4	--	4	4	3	4	4	4	--	--	--			
Trust (10-50)	35	49	**42**	23	50	29	50	**40**		46	41	50	**44**	45	45	50	46	43	50	**46**	**43**	**44**			
Communication (9-45)	23	33	**28**	21	33	22	33	**28**		27	37	39	**34**	45	33	45	36	35	42	**33**	**34**	**43**			
Alienation (6-30)	19	10	--	--	--	--	--	**15**		8	17	8	--	--	--	--	--	--	--	**11**	--	**12**			
Attachment Score	75	108	--	--	--	--	--	**92**		101	97	117	--	--	--	--	--	--	--	**105**	--	**100**			
(Trust+Communication+Reverse Scored Alienation)																									
Attachment w/ Peers																									
Trust (10-50)	31	26	**29**	24	33	28	30	**29**		21	34	50	**45**	50	33	50	36	34	50	**40**	**36**	**36**			
Communication (8-40)	24	19	**22**	33	33	29	26	**27**		31	26	38	**32**	40	22	40	36	24	39	**33**	**31**	**28**			
Alienation (7-35)	27	14	**21**	--	--	--	--	**21**		8	22	12	**14**	--	--	--	--	--	--	**14**	--	**17**			
Attachment Score	70	69	**70**	--	--	--	--	**70**		104	80	118	**101**	--	--	--	--	--	--	**101**	--	**88**			
(Trust+Communication +Reverse Scored Alienation)																									

*A – score from self-administered questionnaire
**B – score from interview, adjusted to A scale
***C – Combined average score
**** -- 1=weak bonding; 2=affectionless control; 3=affectionate constraint; 4=optimal bonding

Scores were determined separately for married and single participants by instrument and then by interview. A combined average for each group, and then a total average for normal eaters by instrument only and by Instrument and interview were recorded.
Note: There is a greater degree of the attachment variable with increasing score.
The lower the attachment score, the more insecure the attachment.

Likewise, other attachment variables showed small differences between the two data sources, ranging from 0-5 points. Nevertheless, in the final analysis, in order to assess the participants' broader attachment perspective, combined instrument and interview scores were used. The only exception was when PBI scores were compared with other scores from studies employing that instrument.

Case Reports and Drawing Cross-Case Conclusions.

For each case study, a single narrative was written to describe the case. The case study database was properly referenced, and a report, listing all the propositions and answers for each case, was prepared. It was expected that this format would facilitate the development of a cross-case analysis tailored to the reader's specific interest.

Interviews were transcribed and color-coded for highlighting various categories. Instruments were scored and charted, comparing both married and single anorectics and normal eaters. An interview evaluation form (Appendix G) was completed for each case, recording attachment, shame, and eating behavior criteria. Differences and similarities between anorectics were noted, as well as differences and similarities between anorectics and normal eaters. An interview summary (Appendix H) was prepared for all cases. Confidentiality was maintained by the use of pseudonyms. With few interviewees, only general observations could be made. However, some polarized differences were indicated between restrictive and normal eaters, as will be explained in the following chapters.

CHAPTER IV

THE RELATIONSHIP BETWEEN ATTACHMENT AND ANOREXIA

Introduction

The purpose of this chapter is to provide a summary of whether the anorectics and normal eaters responded differently to attachment criteria, as measured by the Parental Bonding Instrument and the Inventory of Parent and Peer Attachment self-report instruments, in-person interview, and observations. Each case pair was analyzed separately and progressively, within and across anorectic and normal eater groups, regarding the criteria for mother, father, parent, and peer attachment. As a pattern for comparisons, the following propositions were examined:

1. Insecure attachment with primary caregiver(s), whether parent(s) or guardian(s), is associated with increased restrictive eating behavior.
    a) A perceived lack of *protection* from the primary caregiver(s) leads to insecure attachment.
    b) A perceived lack of *care* from the primary caregiver(s) leads to insecure attachment.
    c) A lack of *trust* in the primary caregiver(s) leads to insecure attachment.
    d) A lack of *communication* with the primary caregiver(s) leads to insecure attachment.
2. A perceived sense of *overprotection* (overattachment) from primary

caregiver(s) is associated with increased restrictive eating behavior.

3. Insecure attachment with peer(s) is associated with increased restrictive eating behavior.

   a) A lack of peer *trust* leads to insecure attachment with peer(s).

   b) A lack of *communication* with peers leads to insecure attachment with peer(s)

Insecure Attachment and Restrictive Eating Behavior

Both Parental Bonding Instrument and Inventory of Parental and Peer Attachment measures showed evident differences between attachment criteria for anorectics, as compared to normal eaters. A pair-by-pair comparison revealed that 4 of the anorectics perceived both mother and father as more protective than was indicated by the normal eaters (Table 6). Three anorectics perceived their mother and 4 their father as less caring than did the normal eaters. Four anorectics indicated they had less trust toward and less communication with both parents, while 3 showed less trust toward and less communication with peers than normal eaters reported. Altogether, 4 anorectics had lower attachment scores for both parents than those scored by normal eaters, while 3 had lower scores for peers. Thus, increased insecure attachment for anorectics versus normal eaters was indicated. However, specific factors were examined more thoroughly and compared with interview data. The anorectic and normal eater groups were analyzed separately for mothers, fathers, and peers, producing parental (maternal and paternal), as well as peer scores for attachment criteria.

Table 6. Attachment criteria by pairs of anorectics and normal eaters

	Pair 1 Married		Pair 2 Single		Pair 3 Single	
	anorectics	normal eaters	anorectics	normal eaters	Anorectics	normal eaters
Age	35	36	32	34	19	19
Mother						
Protection (0-39)	30	28	37	15	13	14
Care (0-36)	22	8	27	34	30	25
Attachment Pattern*	3	2	3	4	4	4
Trust (10-50)	33	21	21	46	21	32
Communication (9-45)	24	17	26	39	19	23
Alienation (6-30)	22	23	14	12	24	22
Attachment Score** (25-125)	68	51	79	101	55	61
Father						
Protection (0-39)	22	18	26	14	14	20
Care (0-36)	28	24	6	34	15	25
Attachment Pattern*	3	4	2	4	1	4
Trust (19-50)	37	30	14	46	37	44
Communication (9-45)	32	23	13	36	27	35
Alienation (6-30)	16	22	19	8	18	17
Attachment Score** (25-125)	87	75	47	101	83	97
Peer						
Trust (10-50)	36	28	28	36	24	34
Communication (8-40)	25	29	24	36	32	24
Alienation (7-35)	22	27	25	8	24	22
Attachment Score** (25-125)	77	70	74	104	85	80

Note: except for alienation & attachment, scores were based on averaged interview & instrument scores.

#'s in parentheses indicate possible score per variable; the degree of a factor increases with higher score.

*1=weak bonding; 2= affectionless control; 3=affectionate constraint; 4=optimal bonding

**Since alienation is a negative factor, items were reverse scored before adding to trust & communication.

Table 6. Attachment by pairs of anorexics and normal eaters (Cont.)

	Pair 4 Married		Pair 5 Single	
	anorectics	normal eaters	anorectics	normal eaters
Age	35	36	25	24
Mother				
Protection (0-39)	35	11	32	15
Care (0-36)	2	36	23	36
Attachment Pattern*	2	4	3	4
Trust (10-50)	10	50	40	47
Communication (9-45)	11	45	31	44
Alienation (6-30)	29	7	13	8
Attachment Score** (25-125)	30	123	80	119
Father				
Protection	27	14	27	19
Care (0-36)	8	35	13	36
Attachment Pattern*	2	4	2	4
Trust (19-50)	13	50	22	50
Communication (9-45)	11	33	16	42
Alienation (6-30)	24	10	23	8
Attachment Score** (25-125)	40	108	57	117
Peer				
Trust (10-50)	32	30	29	50
Communication (8-40)	22	26	26	39
Alienation (7-35)	20	14	28	12
Attachment Score** (25-125)	78	69	79	118

Note: except for alienation & attachment, scores were based on averaged interview & instrument scores.
#'s in parentheses indicate possible score per variable; the degree of a factor increases with higher score.
*1=weak bonding; 2= affectionless control; 3=affectionate constraint; 4=optimal bonding
**Since alienation is a negative factor, items were reverse scored before adding to trust and communication.

Parental Attachment Findings

Protection

Protection, as assessed by the Parental Bonding Instrument and interview, was compared for anorectics and normal eaters. This section sought to answer the question: "Do anorectics perceive their parents as providing less *protection* (Proposition 1a) or more *overprotection* (Proposition 2) than the protection as perceived by normal eaters?" It was apparent that, generally, anorectics perceived parents to provide higher *protection* than normal eaters (Table 7). The difference in *protection* was greater for mothers, with the average anorectic score being 13 points higher than that of the average normal eater. Both parents of normal eaters were scored low for protection, the average score for mother being only 1 point higher than that for father.

Following Pole, Waller, Stewart, and Parkin-Feigenbaum (1988), *care* and *protection* scores for each parent were dichotomized into low and high groups. The median of the PBI *care* and *protection* scales marked the dividing line for assigning low and high (Figure 2). Parents were classified according to low or high *care* with low or high *protection* (Table 8). Only 1 father and 1 mother of anorectics were perceived as providing low *protection*. Therefore, Proposition 1a was not confirmed. A perceived lack of protection was not associated with increased restrictive eating behavior.

Overprotection

Rather than a lack of protection, 8 of the 10 parents of anorectics were show to be highly *protective,* both by PBI and parental during interviews. Three mothers and 1 father

Table 7. Summary attachment scores for anorectics and normal eaters

	Mother		Father		Parent Average		Peers	
	Anorectics	Normal Eaters	Anorectics	Normal Eaters	Anorectics	Normal Eaters	Anorectics	Normal Eaters
Attachment Factors								
Protection (0-39)*	29	16	23	19	26	18		
Care (0-36)*	21	28	14	28	18	28		
Trust (10-36)*	24	39	25	43	25	41	30	36
Communication (9-45)*	22	32	21	34	22	33	26	31
Alienation (parent 6-30; peer 7-35)*								
Regular Score	20	14	20	12	20	13	25	17
Reversed Score	16	20	17	23	17	22	23	21
Attachment Score (25-125)*	62	91	63	100	63	96	79	88

* #s in parentheses indicate possible scores per variable.The lower the score, the more insecure the attachment. Since alienation is a negative factor, items were reversed scored before adding to trust and communication. (trust + communication + reverse scored alienation = attachment score)

Note: Except for alienation & attachment (based only on instrument data), scores were based on averaged interview & self- administered instrument data. The degree of a factor increases with higher score.

Table 8. Assignment of anorectics and normal eaters to parental bonding quadrants

	Low Care		High Care	
	Low Protection	High Protection	Low Protection	High Protection
Anorectics				
Mother	--	1	1	3
Father	1	3	--	1
Normal Eaters				
Mother	--	1	4	--
Father	--	--	5	--

Note: The median points of 18 & 20 for care and protection scales of the Parental Bonding Insturment were used as the dividing line for low and high groups.

were shown to be *overprotective*, while 1 mother and 2 fathers were *protective*, but low low *caring.* Interestingly, only 1 normal eater described a pattern of high *protection* (maternal), which was combined with low versus high c*are.* Thus, Proposition 2 was confirmed. A perceived sense of *overprotection* (overattachment or control) by primary caregiver(s) was associated with increased restrictive eating behavior.

This finding reflects what Minuchin (1974) reported concerning the compromise of adaptive family functioning by diffuse (enmeshed boundaries), which describes *overprotection* as found in this study. Kog, Vandercycken, and Vertommen (1985) have suggested an "enmeshment" continuum, reflecting the degree to which individuals and subsystems behave, think, and feel similarly or differently (enmeshed pole or disengaged pole). Also, in that regard, Waller, Calem, & Slade (1989) found that anorectic and bulimic women perceived their families as more rigid (*protective*) than the controls. According to Chassler (1997), anorectic and bulimic subjects scored significantly higher on parental discipline (*protection*). Mickelson, Kessler, & Shaver (1997) reported that the more *overprotective* an adult individual felt his/her mother to have been, the more strongly s/he endorsed an anxious attachment style.

Care

Care was compared for anorectics and normal eaters. Data were obtained from interviews, as well as the PBI, which assesses one's perception of how well a parent mastered basic care-taking and nurturance tasks. The question addressed was: "Do anorectics perceive their parents as providing less care than do normal eaters?" In general, parents of anorectics were perceived as being less *caring* than parents of normal

eaters (Table 7). There was a difference of 10 points between the average parental care scores between the two groups. Perceived *care* by the anorectics' fathers was even less than that of their mothers, with the average anorectics' score for fathers being only half that of normal eaters. Calem, Waller, Slade, & Newton (1990) also reported lower perceived care by both parents of women with eating disorders versus the control group.

Parental Bonding Pattern

It was not just the degree of care and protection that was important in this study, but also the way the two factors were combined to establish a parental bonding pattern. Following Parker (1979), subjects were classified into four groups, according to their perception of the way they related to parent(s). Proportions of anorectics and normal eaters reporting each of the four combinations (i.e., parental bonding patterns) were compared (Table 9). The parenting quadrant which distinguished anorectics from controls was "optimal bonding" (high care, low protection), to which were assigned 20% of the anorectics' parents, compared to 90% of the normal eaters' parents. Pole et al. (1988) found "optimal bonding" was allotted to 5.4% bulimic parents, as compared to 43.8% of controls. But in that study, controls were not screened for normal eating behavior. Also, 75% of the bulimics in the Pole study, as opposed to 40% of the anorectics in the current study, experienced low parental care. Also, bulimics reported insufficient maternal care, with a slight trend of paternal overprotection. Whereas, 70% of the anorectics in the current study were overprotected, with 30% and 40% respectively divided between the "affectionless constraint" and the "affectionate control" quadrants. This may indicate that bulimics and anorectics have different parental bonding styles. Although Steiger,

Table 9. Parental bonding patterns* for anorectics and normal eaters based on Parental Bonding Instrument Scores

	Optimal			Weak			Affectionless Control			Affectionate Constraint		
	Anorectics	Normal Eaters	Total	Anorectics	Normal Eaters	Total	Anorectics	Normal Eaters	Total	Anorectics	Normal Eaters	Total
Mother	1	4	5	--	--	--	1	1	2	3	--	3
Father	1	5	6	1	--	1	2	0	2	1	--	1
Parental	2	9	11	1	0	1	3	1	4	4	--	4
Per Cent	20%	90%	55%	10%	0	5%	30%	10%	20%	40%	0	20%

*Key:

Optimal -- low protection, high care

Weak -- low protection, low care

Affectionless control -- high protection, low care

Affectionate constraint -- high protection, high care

Van der Feen, Goldstein, and Leichner (1989) identified no reliable differences between anorectic and bulimic PBI scores, Pantano, Grave, Oliosi, Bartocci, Todisco, and Marchi (1997) found that the presence of purgative behavior was associated with a higher incidence of a pathological family background. This may suggest that more bulimics than anorectics would have a "weak" bonding pattern.

Only 10% of the anorectics in the current study were in the "weak" bonding quadrant, while 20% reportedly experienced "optimal" bonding (Table 9). From a mental health point of view, Canetti, Bachar, Gaalili-Weisstub, De-Nour, and Shalev (1997) found that "weak" parental bonding was better than either "affectionate constraint" or "affectionless control". According to Parker (1990), low care and high control, (affectionless control), have been related to neurotic conditions, whereas high care and high control, (affectionate constraint), have been associated with dependency, hypochondrias, asthma, and panic disorders.

Low Versus High Care

For further comparative purposes of the *care* dimension for anorectics versus normal eaters, participants were categorized into low and high *care* groups, irrespective of *protection* scores (Table 10). Although average anorectic versus normal eater maternal *care* scores were lower, the actual level on the care scale was high for 4 of the 5 participants. Generally, mothers of anorectics were perceived as being more *caring*, but more controlling than were their fathers. The bond with the mother was perceived as closer, yet more restrictive. In comparison, both parents of normal eaters' were perceived as high *caring*, with the exception of one mother. In contrast to anorectics, their fathers

Table 10. Low versus high parental care perceptions of anorectics and normal eaters

	Low Care	High Care
Anorectics		
Mother	1	4
Father	3	2
Total	4	6
Normal Eaters		
Mother	1	4
Father	--	5
Total	1	9

Note: Parental Bonding Instrument care scores were dichotomized, without regard to protection scores. The median points of the care and protection scales were used as the dividing line for low and high groups.

showed more care, *and* both parents less protection (control). Four of the anorectics perceived their mothers and 2 their fathers as providing high *care*, while 1 perceived her mother and 3 their fathers as providing low *care*. Conversely, there were 4 high *care* mothers and 5 high *care* fathers of normal eaters, with only 1 mother reported as giving low *care*. In other words, 60% of the anorectics perceived their fathers as giving low care, in contrast 20% who considered mother as providing low care. Thus, split support for Proposition l b was indicated, in that a lack of care from the paternal, but not maternal, primary caregiver(s) appeared to lead to insecure attachment. According to Steiger et al. (1989), feelings of having failed to please fathers may by related to the self-image and heterosexual difficulties, characteristic of anorectics and bulimics.

Comparison of PBI Scores from Other Studies

By comparing PBI scores from Australian adolescents (Canetti et al. 1997), Israeli adolescents (Cubis, Lewin, and Dawes 1989), and Australian adults (Parker, 1983), it is evident that scores are within close range, indicating that the impact of parental bonding continues into adulthood. Findings from a 31-year longitudinal study by Klohnen and Bera (1998) confirmed the continuity of attachment patterns across adulthood.

PBI scores for anorectics versus controls from three studies were compared with scores for anorectics versus normal eaters in the current study (Table 11). Considering the combined average scores, normal eaters were within very close range, except for being 5 points higher for parental care. Anorectics' scores were also within close range, except for maternal protection, which was scored 10 points higher in the current study. This variance was surprising, since both empirical research and clinical practice have

continued to emphasize the separation-individuation process and autonomy disturbances related to high maternal overprotection , as indicated by the current study (Armstrong and Roth, 1989, Cole-Detke & Kobak, 1996, Rhodes and Kroger, 1992, Wechselblatt, Gurnick, and Simon, 2000).

Calam, Waller, Slade, and Newton (1989), in research on eating disordered women, partially replicated the findings concerning bulimics by Pole et al. (1988). Both studies found a trend toward significant differences in paternal protection between the controls and the eating-disordered groups. In the latter study, this was accounted for by perceived paternal overprotection on the part of the bulimic anorectic respondents. Comparing 11 anorectics and 9 bulimics with 20 age-matched non-eating-disordered women, Rhodes and Kroger (1992) also assessed aspects of attachment dynamics.
They found that the eating-disordered women rated their mothers as significantly less caring and more protective than did the non-eating-disordered women, but there were no significant differences found on the PBI paternal measures. That study also incorporated the Separation-Individuation Test of Adolescence (Levine et al., 1986), revealing significant differences between the eating-disordered and control groups on separation anxiety, engulfment anxiety, dependency denial, and healthy separation.

Could the discrepancies in maternal/paternal protection be related to ambivalent thoughts and feelings about needs for both connectedness and autonomy, so that it may be difficult, prior to much therapy, to clearly discern the difference between closeness and overprotection, especially with the mother? None of the anorectics in the current study were in early stages of treatment, as may be true of participants

Table 11. Comparison of parental care and protection scores of different samples as assessed by Parental Bonding Instrument

Study Source	A*	B**	C***	Average	Current Study
Anorexics	N=15	N=31	N=35		N=5
Mean Age	26	23	24	24	27
Maternal Care	22	25	23	23	22
Paternal Care	17	23	23	21	19
Maternal Protection	19	16	12	16	26
Paternal Protection	18	15	11	15	18
Controls	N=24	N=242	N=410		N=5
Mean Age	28	25		28	
Maternal Care	27	27	27	27	26
Paternal Care	25	23	24	24	29
Maternal Protection	16	14	13	14	13
Paternal Protection	12	13	12	12	12

* Canadian study by Steiger et al. (1989); controls screened by Eating Attitudes Test

** British study by Calem et al. (1990);comparison group of female volunteers, mostly college students

*** U.S. study by Palmer et al. (1988), control group drawn from published normative data from Australian general practice patients (Parker, 1983)

Note: Scores were rounded to the nearest whole number.

drawn from hospitals and eating disorder clinics in most studies

In a nationally representative sample of a non-institutionalized population between the ages of 15-54, Mickelson et al. (1997) found maternal and paternal events showed similar relations to adult attachment, suggesting comparable parental influences on their offspring's adult attachment styles. The researchers explained differences occurring between the effect of mothers and fathers on adult attachment were mainly due to a difference in the affinity versus the strength of the relationship. For example, paternal overprotectiveness was negatively related, while maternal overprotectiveness was positively related, to avoidant attachment.

Trust

The Inventory of Parent and Peer Attachment and personal interview data were used to assess trust, along with communication and alienation, all-important components of attachment research. The three factors considered together were used to determine overall attachment to parent(s). But more specifically in this section, the question is: "Do anorectics perceive themselves as having less *trust* toward their parent(s) than normal eaters perceive?" As expected, *trust* scores were dramatically lower for anorectics' perception of parents than that of normal eaters (Table 7). Regarding *trust*, anorectics scored 15 points lower than the average normal eaters' score for mother and 18 points lower for father. This confirmed Proposition 1c. A lack of *trust* in the primary caregiver(s) appeared to lead to insecure attachment. Results supported the premise by Bowlby (1979) that when attachment figures are experienced as *untrustworthy,* unloving, inconsistent or rejecting, the child may develop a disturbed attachment behavioral

pattern.

Chassler (1997) reported that anorectic and bulimic subjects versus controls experienced early attachment figures as significantly less *trustworthy*, responsive, and available. Deprived of a secure attachment base, anorectics and bulimics may fail to acquire the necessary skills and a sense of resiliency (Bowlby, 1979) to deal effectively with hazards and risks of the world and consequently, develop strategies to ensure proximity (Chassler, 1997). Findings by Paterson, Pryor, and Field (1995) have supported the theory that adolescents' self-esteem is associated with *trust* in the availability, accessibility and responsiveness of their parents. Furthermore, the researchers suggest the likeliness that when an adolescent feels it is his/her decision not to utilize the available support, self-esteem may not be affected. However, when parental support is unavailable, low utilization may have a different meaning and effect on self-esteem.

Communication

The question addressed in this section was: "Do anorectics perceive themselves as having less quality of communication with their parent(s)?" As with trust, scores were decidedly lower for anorectics' perception of parental communication quality. Anorectics' rated *communication* 10 and 13 points less with mother and father, respectively, than did the normal eaters. Therefore, there was also confirmation for Proposition 1d. A lack of *communication* with the primary caregiver(s*)* appeared to lead to increased attachment.

Humphrey (1989) found that parents of anorectics' *communicated* a double message of nurturance combined with neglect of their daughters' emotional needs to

express themselves. In turn anorectic daughters were ambivalent about submitting to parental expectation versus disclosing their true feelings. Chassler (1997) linked eating disorders to feeling unwanted when parent(s) are persistently unresponsive or rejective to their daughters' care-eliciting behavior. According to Bowlby (1977), repeated disruptions in attachment (communication being one of the key components) lead a child to feel unloved, deserted, and rejected.

Attachment Score

There was only 1-point difference between average attachment scores for anorectic fathers and mothers. However, lower attachment scores for mother and father of anorectics by 29 and 37 points, respectively, than those for mother and father of normal eaters, indicated that "insecure attachment" was associated with restrictive eating. Interestingly, average anorectic scores for *alienation*, the third component for computing the IPPA attachment score, were the same for both parents of anorectics, being 6 and 8 points higher than that for mothers and fathers, respectively, of normal eaters. The lower attachment scores for anorectics confirm findings by Chassler (1997) that anorectic (and bulimic) subjects scored significantly lower than controls on secure attachment base. O'Koon (1997) has also reported that the quality of parental attachment had a significant relationship with coping aspects of one's self-image.

Peer Attachment Findings

As suggested in the literature review, friends may provide a framework for particular aspects of growing up that could not be provided by parents. Regarding peer attachment, the average anorectic score was 9 points lower than that for normal eaters.

O'Koon (1997) found peer attachment to be significantly related with self-image, particularly in areas of body image, vocational goals, and sexuality. According to Armsden and Greenberg (1987), securely attached adolescents reported a greater likeliness to seek social support. Rice (1990) concluded that adolescents and young adults who reported secure, trusting parental attachment relationships also reported higher levels of self-esteem, social competence, and general life satisfaction. Likewise, Blain, Thompson, and Whiffen (1993) noted that individuals who reported positive models of both self and others (secure attachment) also reported the highest levels of perceived social support from parents and friends. A negative model of self or other (insecure attachment) had a negative impact on perceived social support and attachment to friends.

Trust

IPPA scores for *trust* were compared for the two groups to answer the question, "Do anorectics perceive themselves as having less trust toward peers than do normal eaters?" Although the average difference between anorectics' and normal eaters' scores for parental versus peer *trust* was greater, anorectics scored peers 6 points less than normal eaters scored them. Again, although not as strongly as for parental trust, Propositions 3a was confirmed. A lack of *trust* appeared to lead to insecure attachment with peers.

Communication

Peer communication scores were compared for anorectics and normal eaters to answer the question, "Do anorectics perceive the quality of their communication with peers as being less than do normal eaters?" Regarding the quality of *communication*,

anorectics scored 5 points less than the normal eaters. Proposition 3b was also confirmed, although not as strongly as parental communication. A lack of *communication* appeared to lead to insecure attachment with peers.

Alienation

The lower peer attachment score for anorectics, indicating somewhat more insecurity in peer relationships, may be explained also by higher perceived *alienation*. The average alienation score for anorectics was 8 points higher than that experienced by normal eaters, as well as 5 points higher than what they themselves perceived from their parents. Apparently, perceived parental alienation is related to attachment pattern and carries over into peer relationships.

Raja, McGee, and Stanton (1992) concluded that adolescents who perceived secure attachments to both parents and peers had the highest scores on a measure of self-perceived strengths. But regarding their mental health, adolescents' perceived peer attachment did not appear to compensate for an insecure parental attachment. Canetti et al. (1997) observed that subjects perceiving high care and low control (optimal bonding, as was true for 90% of the normal eaters' parental relationships in this study), reported not only less distress and better general well being, but also better social support than did all other groups. Thus, insecure bonding patterns of anorectics may explain less *trust* and *communication* with peers.

Summary

The analysis confirmed all the propositions except 1a, while 1b was only supported for maternal care. Low protection was not generally found among restrictive

eaters. Even though anorectics perceived a lack of care by fathers, both parents were generally considered overprotective. Despite scores being lower than those of normal eaters, anorectics generally regarded mothers as giving high care, but being more controlling. Trust and communication were both rated lower for parents of anorectics than normal eaters. Anorectics also perceived less trust and communication in regard to peers, although the differences were smaller

The study confirms findings of earlier research on the differences between maternal and paternal bonding of anorectics. Mothers were perceived as being more caring and more controlling, and therefore, overattached with their daughters. The bond with the mother was perceived as closer, but more restrictive. Anorectics' fathers were often perceived as being physically or emotionally absent, but still highly protective.

CHAPTER V

THE RELATIONSHIP BETWEEN SHAME AND ANOREXIA

Introduction

There are social facets to emotional expression. As noted by Freund (1990), "Emotions represent a juncture between society and the most personal realms of an individual's experiences. They also straddle both the mental and physical aspects of our being" (p. 453). As noted in the literature review, shame is necessary for one's emotional ecology to protect the boundaries of the self. However, repeated experiences of negative self-perception through attachment figures' attitudes and responses can lead to a self-structure dominated by shame (internalized shame). When intense negative emotional states are frequently triggered, some means of defense is developed against this painful condition. According to Broucek (1991), "The child may either experience the gaze of the other as supporting his intentionality, excitement, and indwelling sense of self, or he may experience being looked at in a way that objectifies him" (p. 48). Shame occurs when one is tempted to abandon one's authentic subjectivity and become an object, "something thrown in the way" (p. 43). Such perception leads to reactive and mechanical behavior, with a loss of spontaneity and autonomy.

This chapter examines the relationship between shame and the anorexia phenomenon of distorted self-perception. In addition to the investigation of Proposition 4, there is also a comparison of shame and parental bonding patterns. Proposition 4 stated

that:

Internalized shame is associated with increased restrictive eating behavior.

a) Inferiority is related to increased internalized shame.

b) Perceived alienation is related to increased internalized shame.

c) Low self-esteem is related to increased internalized shame.

d) Negative peer influence is related to internalized shame.

Internalized Shame Scale and Interview Results

As with attachment, shame criteria was first compared by pairs (Table 12), then across cases and finally collectively (Table 13). Shame scores were obtained by summing the inferiority and alienation sub-scales. The higher the score, the greater was the level of shame. In general, there was shown a dramatic difference in average shame scores of the two groups. Based upon a scale ranging from 0 to 96, anorectics, on the average, scored 52 points higher than normal eaters. Married and single scores for anorectics were 48 and 56 points higher, respectively, as compared with those of married and single normal eaters. However, it is also noteworthy that shame scores were higher for married participants in both groups. Although shame scores were lower for normal eaters, the difference between married and single was greater, being 13 and 21 points for anorectics and normal eaters, respectively. This would suggest that all married respondents experienced more shame than the single ones. An explanation may be that shame is often around issues of the female role and sexuality, which may be more pronounced for the married individual.

Table 12. Shame criteria by pairs of anorectics and normal eaters

		Pair 1 Married		Pair 2 Single		Pair 3 Single		Pair 4 Married		Pair 5 Single	
		anorexic	normal eater	anorexic	normal eater	anorexic	normal eater	anorexic	normal eater	anorexic	normal eater
Shame (0-96)*		74	54	68	20	60	5	87	12	77	15
Self-Esteem (0-60)		6	14	7	20	8	24	8	22	6	21
Inferiority (0-60)		48	33	44	12	41	1	57	8	49	7
Alienation (0-36)		26	21	24	8	23	4	30	4	28	8
Dying to BeThin (0-80)**	26	26	70	25	69	29	63	23	62	29	69

*50 or higher -- indicative of painful level
60 or higher -- indicative of extreme level

**38 or less -- strong tendencies toward anorexia
39-50 -- strong tendencies toward bulimia
50-60 -- weight-conscious, with poossible compusive-eating or obesity tendencies; not likely to be anorectic or bulimic
60+ -- extremely unlikely to have anorexia or bulimia

Table 13. Summary shame, alienation, and Dying to Be Thin scores for anorectics and normal eaters

	Married		Single		Average	
	Anorectics	Normal Eaters	Anorectics	Normal Eaters	Anorectics	Normal Eaters
Internalized Shame Scale						
Shame (0-96)* (Inferiority + Alienation)	81	33	68	12	75	23
Inferority(0- 60)	53	21	45	7	49	14
Alienation (0-36)	28	13	25	7	26	9
Inventory of Parental and Peer Attachment						
Alienation						
Mother (6-30)	26	15	17	14	20	14
Father (6- 30)	20	15	20	11	20	12
Parent (6- 30)	23	15	19	13	20	13
Peer (7- 35)	25	21	26	14	25	17
Internalizeed Shame Scale						
Self-Esteem (0-24)	7	18	7	22	7	20
Dying To Be Thin**	25	66	28	69	27	68

*50 or higher-- indicative of painful level
60 or higher-- indicative of extreme level

**38 or less -- strong tendancies toward anorexia
39 - 50 -- strong tendancies toward bulimia
50 - 60 -- weight conscious, with possible convulsive eating obesity tendancies; not likely be anorectic or bulimic
60+ -- extremely unlikely to have anorexia or bulimia

Note: #s in parentheses indicate possible score per variable. Except for Dying to Be Thin, the degree of a factor factor increases with higher score.

Cook (1994) reported Internalized Shame Scale scores of comparative groups, which included subjects from several different diagnostic categories. These samples were compared with each other and with a large clinical group. The eating disorder subjects had the highest average ISS score than any other clinical group. The non-clinical and eating disorder groups were compared with the normal eaters and anorectics of the current study (Table 14). While no conclusions may be drawn, it is interesting to note that the average shame score for the clinical group was 13 points higher than that of the normal eaters in this study. Although a possible explanation may be the smaller sample size in the current study, it might also be noted that the non-clinical group was not screened specifically for normal eating criteria, even though psychiatric disorders were ruled out. Albeit not a great difference, anorectics scored 5 points higher than the eating disorders group, which included some anorectics, but also bulimics and compulsive overeaters. This may suggest that anorectics experience more shame than the other eating disorder categories, so that anorectics only in the larger study may have shown a higher average shame score. Reynolds (1991), who studied 28 bulimic and anorectic women, reported a significant relationship between severity of the eating disorder and degree of internalized shame.

Table 14. Average Intermalized Shame Scale scores from clinical and non-clinical groups,* as compared with anorectics and normal eaters in current study

Controls	
Non-clinical (*N*=514; 96% females; average age 22)	34
Normal Eaters (*N*=5; females; average age 30)	21
Abnormal Eaters	
Eating Disorders (*N*=25; females; average age 24)	69
Anorectics (*N*=5; females; average age 29)	74
Other Abnormalities	
Post Traumatic Stress Disorder (*N*=47; males only)	59
Alcohol/Drug (*N*=247; 60% females)	50
Affective Disorders (*N*=84; 32% females)	49
Other Psychiatric Diagnosis (*N*=36; 56% females)	49

*Data from clinical and non-clinical groups reported in Internalized Shame Scale Professional Manual by David R. Cook (1994), p. 32.

Indeed, the relationship of shame to anorexia is complex. Is the shame about self-starvation or some other aspect of the self? Average Dying to Be Thin scores were 41 points higher for anorectics, as compared to normal eaters (Table 13). However, in a study of bulimic women, McCreery (1993) concluded that their elevated shame levels appeared to be not due just to appearance orientation, but were directly related to a insufficient acceptance of normal interpersonal needs and thus, rooted in connectedness to others. Hence, disordered eating may be the way a person expresses symptomatically the sensitivity to rejection, which tends to be characteristic of those who are overly dependent upon emotional support from others. This may suggest that the ambivalent *overprotection* conflict of autonomy versus interdependence induces shame.

Inferiority

Table 13 shows elevated inferiority scores for anorectics, as compared to normal eaters. On a scale of 0 to 60, the average inferiority score for anorectics was 35 points higher than that for normal eaters. The greater difference was seen between single anorectics versus single normal eaters, being 6 points more than the difference between married anorectics versus married normal eaters. These findings substantiate Proposition 4a, as inferiority appeared to be related to increased internalized shame. Reynolds (1991) also reported that eating disordered participants viewed themselves with extreme feelings of inadequacy and self-loathing. Vitousek and Ewald (1993) used the "unworthy self" theme to describe the anorectic's feelings of helplessness, ineffectiveness, poorly developed sense of identity, extreme sensitivity to criticism, and conflict over autonomy/dependency.

Interviews further confirmed this sense of inferiority. One anorectic pseudo-named Amy, for the purposes of this study, said, "I didn't feel worthy to have the material things I had, my husband, my family...those three beautiful kids...The more I felt those negative feelings toward myself, the fatter I looked…. It's just a feeling of fat. You don't even have to look in a mirror. I felt bad about myself, about everything and everybody." It's as though the anorectics were convinced they were taking up too much space, eating or wanting food too much, too emotional, and too needy. For example, Sally reported, "I would deny myself food, because that was nurturing myself. I felt I wasn't worthy of nurturance."

Alienation

Alienation scores were compared for anorectics and normal eaters, revealing that, on a scale of 0 to 36, the average anorectic's score was17 points higher than that for the normal eater (Table 13). Therefore, results supported Proposition 4b, in that perceived alienation appeared to be related to increased internalized shame. The difference was greater as reported by the ISS, which measures more of a global sense of alienation, than the IPPA, which assesses alienation specific to mother, father, and peers. Thus, the alienation measured by the IPPA may be foundational for that measured by the ISS, which becomes more pervasive.

Both literature and interview data indicate that alienation increases as an eating disorder worsens. According to Bordo (1993), "The practice of dieting (saying no to need for food) contributes to the anorectic's increasing sense of hunger as a dangerous eruption from some *alien* part of the self and to a growing intoxication with controlling

that eruption" (p. 143). Thus, there appears to be a dualistic separation between body and mind. Not only is the body sensed as alien, but also as confining (a prison, a cage, etc.), and as an enemy, threatening all attempts at control. The anorectics in this study often portrayed food as an enemy. Amy, an anorectic in this study considered her restrictive relationship with food as "more important than my marriage at the time." Whereas, another anorectic, Susan said she continued to have a hate relationship with it. "I don't like it, and I don't want anything to do with it, but it's something I need for nourishment and survival."

Bordo (1993) described the anorectic's constant battle against the unruly forces of the body, which erupt, disrupt and overwhelm the mind. Vitousek and Ewald (1993, p.229) have described the "over-whelmed self" as having a sense of being intolerably burdened by complex or ambiguous situations, and often paralyzed with indecision, longing for simplicity, clarity, certainty, and predictability, while retreating from complex or intense social environments. Amy also reported that, as the eating disorder worsened, "I would withdraw from everybody. I would talk with my girls and husband, only because I had to." Another anorectic participant, Saundra stated, "I wanted to stay in my own little zone." Thus, self-denial is pursued as an end in itself, out of an almost mystical belief in the purity it confers. Saundra added, "I just wanted to be perfect and pure. . . . I always felt like there was something wrong with me if I weren't perfect. I would drink tons of water to cleanse myself, like gallons and gallons."

Low Self-esteem

Normal eaters' self-esteem scores were nearly three times that for anorectics

(Table 13). Although there were no differences between scores of single and married anorectics, single versus married normal eaters' scores were 4 points higher. Higher shame scores paralleled low self-esteem evaluation. Therefore, findings seem to confirm Proposition 4c. Low self-esteem did appear to be related to increased internalized shame.

Scheff (1988) has conceptualized low self-esteem as "a tendency toward endlessly recursive shame spirals of potentially limitless intensity and duration," (p. 405). Thus, a situation that threatens to cause shame is perceived as overwhelmingly painful. Interview transcripts demonstrated that anorexics, having low self-esteem, were unable to manage shame. There is a strong statement about avoidance of conflict and denial of feelings through self-deception.

Although not specifically identifying shame, each anorectic spoke of emotional control. Concerning her eating disorder, Amy explained, "It's just a way to handle emotions or stress. It's just a way to stuff those emotional feelings, instead of saying something." As Saundra put it, "In public, when I feel like someone is angry at me, or I haven't measured up . . . that's when I feel like I shouldn't eat." And Sally commented, "I'm afraid of rejection.... My therapist says I have enough anger inside to fill the world, and I'm never going to get over my eating disorder until I let myself get angry...but I'm terrified of totally getting angry."

Unable to restrain events outside themselves and having overpowering emotions, the anorectic's preoccupation with reestablishing control becomes paramount. Wurmser (1981), in summarizing the main dynamics of the shame syndrome, suggested two paradoxical ways to regain control: by closing off interaction with the outside or by

overwhelming and overpowering the outside world. This polarity is enacted in various ways. First, emotions may be displaced either by perceptual-expressive blocking of feelings or by self-exposing, emotional display. Secondly, emotional control may be displaced onto eating and exercising to conquer and subdue the body. Abstinence, tests of endurance become ways of proving self-sufficiency and invulnerability. This is "the perfectible self" described by Vitousek and Ewald (1993, p. 227), with grandiose fantasies of omnipotence. Thirdly, the individual may vacillate, with defiance and spite, between rage and depression.

Four of the anorectics interviewed specifically mentioned suicidal thoughts and/or attempts. One participant said she tried three times to take her life. In contrast, none of the normal eaters reported ever giving any thought to suicide. According to Wurmser (1981), closing off emotions and/or failing to meet goals may lead to anger turned against the self, in the form of obsession with self-punishment, death and dying. With the unworthy self, being confirmed by repeated experiences of self-defined failure; the overwhelmed self, confounded by the multiplicity of impossible roles and identities; and the perfectible self, struggling to restore a sense of order and purpose, an impasse of hopelessness is inevitable. (For adaptive functions of the aspects of self, see Table 15).

Costin (1996) has explained that "The development of an eating disorder may begin early in life when childhood needs and mental states are not properly responded to by caregivers, and thus get disowned, repressed and shunted off into a separate part of a person's psyche. The child develops deficits in his or her capacities for self-cohesion and self-esteem regulation. To Claude-Pierre (1997) it makes little sense to talk about

Table 15. The adaptive function of anorectic symptoms for aspects of the self

Aspects of the self	Functions of anorectic symptomatology
Unworthy Self	
Low self esteem	Weight loss leads to feelings of pride and accomplishment Scale permits daily assessment of personal worth
Feelings of helplessness and ineffectiveness	Personal control established over one area of functioning Self-denial enhances sense of self-efficacy Control over others increases
Poorly developed sense of identity	Identity of an anorectic is acquired Thinness and fasting help to define boundaries of self Complex issues surrounding adult identity are bypassed
Tendency to seek external verification	Weight becomes template for determining correct conduct Social endorsement of thinness and self-control
Extreme sensitivity to criticism	Teasing about weight avoided; importance of weight increases sense of vulnerability in other domains
Conflicts over autonomy and dependence	Disorder allows defiant assertion of independence, while simultaneously eliciting concern, nurturance, and attention from others
Perfectible self	
Perfectionism	Weight, calories, and exercise offer quantifiable standards for achievement Strivings focus on a domain amenable to exercise of will
Grandiosity	Visibly surpass others in a domain highly valued by others Sense of uniqueness and superiority derived from disorder
Asceticism	Bodily urges suppressed through self-control and starvation Sins of overeating can be atoned for through fasting,, purgation, and exercise
New Year's resolution cognitive style	Preference for dichotomous good/bad rule systems satisfied Disorder sets attainable series of challenges

Table 15. The adaptive function of anorectic symptoms for aspects of the self (Cont.)

Aspects of the self	Functions of anorectic symptomatology
Overwhelmed self	
Preference for simplicity	Cognitive focus narrowed by starvation and schematic processing Weight control provides simple, predictable rule system
Preference for certainty	Belief in thinness exempt from mistrust of experience Weight and calories provide quantifiable feedback
Tendency to retreat from complex social environments	Dieting and starvation aid retreat into self Social demands and expectations become less relevant Conflict created by sexual maturation is alleviated
Avoidance of strong affect	Emotions blunted by starvation Eating, purging, and exercise used to regulate emotions

Taken from Vitousek, Kelly B. & Ewald, Linda S. (1993). Self-representation in eating disorders: A cognitive perspective. In Segal, Zindel V. & Blatt, Sidney (Eds.), The Self in Emotional Distress: Cognitive and Psychodynamic Perspectives. Used by permission of Blatt and Vitousek.

struggling to build an anorectic's self-esteem, "…because that person has no clear sense of self to which to attribute the esteem. This makes the victim feel more worthless, and the parent and loved one more guilty." The author concluded, "Esteem will naturally begin to develop after the self has begun to emerge."

Peer Influence

There was a slight difference in peer alienation, as measured by the IPPA, experienced by married and single anorectics (Table 13). The average ISS peer alienation score for anorectics versus normal eaters was 8 points higher. As with other shame variables, higher peer alienation scores for anorectics paralleled higher shame scores than those for normal eaters. Therefore, these findings, as well as interview data, described below, confirmed Proposition 4d, as negative peer influence appeared to be related to increased internalized shame.

Anorectics seemingly had more difficulty making friends and isolated more than normal eaters, primarily due to low self-esteem and food issues. For example, Amy, reflecting on her thought process, explained, "If I got thinner, then maybe it would be easier to make friends...if I could get thinner, smaller, then I would feel better about myself and other people would like me better." As the eating disorder worsened, she would avoid people, fearing that " I'm so much heavier than I was the last time they saw me. And I don't like being in big crowds...because I feel that everybody is going to think I'm fat." Sally also acknowledged being introverted and having difficulty making friends. She recalled, "I tended to have one or two friends at a time... I had one best friend and almost became enmeshed, and when, that person was not there, I felt abandoned." And

even at the time of the interview, she expressed, “I don’t feel I should even continue to have friends. I don’t deserve it.” Susan also expressed difficulty in making friends, because, “I don’t like to lay myself out to get hurt. Although Amy, Sally, and Susan expressed difficulty in making friends, Saundra said she hung around a lot of clubs, and a lot of time with bad crowds. In order to get refocused, “I started working out more. And then I ‘d feel fat and not want to go out.” Even though she reportedly made friends very easily, Saundra acknowledged that she “had very limited trust and could not get close.” As for Alice, “I could make friends, but could not maintain relationships…I hung out with every crowd. I was with the actors...I hung out with the potheads. You name it. I was heavy into alcohol and drugs, just trying to get through high school any way I could…it was more of a place where I could go cry. Crying was not allowed in my house.”

O’Koon (1997) reported that peers had a strong effect on self-concept, such as body image, vocational goals, and sexuality attitudes. Although not fully aware of it, anorectics appeared to learn anorexia from peers. Sally acknowledged being influenced by her sister’s college anorectic roommate. She also recalled, “I would always look at what other people were eating. And I’d say, ‘Oh great! I’m eating the least.’ ” During out-patient recovery, she turned perfectionism on its head. “This is a place where I can succeed when others fail—by eating, by working though problems.” Saundra, who reported never noticing any eating problems among the girls in her sorority, said, “I feel like everyone has an eating disorder and no one has an eating disorder. I mean, no one ever said, ‘Let’s all not eat together. Let’s go throw up together.’ That was never

presented to me. It was just me. I wanted to be perfect. I felt like I was more extreme than anyone I saw." O'Koon (1997) suggested that self-expression and self-discovery groups enhance female attachment relationships and self-image. Although anorectics generally reported support groups strengthening their recovery, there was one exception. Susan said she knew no one in college with an eating disorder, but recalled that when put into a treatment center for a suicide attempt, "I learned a lot from people in that program. It was after that, when I really got into not eating and losing weight. I lost 30 pounds after that."

Where insecure relationships with peers were reported, anorectics also indicated not only insecure parental attachment, but also discomfort and shame in being with family in public. As Amy described her feelings, "I was nervous, on edge, anxious. I put pressure on myself to be the daughter of a family so respected in the community." Sally related that she was embarrassed to be with her family and always tried to get their attention off fighting. Alice described her family as living in two different worlds. "In public, we were supposed to look like this perfect little family . . . In public, she was this wonderful mother. And she would hug on me and say, 'Oh, I'm so proud of my daughter.' But then she would be putting me down, putting me down . . . And everything was a big lie, and so I felt real ashamed, because I was part of this big lie."

Paterson et al. (1995) found that the quality of adolescent relationships with mothers and fathers had a stronger impact on adolescents' overall self-esteem and their coping abilities than the quality of peer influence. Although there was no significant correlation with overall self-esteem or coping abilities, the quality of affect toward friends showed a significant relationship with social competence. Thus, Paterson et al.

(1995) concluded that interpersonal peer relationships play a very important role in adolescent life and certainly exert some influence on adolescents' feelings and behavior. In research by Tiller, Sloane, Schmidt, Troop, Power, & Treasure (1997), it was shown that eating disorder patients had smaller and more significantly impaired social networks, as compared to controls. Chassler (1997) reported differences in peer affectional support of eating disorder subjects versus controls. As children, anorectics and bulimics reported feeling significantly more unwanted, alone, and helpless, experiencing significantly more shame and guilt than did those in the control group. Peer relationships were significantly affected. In childhood, the anorectics reported poorer peer support systems, fewer friends, and more difficulty making friends than did the controls.

Shame Scores and Parental Bonding Patterns

Since shame is a response to a negative self-evaluation, arising from exposure to one's perceived deficiencies and unacceptability; there may be differences in levels of shame according to parental bonding pattern. Respondents with optimal bonding reported the least shame (Table 16). Of both normal eaters' parents, 90% showed optimal bonding. Participants with weak parental bonding (10% anorectics) indicated less shame than did those, who reported either an "affectionless control" or "affectionate constraint" pattern. There were 10% more anorectics indicating "affectionate constraint" versus "affectionless control" parental bonding, but "affectionate constraint" most represented their mothers. Furthermore, average anorectic shame scores were 8 points higher in the "affectionless control" versus "affectionate constraint" quadrant, along with higher

Table 16. Average shame scores for anorectics and normal eaters according to parental bonding patterns*

	Optimal			Weak		
	Mother	Father	Parental	Mother	Father	Parental
Parents/Pattern (N=20)	5	6	11	0	1	1
% in pattern	25%	30%	55%	0%	5%	5%
% Anorectics' Parents	10%	10%	20%	0%	10%	10%
% Normal Eaters' Parents 80%	40%	50%	90%	0%	0%	0%
Shame (0-96)**						
Anorectics	60	77	69	--	60	60
Normal Eaters	22	28	26	--	--	--
Average	30	37	33	--	60	60
Inferiority (0-60**)						
Anorectics	41	49	45	--	41	41
Normal Eaters	10	18	17	--	--	--
Average	20	26	23	--	41	41
Alienation (0-36)**						
Anorectics	24	23	24	--	18	18
Normal Eaters	12	13	12	--	--	--
Average	15	14	14	--	18	18
Self- Esteem (0-24)**						
Anorectics	8	6	7	--	8	8
Normal Eaters	22	20	21	--	--	--
Average	19	18	18	--	8	8

Table 16. Average shame scores for anorectics and normal eaters according to parental bonding patterns.* (Cont.)

	Affectionless Control			Affectionate Constraint		
	Mother	Father	Parental	Mother	Father	Parental
Parents/Pattern (N=20)	2	2	4	3	1	4
% in pattern	10%	10%	20%	15%	5%	20%
% Anorectics' Parents	10%	20%	30%	30%	10%	40%
% Normal Eaters' Parents	10%	0%	10%	0%	0%	0%
Shame (0-96)**						
Anorectics	87	78	81	73	74	73
Normal Eaters	54	--	54	--	--	--
Average	71	78	74	73	74	73
Inferiority (0-60)**						
Anorectics	57	51	53	47	48	48
Normal Eaters	33	--	33	--	--	--
Average	45	51	48	47	48	48
Alienation (0-36)**						
Anorectics	29	22	24	16	22	18
Normal Eaters	23	--	23	--	--	--
Average	26	22	24	16	22	18
Self- Esteem (0-24)**						
Anorectics	8	8	8	6	6	6
Normal Eaters	14		14	--	--	--
Average	11	8	9	6	6	6

*Key: Optimal -- low control, high care
Affectionless control -- high control, low care
Weak-- low care, low control
Affectionate constraint -- high control, high care

**#s in parentheses indicate possible scores per variable. Degree of a factor increases with higher score.

in the “affectionless control” versus “affectionate constraint” quadrant, along with higher inferiority, alienation, and self-esteem scores of 5, 6, and 2 points, respectively. This may indicate that caring control is less shaming than uncaring control.

In the interviews, anorectics described how they felt about the parental control and lack of attunement. Alice recalled being the scapegoat to a controlling 'rage-aholic' and prescription drugs-addicted mother. “My mom was the only one who was allowed to have needs... The whole point of living there was not to get her angry.... For some reason (she) did not like me. I felt that, from a very young child…. I was this horrible, rotten kid who was making her life miserable.... I just remember trying to do everything I could, trying to make her happy.... I spent my whole childhood and adolescence trying to be the person she wanted me to be, but she never made up her mind who she wanted me to be.” Susan, whose parents divorced before she was 1 year old, described her role as caretaker of a mother, who was always depressed and sick in bed. She reported feeling rejected by her father, who appeared distant, cold, and angry. Lack of healthy parental connection left her feeling “disconnected and detached from others.” Amy, whose mother was a perfectionist and father more laid-back, said, “Things very personal and intimate were not talked about.... There were not a lot of close conversations.... It was just kind of flat emotionally all the time.... Anger was rarely expressed. If you did get angry, you were told to talk in a normal tone of voice... So I just capped it off.” Sally, who was enmeshed with her mother and later an older sister, stated about her mother, “She would always buy things, but there were definitely strings attached…. She still wants to take care of me.” Concerning her emotionally distant father, whom she felt she was more like, she replied,

"I continue to have a relationship through achievement in sports and other areas. But it was never enough [to please him]." Finally, Saundra described her mother as nurturing with strings attached, because everything had to be perfect. She considered her dad another kid and herself "the peacemaker". "When I look back on it, they would love me if I could make things work…. I was trying to help everyone else out and trying to make the family smooth." She said when her parents were divorced, she reportedly felt worthless.

A Self-Belief Model

As has been seen, the most common bonding pattern for anorectic respondents was a high care/high-controlling (protective) mother, often coupled with a low care/high-controlling (protective) father. Shame scores increased with higher controlling parents, the highest scores occurring with an "affectionless constraint" (high protection, low care) maternal bonding pattern. The study, along with previously cited research, suggests an ambivalent overprotection conflict between autonomy versus interdependence. This confirms the writings of Bowlby (1969, 1973), describing the complementary development of connectedness and autonomy (attachment and separation). Overprotection appears to enmesh and inhibit the formation of an individual's self-identity. An overwhelming sense of overprotection, coupled with a lack of emotional intimacy, renders a sense of powerlessness, often described by anorectics. According to Perosa et al. (1996), a sense of identity is best fostered within a family climate that balances individuality with connectedness.

Perosa et al. (1996) suggested that examination of the separation-individuation process could link the family systems paradigm with models of individual development.

According to Perosa et al. (1996):

> Identity refers to a person's stable, coherent, and integrated sense of self; that is, who one is and what one stands for as a member of society (Erikson, 1968). According to Erikson (1968), adolescence is a distinct life stage in which the complex interplay of psychological, social, historical, and developmental forces propel the individual to search for and consolidate a purposeful sense of self. Resolution of this crisis or struggle for self-integration is the achievement of a sense of identity; failure leads to a sense of confusion about who one is and an inability to commit to values when faced with choices in occupations, intimate relationships, and an ideological worldview (p. 817).

Erikson's (1950) model, although basically, presented as a linear developmental process, supports the view that normal personality development involves the simultaneous and mutually facilitating development of interpersonal relatedness and self-definition. Reformulating Erikson's epigenetic model of psychosocial development, Blatt and Blass (1992, 1996) have emphasized the two fundamental developmental lines of self-definition and interpersonal relatedness, as well as the relationship between those constructs and their eventual integration. One line is concerned with the establishment of stable and mutually satisfying interpersonal relationships (i.e., attachment or inter-relatedness), while the second line follows either the pathway of shame or of building a positive and differentiated identity (i.e., self-dimension). Rather than being a parallel process of simple interaction or integration, the authors suggest a complex dialectical process throughout the life cycle, with progress in each developmental line being

essential for advancement in the other.

Perosa et al. (1996) found that "…family variables together explain only a small proportion of identity formation (i.e., they account for only 21% of the variance on this criterion). These findings imply that separating from the family is but one step in the process of identity formation…. Ultimately, the influences of schooling, peer groups, and cultural forces (i.e., television, movies, magazines, etc.) are instrumental in providing the experiences that permit the individual to explore options" (p. 830). It would then seem that the self-belief model might be expanded to further explain the interactive process between attachment and shame, as related to the anorexia phenomenon. Thus, borrowing from the model by Blatt and Blass (1996), a dialectic interaction of the two lines, relatedness (toward parents, peers, culture and food) and self-definition, may be seen (Figure 3), the dynamics of which could lead to restrictive eating.

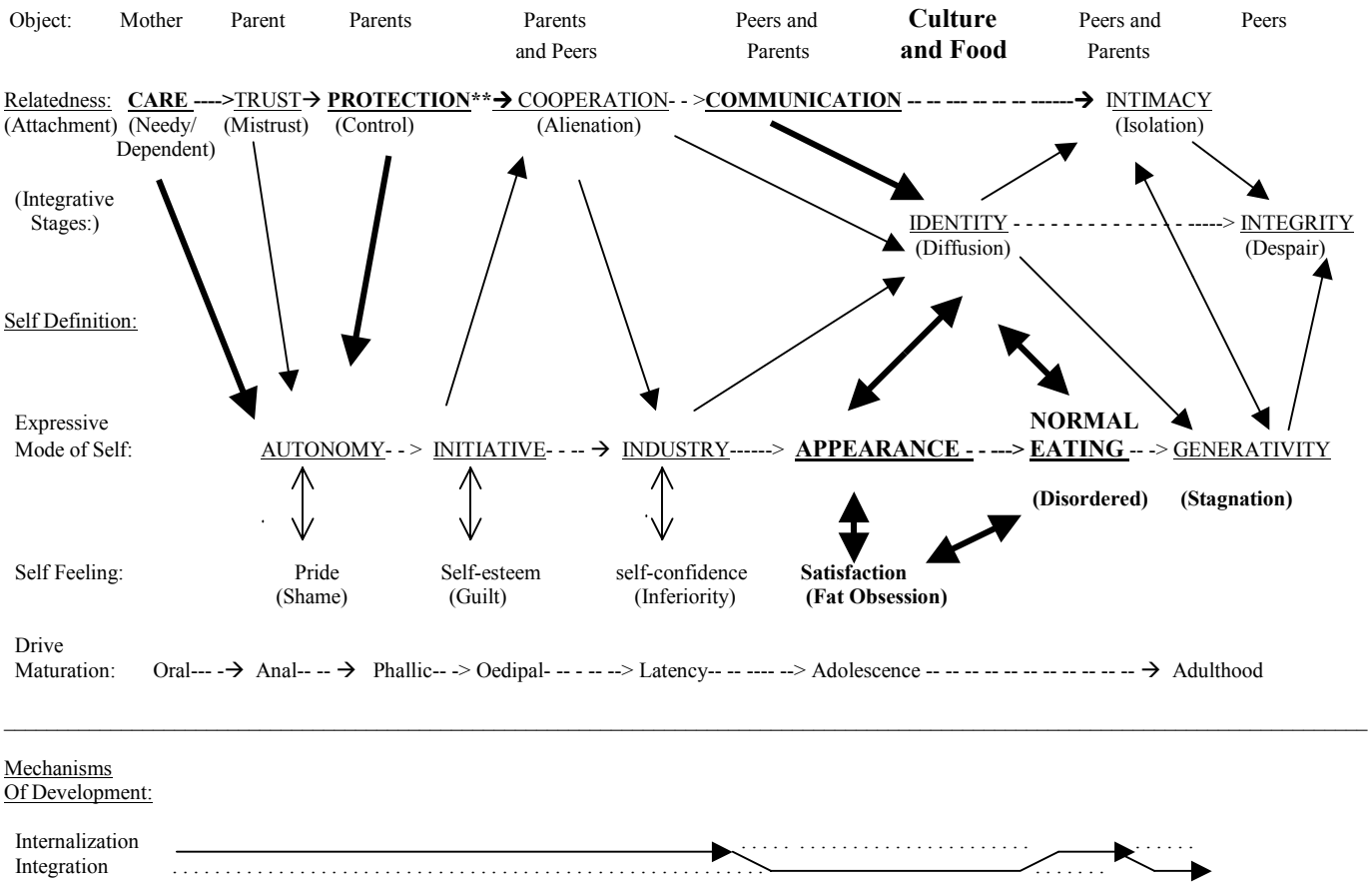
According to Blatt and Blass (1996), the initial development of parental trust enables the child to begin the process of self-definition, first in asserting autonomy and independence. If this effort is accompanied by feelings of shame (versus pride), there is more reactive (versus proactive) expression as the initiative stage is entered. The relative balance of parental interactions concerning approval/disapproval of the child's initiative determines the quality of internalized self-esteem. Initiatives establish a new sense of relatedness, with an emergent reciprocal sharing and cooperation, first with parents, and later with peers. Thus, the experience of trust and cooperation contribute to the development of a sense of self –confidence in relation to others. However, considerting other attachment variables, care would seem to precede trust, while protection would

precede cooperation, and communication would have the greatest impact during adolescence.

As Blatt and Blass (1996) have explained, gratifying involvement is experienced in both the quality of attachment, as well as parental and peer reaction to one's emergent expressions of a sense of self. The degree of gratification internalized from the attachment, self-feeling, and expressive mode of self provides the basis for the formation and consolidation of self-identity. An ongoing balance between the processes of internalization and integration is essential to normal development. While integration depends on the qualities of prior internalizations of aspects of self-definition and of increasing mature relationships, internalization, without integration, would also result in limited psychological development.

Self-identity, although a stage in self-definition development, is also a cumulative, integrative process of the capacity to connect, cooperate, and share with others, being coordinated with a sense of individuality that has emerged during the successive stages of autonomy. Since identity involves a synthesis and integration of relatedness, a marked change occurs in the developmental process in adolescence. Whereas, the various constituents of the two developmental lines were earlier internalized, primarily as independent components, there is later a synthesis of these coordinated and integrated elements (Blatt and Blass, 1992). "At adolescence and beyond, the major effect of deficient integration would be the emergence of a sense of meaninglessness, fragmentation, and a lack of purpose, partially expressed by despair. In contrast, sufficient integration in adolescence and beyond creates a psychological context

Figure 3. Dialectic interaction of relatedness and self-definition as applied to eating*



*Adapted from Blatt, Sidney J. and Blass, Rachel B. (1996). Relatedness and self-definition: A dialectic model of personality development. In Gil G. Noam and Kurt W. Fischer (Eds.), Development and vulnerability in close relationships, p 324. Used by permission. Bold indicates addition to original model.

** Low versus high protection (supportive guidance with freedom of choice versus rigid control)

that enables the individual to develop coordinated, mutually facilitating, mature expressions of relatedness and self-definition, that enable him or her to cope with the vicissitudes of later stages of the life cycle…" (Blatt and Blass, 1996, pp. 328-329).

Industry--the capacity for sustained goal-directed, task-oriented activity--would not appear to be so problematic for anorectics, since most of them are intelligent, skilled and productive until the latter stages of the illness. However, industry represents a work-emphasis stage. And throughout the growth cycle, there needs to be a balance between work and play. A strict work mentality could lead to less inter-relatedness and isolation.

Peer relationships are affected by and can either confirm or adjust one's self-definition. Healthy peer relationships can lead to an integration of mind, body, and emotions. Draper (2001) has coined the word 'biolimbics,' which refers to balancing feelings and thoughts that merge into behavior. Perhaps an imbalance could, in part, explain the disembodied self-concept, often described of anorectics.

Appearance satisfaction is an accumulated self-definition from the parental-peer attachment process, which may be confirmed or challenged by the culture. Fat obsession generally leads to unhealthy eating and behavior. According to Beardsworth (1995), "Fischler (1980, 947-948) uses the term '*gastro-anomy*,' [derived from Durkheim's concept of anomy] to describe the situation in which consumers find themselves when freed from the constraint and reassurance of the customary rules, norms, and meanings associated with food…. In such circumstances, anxiety is likely to be the response to a lack of clear criteria for nutritional decision-making. [Gastro-anomy] clearly involves the proposition that food-related anxiety is an inherent and inevitable feature of the

individualistic and anomic tendencies of modern urban society" (p. 132). Thus, without ego resiliency, one may be emotionally overwhelmed when confronted with eating choices. This, in turn, may affect one's relationship to food, potentially resulting in restrictive eating, especially when there is identity diffusion. Increased appearance dissatisfaction and disordered eating may lead to further role diffusion, which is likely to inhibit intimacy. Isolation may produce stagnation, rather than generativity, and in turn, result in despair, as opposed to one's having a sense of personal integrity.

Summary

In general, anorectics showed markedly higher internalized shame scores, and their interviews revealed more shame criteria than normal eaters. Married versus single respondents in both groups indicated greater shame. There were polarized differences between anorectics and normal eaters, in regard to self-hatred, low self-esteem, and suicide ideation. All sub-points of Proposition 4 were supported, as anorectics reported more inferiority and alienation, as well as lower self-esteem than normal eaters. Negative peer influence seemed to be greater for anorectics, as evidenced by elevated peer alienation scores, as well as interview data, indicating more social distress and impaired peer relationships. There was also indication that parental bonding patterns were related to the shame experienced by anorectics. The pattern showing the greatest shame was affectionless control.

Extreme shame appeared to result from an attempt to control overpowering emotions that anorectics, as children, somehow had never felt permission to express. Such suppression is subject to result in either depression or to erupt in rage toward the

attachment figure or oneself. A sense of unworthiness, with a drive for perfection, eventually may lead to an overwhelmed sense of hopelessness and despair. For no achievement or weight loss is ever sufficient to fulfill the elusive goal of self-esteem and to provide that reassurance so desperately craved.

The self-belief model follows a complex dialectical process of two developmental lines throughout the life cycle. The first line, the other dimension, is concerned with, the establishment of stable and mutually satisfying interpersonal relationships, while the second line, the self dimension, follows the pathway of building a positive and differentiated or shame-based identity. Progress in each developmental line is essential for advancement in the other. This could explain how insecure parental attachment results in shame, which in turn affects developmental stages of self-definition and successive stages of interrelatedness, not only to family and peers, but also to culture and food. The result may be appearance obsession, a perfect standard and an overwhelmed self, setting the stage for restrictive eating and anorectic behavior.

CHAPTER VI

FAMILIAL, PERSONALITY, SOCIAL, AND SPIRITUAL PATTERNS

Introduction

As shown thus far, insecure attachment and internalized shame were associated with increased restrictive eating behavior. The highest shame level and lowest self-esteem were found in anorectics who indicated affectionless control (high protection, low care) bonding patterns, especially maternal. To better understand this phenomenon, other recurrent patterns within and between the interviews were identified. Although not specifically sought in the study, these findings stood out as data was reviewed. This chapter explores those data-generated patterns, which emerged, including family structures, personality characteristics, social influences, and spirituality. As previously noted, any specific examples from interviews have been given by pseudonyms. A conceptual model is suggested as a framework for understanding the development of anorexia and further empirical investigation.

Family Structures

In regard to relationships and roles within their families, certain differences were noted between anorectics and normal eaters. These included birth order, parents' conflictual marriage, unavailable father/ dominant mother, compulsive care giving, lack of autonomy, and trauma.

Birth Order

Three of the anorectics studied were the youngest in *birth order*. One was a middle child and 1 an only child. Among the normal eaters, there were 2 middle children, 2 oldest, and 1 only child (Table 17). In contrast, Levenkron (1982) reported that in 80% of the cases, the anorectic was the second or third child. Although *birth order* was not in agreement with this study, the author's description of the anorectic's family role was in accord with much of the interview data. She is typically compliant and a high achiever. However, not being in the spotlight at home, she attracts little attention for her accomplishments. Often, it is another family member, rather than the anorectic, who is officially labeled the problem. With Sally, an anorectic in this study, it was a sibling; while with Susan, Saundra and Alice, it was a parent with an identified chronic medical, emotional, or addictive problem.

Parents' Conflictual Marriage

Only 1 anorectic, versus 3 of the normal eaters, reported having an intact family with happily married parents, while 3 came from divorced/blended homes and 1 had unhappily married parents who had stuck together. Apparently, *parental conflict* had a negative impact on their self-esteem. Levenkron (1982) characterized an anorectic's family as, typically, depleted, with external energy demands having outstripped their emotional resources. Three anorectics versus 1 normal eater reported a negligent mother. It is also noteworthy that 4 anorectics versus 1 normal eater reported non-positive family mealtimes. One anorectic told how she was literally starved by her mother, and 2 others described themselves as latchkey kids. As found in parental descriptions in this study,

Table 17. Family Structure and Personality Attributes of Anorectics and Normal Eaters

	Anorectics	Normal Eaters
Birth Order		
Youngest	3	--
Only child	1	1
Middle child	1	2
Oldest	--	2
Parents		
Divorced	3	2
Happily married	1	3
Unhappy, but stayed together	1	--
Both used alcohol/drugs	2	--
One parent used alcohol/drugs	3	2
Dominant mother	5	3
Negligent mother	3	1
Career mother	1	2
Housewife mother	1	2
Mother engaged in criminal activities	1	--
Dominant father	--	2
Absent or unavailable father	4	--
Quiet, inexpressive father	5	--
Family Socialization		
Social family	2	4
Sheltered from social activity	3	1
Caretaker of parent(s)	3	1
Separation/individuation problems	5	--
Indication of Trauma		
Physical/verbal abuse	1	1
Sexual abuse	3	--
Loss of childhood memories	2	--
Mealtimes		
Positive mealtimes	1	5
Forced to eat all on plate	1	1
Starved by mother	1	--
Latchkey kid	2	--
Personality Characteristics		
Introverted	5	--
Ambivalent Thinking	5	--
Limited social ability	5	--
Stuffed emotions	5	--
Food restriction to avoid feeling	5	--
Fractured identity	5	--
Self-esteem tied to body weight	5	--
Compliant/perfect child	4	--
Extreme sensitivity to criticism	5	

Wechselblatt et al. (2000) reported that parents of anorectics, though often preoccupied with themselves, overtly seemed worried or concerned about their family. But with the mother just trying to meet her own needs and unable to empathize deeply, the anorectic daughter feels perpetually discounted.

Smith, Hill, & Mullis (1998) proposed that when intimate family relationships become problematic, it may be a result of *conflict* that occurs in a context of no strong emotional bonds of affection, denied dependency needs, and suppressed interdependency. Apparently, as Wechseblatt et al. (2000) found, parental marriage difficulties make it unlikely for the individual to view closeness (intimacy) as desirable. Ensign, Scherman, & Clark (1998) reported that greater *conflict* between parents was significantly correlated with less closeness in the parent-child relationship, including affective quality of attachment, emotional support, and parental fostering of autonomy. The authors suggested that the more parents engage in *conflict*, the less involved they may be in meeting the needs of their children. However, they additionally noted that it was *parental conflict*, rather than divorce, that negatively affected children. In terms of psychological and social adjustment, high school students of divorced parents, who maintained a close parental relationship, did not differ significantly from children who came from happily intact families. As Claude-Pierre (1997) has explained, "…it's not the particulars of the divorce itself, but the manner in which the …child takes the blame and burdens upon herself that triggers the eating disorder. This can happen in the most civil divorces. A divorce represents a failed marriage, and the person with CNC [Confirmed Negativity Condition] will inevitably see herself as responsible for the failure—or as a failure for not

being able to prevent it" (p.71).

Compulsive Care giving (Parentification)

Compulsive care giving, is a style of attachment behavior, which emphasizes the importance of *giving*, rather than receiving, *care* in a relationship (West and Keller, 1991). This compulsive nurturing style was not generally found among normal eaters. Except for Sally, who, as a child, "was always taken care of," all other anorectics in this study reported taking either a "pleaser" role and/or a "caretaker" role. Levenkron (1982) wrote about a *role reversal* of dependency between parent and child resulting from parental emotional depletion. When the message is, "You have more strength than I," the child may try to raise family morale by assuming the role of supporting the parent(s) emotionally. The parent(s) then becomes dependent upon her strength and assistance, rather than seeing her need for his/her own emotional support. Rarely being provided advice or reassurance when upset and seeing herself as loved for not having needs, she learns to deny her neediness. Since other people can't make her feel safe, it is as though she becomes answerable to an imagined parent, who demands perfection or imposes rejection. Although on the surface, the child appears outgoing, cheery, and competent, as she becomes ill, her anger begins to emerge toward her parent(s) for prematurely casting her into a role of *nurturer*. West and Keller (1991) have explained *parentification* as "a mode of adaptation that, in childhood, offered the best possibility for achieving proximity to the parent. It is likely that the activation of the child's attachment system evoked anxious and ineffective concern, rather than comforting responsiveness from the parents" (p.427). Thus, when the child learned that a relationship can only be maintained by a care

giving role toward parent(s), the deactivation of the child's attachment system offered the best chance to achieve a degree of parental proximity.

This behavioral pattern can lead to dysfunctional relationships later in life. Accordingly, Wells and Jones (2000) found that childhood *parentification,* is associated with shame-proneness in adults. Having required a premature identification with the parent(s)' expectations and needs, at the expense of the development of the child's true talents and gifts, often leaves the child feeling ashamed of the true self's unrewarded strivings.

Unavailable Father/ Dominant mother

All 5 the anorectics, as compared with 3 normal eaters, reported *dominant mothers*, while 5 anorectics also described quiet, inexpressive fathers, 4 of whom were noted as absent workaholics and/or emotionally *unavailable*. Only 1 normal eater reported having a poor relationship with her father. However, she stated that, although not emotionally supportive, he was always physically available. Cubis et al. (1989) found that adolescents who perceived their father as *uncaring* and their mother as *controlling* were more neurotic and introverted, and had poorer perception of their bodies. According to Costin (1997), "The best thing a father can do for his daughter is to love her mother" (p. 41), as daughters respond not only to what fathers say to them, but also to what their actions say about women in general. Furthermore, the author suggested that appropriate father bonding helps the daughter confirm her sense of self and enhances her transition from maternal dependency.

Steiger et al. (1989) found that eating disordered patients uniformly recalled *less*

paternal empathy than controls. Cole-Detke and Kobak (1996) found that a lack of *paternal care* and *high paternal hostility* left daughters feeling that they had failed to please their fathers and led to deactivating strategies and reports of eating disorder symptoms. Ironically, the daughters may be trying to improve the father-daughter relationship by focusing on appearance and disengaging from efforts to gain comfort and support. This was clearly the case with Sally, and may be inferred from statements about the father-daughter relationship of the other two single anorectic women in this study.

Addressing the enmeshment issue in anorectics, Costin (1997) indicated that if a mother were getting appropriate nurturing from her husband, gratification of her emotional needs through her child would not be necessary. In a nationally representative adult sample, Mickelson et al. (1997) found that the more *maternal overprotection* perceived from one's mother, the more strongly the individual endorsed an anxious attachment style. Beattie (1988) has reported, "When the mother-daughter relationship is *overly close* and *hostile-dependent*, when the mother unconsciously refuses to let go and the daughter is unable to achieve actual or psychological separation or a distinct identity of her own, then the stage is set for many types of psychopathology. Depression and eating disorders are among the most common of these, and often go together" (p. 456).

Lack of Autonomy

Ryan and Solky (1996) have defined *autonomy* as "…the fundamental human propensity to have one's behavior emanate from the self, that is, to feel volitional and self-determined…as opposed to being a 'pawn' to external forces or a mere cog in a chain of events…. [Thus, the need for autonomy], "the support for an individual's self-

regulation, …involves respect for another's feelings, values, and perspective…." (p. 251).

On the other hand, the need for relatedness refers to "… the basic human need or propensity to be securely connected to and esteemed by others, and belong to a larger social whole…. The need for relatedness has often been cast in opposition to the need for *autonomy*…. However, when *autonomy* is defined in terms of volition and being an 'origin' of one's actions (rather than as independence), then relatedness and *autonomy* not only are [unopposing] needs, but also are typically mutually facilitative" (Ryan and Solky, 1996, p. 251).

All 5 of the anorectics and none of the normal eaters reported problems with separation-individuation. Furthermore, 3 anorectics considered themselves as being separated from social activity, while 4 of the normal eaters' families were described as very sociable. McCormick and Kennedy (1994) found that adolescents who classified their parent-child attachment as secure rated their parents as high, both for acceptance and encouraging independence. Thus, *autonomy* must be understood in relational terms. According to Ryan and Solky (1996), when *autonomy* is supported in relationships, fundamental human psychological needs are satisfied, specifically those for relatedness and competence. *Autonomy-supportive* relationships stand in contrast to relationships in which others take an evaluative and judgmental stance or otherwise control, pressure, or impinge upon one's behavior and experience

In relationships, individuals struggle with the desire to be both separate, "I," and intimate "we". Since most daughters have a strong identification with their mothers, it may be difficult to view themselves as two separate individuals. When the daughter's

developmental process of possessing her own physical and mental boundaries becomes thwarted, conflict can occur. Smith et al., (1998) suggested that when strong and secure emotional bonds exist between mother and daughter, an environment of both closeness (intimacy) and separateness (*autonomy*), is created for interdependency, in which conflict can be openly acknowledged, but without threatening the relationship.

According to Wechselblatt et al. (2000), the level of *autonomy* one may achieve depends upon how much one can hold the idea of the relationship in one's mind while being away from the attachment figure, rather than how much a parent is able to deal with being separated. In contrast, Sally, one of the anorectics in the study, regarded the relationship with her mother as being "strictly a love relationship until I tried separating from her."

By examining the transcripts of normal eaters participating in this study, it was clear that the key factor of their being secure and autonomous adults was not that they all experienced entirely secure attachments with both parents. Although 3 had happily married parents, 2 endured the trauma of divorce and 2 had an alcohol-dependent parent. But, they were distinguished from the anorectics by a resiliency and an open and clear way of reflecting on their childhood. To the extent they had felt wounded by a parent, they had managed to work through it, no longer cut off from true feelings nor embroiled with hurt, rage, and blame. One had even gone beyond what she had experienced in childhood relationship with her parents to having a loving, forgiving, open interchange with them in later life. According to Cole-Detke and Kobak (1996), this may be explained by the presence of what Main and Godwyn call 'earned security,' referring to

"participants who have developed a secure state of mind with regard to attachment, despite poor relationships with parents" (p.287).

As Stierlin and Weber (1989) suggested, "Even in a very strongly bound-up family, children may still manage to find a niche for themselves, in which they can develop with a comparatively high degree of latitude (i.e., not weighed down by parental expectations). [They can] … at the same time, … [have] the opportunity of earning the approval of the parents…. Such children find it easier to free themselves from the grip of the family and make progress toward all-around individuation than those who are more *accepting* of binding delegation" (pp. 28-29).

Trauma

All anorectic participants, as compared to 1 normal eater, indicated experiencing some level of family *trauma*. Three reported negligent care, 1 physical/verbal abuse; 3 reported sexual abuse, and 2 loss of childhood memories. Schmidt, Tiller, Blanchard, Andrews. & Treasure (1997) have reported that significantly more (76 %) anorectic and bulimic patients versus few community controls had either a severe life event or a marked difficulty during the year before onset. Toth and Cicchetti (1996) found that maltreated children with non-optimal patterns of relatedness (versus maltreated children with optimal or adequate patterns of relatedness) evidenced elevated depressive symptomatology and lower competence.

Schecter, Swartz, & Greenfeld (1987) suggested that sexual assault, involving intimate bodily intrusion, real or implied physical threat and often, severe humiliation, may lead to alteration of body image and pathologic concern with bodily contour and

function. This may especially be true for patients predisposed to anorexia, since they are frequently uncomfortable with issues of sexual attractiveness and often avoid sexual involvement. As for those patients who already may be manifesting symptoms of anorexia and struggling with issues of emancipation and independence, sexual assault, with its potential repercussions of damaged esteem, body image, self-efficacy, anger, and shame may heighten need for control. Troop and Treasure (1997) concluded, "There is a higher rate of childhood helplessness and a lower rate of childhood mastery in women who develop eating disorders. Thus, it is not simply the presence of adverse experiences in childhood that is of etiological importance in eating disorders, but how these are negotiated" (p. 537).

Although the nature of the relationship between child sexual abuse, family factors, and disordered eating remains undefined, Smolak, Levine, & Sullins (1990) offered some possible explanations. Perhaps abuse activates or intensifies those dimensions of poor family functioning, which elevate the risk of an eating disorder. Conversely, a dysfunctional family system may set the stage for child sexual abuse, the trauma of which may increase the risk for an eating disorder. Or finally, eating disorders may reflect the bi-directional transaction of both variables, which in turn may be compounded by other powerful influences, such as parental and child pathology.

Claude-Pierre (1997) has attempted to "…set aside the common misconception that every eating disorder is the product of abuse—physical, sexual, or otherwise, [claiming]…. that it may not be the *trauma* of the abuse per se, but the individual's perception of reality that will cause anorexia. We can change reality only to a certain

point (by addressing the *trauma* and distress that act as triggers), but we can try to change people's attitudes toward and perceptions of reality…. Compassion and understanding for the limitations of human awareness would seem more likely to heal the victim than criticizing her for not condemning her abuse or her abuser" (pp.71-72).

Personality Characteristics

There was a remarkable distinction in personality characteristics between anorectics and normal eaters (Table 17), which appears consistent with what researchers and therapists have observed. In addition to low self-esteem, high shame, and an unhealthy obsession with slimness, all anorectics exhibited mistrust in others and self, as well as a lack of intimacy. Their families were perceived as valuing sensitivity, loyalty, and/or self-sacrifice. Thus, compliance, perfectionism, intellectualism, ambivalence, a sense of powerlessness, a need for control, and a desire to be special resulted from efforts to attend to family and cultural requirements.

Compliance

Anorectics described their attempts to please others in any way possible to avoid conflict. Bruch (1973) suggested that women with anorexia were usually good and *compliant* children. With the exception of Alice, who, calling herself the "scapegoat," gave up trying to please her mother, all the other anorectics in this study depicted themselves as *compliant*. All were introverted, reported limited social ability and extreme sensitivity to criticism. Wechselblatt (2000) found that among anorectics, *compliance* and perfectionism were personality characteristics most influencing the substitution of others' needs for one's own.

Perfectionism

Although 1 normal eater described a perfectionist tendency, it was not related to appearance, but rather to academics and career. In listening to the narratives of the anorectic respondents, it was clear that all the anorectics were concerned with *perfection*. Four specifically spoke of trying to be the *perfect* child. All reported experiencing a sense of failure and worthlessness, because they could not attain that internalized parental standard set before them. All indicated that their self-esteem was significantly tied to body weight and appearance. Furthermore, they expressed fears of giving up their eating disorder, being concerned about potential loss of its perceived benefits. Alice, an anorectic in this study, described the experience as "like this microcosm world of *perfection,* where I could feel like I could do something right…. No one could tell me that I wasn't doing it right, because I made the rules."

According to Claude-Pierre (1997), anorexia is the consequence of *perfectionist* people failing in their desire to be *perfect*. For an individual with an eating disorder, p*erfectionism* is about appeasing society and placating its expectations. The anorectics in this study seemed to have need for respect and admiration, as well as a terror of not measuring up. According to Kemper (1978), the socialization of competence can avert the emotion of shame. "If one has been socialized to unrealistic standards for performance, that is, where one's abilities have been evaluated far above their true measure and therefore, performance must always fall beneath the standard, the likelihood of shame is very strong" (p.280). Reynolds (1991) suggested that *perfectionism* is a compensation for a less-than-adequate sense of self.

Kerr (1998) noted that "the drive to get 'nearer the bone' is pervasively and problematically linked with notions of autonomy, intelligence, beauty, excellence, self-control—the mastery of 'feminine' emotion and the triumph over domestic ease" (p.312). Yet, Bruch (1973) observed that whatever weight the anorectic reaches in this struggle for self-respect and respect from others, it is never sufficient for achieving the elusive goal of reassurance. For example, in this study Susan, who had reached 69 pounds and currently weighed 80 pounds, still saw herself as fat.

Intellectualization/Dichotomous (Black & White) Thinking

According to Zerbe (1999), "Clinical work with eating disorder patients confirms that as a group, they are among the most extraordinarily bright and talented of people… [but] given the opportunity, they can use their intellect either constructively or destructively…. One potentially harmful way is to use *intellectualization* to avoid facing one's feelings or life circumstances…. Life is lived only 'in the mind'. The person denies her physical body to focus instead, on developing brilliant verbalization skills" (p. 85).

The anorectic's irrational b*lack and white thinking,* which leaves no room for grays, leads to following self-imposed rules and rituals. According to Shaef (1987), dualistic thinking serves many functions in this illusionary system. One function is "to oversimplify a very complex world, thereby giving us the illusion of control over what is, in fact, a universe in process…. In dualistic thinking, if we state that something is right, then the assumption is that the opposite must be wrong. The world is perceived as pairs of opposites. There is no recognition that both opposites can be right, or that there may be other alternatives, besides those two" (p. 112). However, balance is the key to moving out

of a disordered eating pattern.

Ambivalence

A major distinction noted with normal eaters' was the lack of *ambivalent* behavior, as well as indecisive thoughts and feelings about the parental/child relationship. As noted by Beattie (1988), anorectic women "…*waver* between excessive dependence, marked by slavish conformity and lack of self-assertion versus exaggerated pseudo-autonomy and defensive rejection of help and intimacy" (p.459). As Chassler (1997) has recorded, Freud (1915) and Winnicott (1965) identified the crucial role in personality development of the child's capacity to tolerate *ambivalence*—that is, of being able to regulate the *contradictory* impulses of dualistic feelings such as love and hate.

Anorectic ambivalence may be explained, in part, by parental *ambivalence*. Steirlin and Weber reported that mothers would "on the one hand, anxiously hover over the anorectic daughter… and on the other hand, treat her as an adult (i.e., parentified) confidante" (1989, p. 28). Stierlin and Weber (1989) have explained that "the binding encountered in anorectics' families is compounded by tremendous *ambivalence* and desires to reject, get rid of, and escape, along with feelings of anxiety and guilt" (p.38)

Salzman (1997) observed from interviews with young adult daughters that an *ambivalent* subgroup focused on their mothers' perceived emotional inconsistency as the source of their turbulence, describing the nature of their relationship to their mothers as "push-pull," "hot-cold," and "addictive love." As indicative in the current study, mothers were portrayed as frequently unable to protect or comfort children in distress, often being preoccupied, even incapacitated, by their own problems. Although unable to hold the

mothers' attention when needed, at times mothers' unsolicited, negative attention would catch them unaware with attacks on their self-esteem, especially on issues of physical self-image and social acceptability. Thus, the daughters found themselves in a *paradox,* longing for the mother, but also wanting to reject her. And through anorexia, they, for once, could orchestrate the pushing and pulling in the relationship.

Difficulty Identifying and Expressing Feelings (Calexthymia)

All of the anorectics studied reported a *terror of expressing feelings* and having needs, in contrast to the normal eaters, who more easily expressed both feelings and needs. Anorectic respondents described themselves as having low frustration tolerance, feelings of emptiness, anxiety, as well as difficulty handling stress. Each explained that anorexia was a means to turn away from *emotional aspects she feared confronting* and/or to distinguish herself from the family system. According to Cietola (1999), "Eating disorders are symptoms *of underlying emotional distress*, a way to numb or distract from *underlying painful feelings*" (p. 16).

Zerbe (1999) noted that as much as the anorectic wants nurturance, she fights it in the form of refusing sustenance, because eating makes her feel all the more deficient and aware of what she really covets. Furthermore, Zerbe (1999) suggested that generosity toward an anorectic "incites envy, because she feels so unable to give anything herself. She must then attempt to show others up, to deflate the value of those who seem to have more than she has. Her refusal to eat signals to others that they should want what she has and what she can do by refusing food, so that she becomes the object of envy herself.

Because they attempt to please others in any way possible to avoid conflict,

anorectics *deny feeling* angry or frustrated, fearful that others will not like them. As explained by Beattie (1988), the anorectic tries to show others she can get along without whatever they have to offer. Paradoxically, it may feel safer for her to induce rejection than to risk open expression of anger, resentment, or envy, which she fears, if unleashed, would destroy the relationship. As Schaef (1987) described the addictive process, "The more dead inside [she becomes], the more she must heighten the intensity of [her] feelings in order to feel anything at all. [She sets] up situations for [herself] of extreme anger, pain, or fear, just to remind [herself] that [she is] alive" (p. 90).

Powerlessness

Normal eaters in this study expressed a sense of stability and inward strength, definitely not tied to body weight. They spoke of *empowering* familial and peer relationships. In contrast, all anorectic respondents reported that they sought *power* through controlled eating. Furthermore, exercising was given a prominent place of *empowerment.* Apparently, rigorous exercising gives reassurance that one can overcome all physical obstacles in the pursuit of goals, as well as the exhilarating thrill of being in total charge of the shape of one's body. "I weighed every morning after I ran," replied Amy. "If I would exercise, I used to feel better about myself."

In the most general sense, *power* is getting what one wants and getting things accomplished (Freund & McGuire, 1991). In depicting the clinical anorexia syndrome, Bemporad et al. (1988) referred to the paradoxical phrase, "exercises in *power* by the *powerless,*" a term of the turbulent'60's riots, involving minorities and other socially disadvantaged. "By becoming the 'thinnest' or the 'greatest sufferer,' the anorectic

patient creates within herself an illusion of *power*. [As a result, the illness permits her to] turn the tables on those who symbolically or realistically deprived [her] of her childhood. For once, [she holds] the *power* to cause concern and worry; for once [she] can demand the care [she wished she] had received and decide whether to take it or reject it" (Zerbe, 1999, p.82).

Need for Control

One normal eater respondent acknowledged a time when she felt out of control. She used alcohol and tried bodybuilding for a while, but stated that she never had any anorectic tendencies. In comparison, all of the anorectics studied engaged in eating behaviors to assert *control* over their bodies and other aspects of their lives. As expressed by Saundra, an anorectic participant "It's a matter of *self-control*. I don't even need food. I rely on no one. I am self-sufficient." According to Freund and McGuire (1991), *control*, referring to the exercise of power in a particular situation, is related to the ability to manage one's environment, so as to feel safe and secure in it. Shaef (1987) has described the illusion of *control* that is prevalent within any addictive system. "This belief is so common within our culture that many people would rather feed their illusion of *control* than risk getting what they want. If they find they are more successful at making people dislike or even hate them, they opt for that" (p.43).

Waterhouse (1997) has suggested that a *controlling* parenting style may hinder the individual's ability to develop internal self-*control.* The author has explained the counterproductive effects of food *control* by unknowing parents. Costin (1997) has cautioned, "It's important for parents to keep in mind that there are some battles that

aren't worth fighting…. It's best to save energy for more important things…. Ultimatums and *control* tactics like ['You are grounded until you gain weight;' 'Eat your dinner or you can't go to the movies.'] will not work and may even entrench the *control* issue more deeply" (p. 95). The author suggests that to let go of *control* in the area of eating, the anorectic must experience more *control* in other areas of her life.

Desire to be Special/Unique

Normal eater participants described how parents, other family members, or peers gave them a sense of *specialness*, just being themselves. On the other hand, anorectics often reported that dieting and weight loss made them feel *special*. Lester (1997) suggested that "refusal of food (a substance usually associated with women) makes her feel different from other women—stronger, less vulnerable, more logical, spiritually superior, pure, purged of contaminating femaleness" (p. 487). As an anorectic, Amy, explained, "Starving myself was something I could do extremely well.... I could be the best in the family at losing weight.... It was just something that was totally and completely mine. And nobody else had anything to do about it." As reported by Zerbe (1999), an anorectic, having a special sense of finally achieving something grand feels entitled to *special* treatment and understanding.

Way (1993) has described how the anorectic twists things in her head, so that hunger is satisfying, because it's clear evidence of achievement. "The gnawing hunger pains actually encourage her to go on, luring her with the possibility that tomorrow, the scale will go even lower…. Watching the numbers go down on the scale every day is the high that the anorectic is on. It's what she lives for, the only thing in her life that means

anything" (p.62-63).

Levenkron (1999) has suggested that all the benefits of anorectic behavior can be transferred from important people in her life to the place of the "it" (the disorder). As Alice, an anorectic in this study, explained, her disordered eating resulted from "…a lack of any real significant relationship that was stable for me and secure as a child. Food wasn't secure. Parents weren't secure. Where we lived, or how many times we were going to be abused. There was no consistency, no security, no trust, no love, no comfort." This may explain why Levenkron (1999) has termed anorexia "the mistruster's disease" (p.115). Nevertheless, becoming vulnerable toward reliable people, using them as guides and mirrors of one's appearance and personality is essential to recovery.

Social Influences

Although normal eaters in this study expressed awareness of social expectations set forth by magazines, media, etc., they felt no compulsion to ascribe to those standards of perfection. As for anorectic participants, they seemed to be unaware of any real impact of cultural influences on their lives. Amy stated, "I don't even remember looking at magazines and thinking, 'Oh gosh, I want to look like her.'" Sally said, " When I'm thin, that's when I start looking at the models and how thin they are. When I'm heavier, I don't look at them." Saundra commented, "Well, I guess they show you what perfect is, and if I was going to be perfect, then I had to be that."

As Wegar (1992) suggested, it is not sufficient to focus primarily on familial and individual differences, interpreting *contradictory* or *ambivalen*t attitudes and behaviors as mere signs of inconsistency, immaturity, delusion, or experiences of temperament.

Rather, a more clear understanding is needed of the themes embedded in the culture to explain motives of *ambivalent* practices, which may be done unthinkingly.

The Paradoxical Nature of Society

According to Freund and McGuire (1991), "Eating disorders are not really problems of appetite for food, but rather self-destructive responses to cultural *constraints* and *contradictions*…. On the one hand, people are urged to control their appetites and to diet in order to be sexy and desirable. At the same time, there is a *conflicting* message to enjoy life, to consume, to indulge [oneself and her appetite]" (p. 52). Beardsworth and Keil (1999) suggested that the *paradoxical* nature of society, where there simultaneously exists a cultural ideal of slimness and rising trend towards obesity, potentially creates tension for many individuals in their relationship to food.

The Social and Cultural Cycle of the Thin Ideal

Williams and Germov (1999) have adopted a conceptual framework, reconciling the structuralist and post-structuralist approaches toward understanding why women diet and why the thin ideal is so pervasive. On the one hand, the structuralist approach has argued that the thin ideal is the *outcome* of a patriarchal society, in which powerful men (as well as the various industries and social institutions they control)--structural factors--construct the beauty myth for their own material and political interests. In contrast, feminist post-structuralism theorists have been concerned with the *role* played by females in reproducing or resisting the thin ideal. From this viewpoint, the social control of their bodies, in effect, becomes self-internalized. But actually, Williams & Germov (1999) have suggested that women are neither merely victimized by

patriarchal and capitalist imperatives nor completely free from media, fashion, and gender-socializing influences. Women can respond to Western societal pressures by ignoring or actively rejecting the thin ideal. Alternatively, they may resort to dieting and restrained eating practices. Dieting behavior reinforces both structural interests (i.e., fashion and the dieting industry) and post-structural factors (i.e., self-surveillance), which in turn, reinforce pressure to conform to the thin ideal and dieting behavior. And so the cycle continues.

Spirituality

For many, "…slimming has become the national religion in America and slenderness the measure of one's moral caliber" (Driscoll, 1997, p.96). Woodman (1982) has suggested that it is the sense of finality that has placed such compulsive emphasis on the body in modern culture. As Chassler (1994) has suggested, "While the problems of anorexia are existential, that is, related to being in the world, the problems of anorectics lie deep in their inner world" (p. 399).

In congruence with what Garrett (1997) has reported, the anorectic participants' transcripts revealed a search for meaning, often identified as a spiritual quest. "What they found in recovery was a sense of peace within themselves, of oneness with nature and with other people. Four of the anorectics in this study mentioned that they attributed progress toward recovery to "getting back to God," being in a Christian treatment center, and/or their relationship(s) with Christian therapist(s). The importance of spirituality, which participants attached to their recovery, was reminiscent of Durkheim (1976), who referred to religion as a kind of 'social glue,' essential to the existence of society itself.

As with any addiction, the anorectic is, at all costs, habitually devoted or surrendered to the disorder. The obsessive illusion, as described by Shaef (1987), is that she has "…the ability to be God, to know and understand everything, to be always logical and rational, and to be superior and in control " (p. 104). Since perfection belongs to God, completeness or wholeness is the highest a human can attain. Consequently, in the attitude of greater control, lie the seeds of the next failure. Anything accomplished by the willpower alone will not be sustained (Welbourne and Purgold, 1984). Thus, Sneed (1993) has related willpower to an individual's furnishing her will, while God supplies the power.

Caught in the throes of inflexibility, ambiguity and paradox, the anorectic seemingly is enacting through her much politicized and macerated body, a culture that is hungry for genuine relationship. But the self, being so abhorrent to the anorectic, must be concealed. Billingmeier (1991) has suggested, "Since the core self shrank as she starved herself, that very core self [needs] affirmation (p.226). Whereas formerly, she used her strength to escape the self that she feared, now she must use her strength to build her core self upon reality, rather than upon some perfect image of herself. The author suggested that when she reclaims her core self, the anorectic will no longer feel empty. In accordance, Lynd (1958) has concluded, concerning the relationship of humility and pride, that paradoxically, "…the more fully one is unaware of [her] own individual identity, the more fully [she] is aware of the immensity of the universe and of [her] place in it" (p. 255).

According to Bevere (1998), every individual began life with the same

unawareness of self. But the anorectic, somewhere between childhood and adulthood, lost the unconscious sense of her physical body and exchanged the truth for a lie. "She began to believe she is what she does, what she has, what she wears, what she knows, how she looks, who she knows, and what she weighs. Thus, she begins to feel a separation between the "…physical me and the real me…the obvious and the unseen" (p. 49. Bevere (1998) further explains.

> Self-image is a defense mechanism. It's the image we project while we try to protect who we really are. It's the projected image versus the protected one. Self-image is the one left vulnerable when we lose the innocence of self-unawareness…. The opposite of self-conscious is not a 'good' self-image or self-esteem. The opposite of conscious is unconscious. To lose consciousness of one's self happens when we become more conscious or aware of God and His will than we are of self and its will (pp. 49-50). When our lives are divinely ordered, [the] spirit will direct [the] soul and mind, which in turn will guide [the] physical self (p. 10).

Being so compulsively food- and body-focused, the anorectic evidently attempts to hide from the shame of her inability to attain impossible standards. Thus, by projecting a false self, she loses awareness of her core self, body signals, and true needs.

Summary

This chapter has outlined the factors of family structures, personality characteristics, social influences, and spirituality, which emerged from the data, confirming other research findings and clinical experience. Although not every point may

be applicable to every anorectic, all factors taken together may suggest the following model for developing anorexia.

A female who experienced non-optimal attachment as a result of certain problematic family structures, such as:

1) conflict in regard to parents' marital relationship and low relatedness (intimacy) in parent-child relationship(s)
2) father perceived as uncaring or emotionally unavailable
3) overly-close and/or hostile-dependent mother/daughter relationship
4) expectations and needs of emotionally-depleted parent(s) resulting in role-reversal, at the expense of daughter's inability to express needs and experience (versus always giving) nurturance
5) potential trauma of divorce, negligent care, and/or abuse (verbal, physical, and/or sexual),

adapting personality characteristics to deal with a shame-based identity, such as:

1) compliant, people-pleasing behavior, seeking external validation
2) perfectionism in response to unrealistic standards of performance and fear of not measuring up or being respected
3) intellectualization and dichotomous thinking, irrationally living only in the mind, and relentlessly pursuing the "Thin Commandments" (Appendix I)
4) ambivalent behavior and indecisive thoughts, wavering between pseudo-autonomy and dependence

5) difficulty identifying and fear of expressing feelings, with numbing sought through restrictive eating
6) sense of powerlessness, creating an illusion of power through efforts to become self-sufficient
7) need for control, resulting in obsession with the numbers on the scale
8) desire to be special and unique, such as the strongest, least vulnerable, most logical, purest, and/or thinnest,

encountering embedded social influences (structural), such as:

1) fashion, the beauty myth, and the diet industry
2) the paradoxical nature of society
3) a culture of finality
4) crumbling social structures such as the nuclear family, community, and church,

and internal post-structural factors, such as:

1) internalization of the thin ideal
2) body surveillance
3) expression of body control,

who then embraces (rather than ignoring or actively rejecting, the thin ideal) and submits to obsessive dieting, exercise and fat phobia, strengthens both structural and post-structural interests. As this, in turn, reinforces the pressure to conform to the thin ideal, the cycle continues.

The course of those who aggressively pursue thinness is generally, one of

self-destruction and obsession with dying, resulting in an illusionary addictive system of dualistic thinking, self-centeredness, and self-hatred. The journey to recovery may include a quest for true meaning, the discovery of and reconnection with one's core versus false self, a loss of self-consciousness, an acquisition of God-consciousness, and replacement of false adaptive eating behavior functions with meaningful relationships.

CHAPTER VII

CONCLUSIONS, IMPLICATIONS AND RECOMMENDATIONS

Introduction

This study has explored the relationship between anorexia and attachment and shame. It is intensely vital for an individual to keep proximity or accessibility to an attachment figure, someone seen as stronger or wiser, and who, if responsive is deeply loved. Acute or chronic anxiety and discontent may result if the need is unfulfilled (Bowlby, 1991). Subsequently, shameful feelings of being unlovable or socially disconnected often leave a crippling, irrational sense of being fundamentally bad, inadequate, defective, diminished and not fully valid as a person (Fossom and Mason, 1986). This chapter contains a concluding summary, along with social implications, clinical applications, recommendations for further research, and limitations of the study.

Summary

The goal of the current study was to better understand the relationship of attachment and shame in the anorectic's experience, as compared to that of a normal eater. Even though findings are suggestive only and cannot be generalized to all women who experience anorexia, they were shown to be supportive of some previous research.

Attachment and Anorexia

Findings in this study indicated that attachment is related to anorexia. Only Proposition 1a was entirely unsupported by the study. The proposition stated that: "A

perceived lack of protection from the primary caregiver(s) leads to insecure attachment." Low protection was not generally found among anorectics. Although their fathers (but not mothers) were perceived as showing a lack of care, both parents were generally considered less caring than normal eaters' parents. Also, both parents of anorectics were reported to be overprotective. Furthermore, all described a dominant mother, to whom 4 appeared to be overattached, as well as a quiet, inexpressive father, whom 4 considered either absent or unavailable. Thus, as Beattie (1988) has reported, the eating disorder appears to be derived, at least in part, in response to a hostile-dependent conflict with the mother and an ambivalent struggle for autonomy.

Research by Steiner-Adair (1990) suggested that the anorectic may be using her body as a political, social, or spiritual statement of protest against the unempathic, emotionally distant, and simultaneously enmeshed family relationships. In an enmeshed family system, growing up is often associated with betrayal and isolation. Thus, separation from the parent(s) and establishing one's own identity is often feared as a loss of connection. A cultural bias, defining adulthood in terms of independence, rather than interdependence, reinforces such thinking. But as Bowlby (1973) explained, a complimentary development of connectedness and autonomy (attachment and separation) is needed.

Trust and communication scores for anorectics versus normal eaters were generally lower toward both parents and peers (although not as markedly). As Bowlby (1991) suggested, "Indeed, the principal criterion of mental health and ill-health, inherent in all psychoanalytic thinking, is the extent to which communications within an

individual personality are open or closed, and, if open, are clear and coherent or else opaque and contradictory…. The more complete the information that a person is able to communicate to someone he trusts, the more he, himself, becomes able to dwell on it, to understand it, and to see its implication"(p. 293).

Shame and Anorexia

Shame affect's one's meaning of the world and sense of self. According to the shame-rage theory as explained by Scheff (1989), "The specific cause of anorexia involves unacknowledged shame in a family and the inability of the members of the family to acknowledge and dispel it" (p. 160). In the current study, all sub-points of the proposition regarding internalized shame were supported. Generally, anorectics (versus normal eaters) showed markedly higher internalized shame scores, while their interviews also revealed more shame. There were polarized differences between normal and restrictive eaters, especially in regards to self-hatred, low self-esteem, and suicide ideation. Anorectics also reported more inferiority and alienation. All restrictive eaters were introverted, had social anxiety and a drive for perfection. Elevated peer alienation scores, as well as interview data, indicated that anorectics experienced more social distress and impaired peer relationships. All "felt fat", restricted eating to avoid facing negative emotions, and basically, considered themselves unworthy of nourishment.

When considering factors associated with shame, findings indicated that parental bonding patterns were related to the shame experienced by anorectics. The pattern with the greatest shame was affectionless control (high protection, low care), characterizing 2 fathers and 1 mother. Affectionate constraint (high protection, high care), the pattern

reported for 3 mothers and 1 father, indicated the second highest shame. According to Cook (1990), in correlating the Internalized Shame Scale with the Parental Bonding Instrument and the Parental Acceptance-Rejection Questionnaire, the most variance in shame was accounted for by the care dimension for mothers. This may indicate that insecure maternal versus paternal attachment is more shaming. A further implication may be that caring control is less shaming than uncaring control. Cook (1990) also reported that the protection dimension of parenting was positively correlated with shame and also accounted for slightly more of the variance in shame for fathers than did the father care dimension. This suggested a pattern, associating high levels of internalized shame with low levels of maternal care and high levels of paternal protection. However, since in the present study, most mothers were high caring and shame measurement was not specific to parent gender, the higher shame scores may reflect the dynamics of an interrelationship of the maternal and paternal bonding patterns.

Other Findings

As data were analyzed, differences were observed between anorectics and normal eaters in familial, personality, social and spiritual patterns. Three of the anorectic participants (versus 1 normal eater) were youngest in birth order. Three normal eaters (versus 1 anorectic) described happily married parents. The 2 normal eaters who came from divorced homes did not blame themselves for not being able to prevent the marriage failure, as did anorectics.

All 5 anorectics studied and 3 normal eaters indicated having dominant mothers. However, only l normal eater reported a poor paternal relationship, in contrast to 4

anorectics who described an absent or emotionally unavailable father. This reportedly resulted in a compulsive care-giving role, as well as an overly close and hostile-dependent mother-daughter relationship. Thus, all anorectics reported sensing a deficiency of parental nurturance.

Aside from the divorce shock, anorectics reported more traumas in other areas than normal eaters. Nevertheless, 2 normal eaters experienced severe divorce traumas and 2 had an alcohol dependent parent. However, they were distinguished from anorectics by a greater sense of resiliency, security, and autonomy in dealing with difficult situations.

Receiving their families as valuing sensitivity, loyalty, and self-sacrifice, anorectics generally exhibited a lack of trust, both in others and themselves, as well as a fear of intimacy. This apparently resulted in polarized differences in personality characteristics between anorectics and normal eaters. Anorectics expressed compliance, perfectionism, dichotomous and ambivalent thinking, difficulty expressing feelings, powerlessness, and a desire to feel special. Normal eaters perceived their families as more affirming and sensitive to their needs. Thus, their thinking and behavioral patterns were evidently quite different from those of the anorectics. Since normal eaters were more self-assured and expressive of emotions, they reportedly found no need for seeking acceptance through appearance or anorectic behavior. Rather, they seemed to have a sense of more wholeness and being in touch with their true core self.

Social Implications

As has been shown, insecure familial and peer attachments and a shame-based identity could be prerequisites for developing anorectic tendencies. This could, in turn,

effect the developmental stages of self-definition and then dialectically affect successive stages of interrelatedness, not only to family, peers, and other personal relationships, but also to culture and food. Oppressive cultural forces may reinforce insecurity and a sense of social disconnection. Bombarded by conflicting messages regarding appearance, the emotionally insecure individual may be further impacted by societal identity confusion. She may then attempt to cope by striving for thinness and physical perfection. Therefore, females need encouragement from family, friends, educators, church, and community leaders to feel whole, vital, and beautiful exactly as they are. Perhaps then, they would not seek such means of self-acceptance as anorectic behavior.

Treatment Suggestions

Findings from this study may suggest a treatment approach in which attempts, directed at normalizing eating behavior, become more balanced between care and control, so as to encourage correction of childhood distortions. What is needed, as Katzman and Lee (1997) have argued, is a therapeutic process honoring personal power, relational satisfaction, and supporting position in the family, and in society at large.

Once a trusting therapeutic relationship is established, cognitive-behavioral treatments, focusing on shame-based cognitions and feelings, surrounding food, eating, and body image, may assist the client in adopting a more normal eating pattern, by challenging dysfunctional beliefs and providing alternative choices. It is important to diffuse the shame experienced by the anorectic. Claude-Pierre (1997) has maintained that the key to recovery from anorexia is reversing the negative mind. O'Hanlon (2000) has recommended a "possibility" form of therapy, by which a client is acknowledged and

validated, without closing down the potential for change. "Too much emphasis on change and possibility can give the message that the therapist does not understand or care about the person's suffering or dilemma. Too much emphasis on the acknowledgment side can give the message that the client cannot change or might encourage wallowing in the pain and hopelessness" (p.3).

By learning to resist the thin ideal through size acceptance, while exploring the source and triggers of shameful feelings, the anorectic may learn to recognize and counteract them. Through the use of food records and diaries, with noting of observations and inner-dialogues, cues, etc., she may begin to see beyond the mirror and eventually, find the eating disorder no longer serves a function.

As the client struggles with identity issues, it is important to continually assess the nature of family-of-origin influences. For chronic conditions, when family therapy may not be received, Selvini-Palazzoli & Viaro (1988) and Viaro (1990) have suggested a six-stage model for identifying and addressing concealed family games, which reinforce the disorder. But family therapy is most ideal. For it can assist all generations present to identify the losses and rejections that may have handicapped them, but do not leave them powerless to change present feelings and behavior. As noted by Cook (1991), in doing family therapy, the intergenerational transmission of attachment insecurity and shame means it is likely that the client's parents were themselves inadequately parented. Thus, a "no blame" stance must be coupled with the expectation that the client must now take responsibility for herself in changing behaviors and learning a healthier lifestyle.

Recommendations for Future Research

Overall, this research, while adding detail to the portrait of an anorectic, has indicated that the relationship to anorexia of attachment and shame bears further investigation. Future studies may consider more controlled conditions in evaluating women's psychopathology with respect to attachment difficulties. Perhaps care and protection constructs could be more refined to elucidate the mid-range patterns, as well as those of high /low levels.

Possibly a third attachment instrument, such as Parker's Measure of Parenting Style, could be implemented. The MOPS, which has refined Parental Bonding Instrument-like scales (labeled 'indifference' and 'over control'), along with a scale assessing parental abuse, has been employed in research by Parker, Roy, Wilhelm, Austin, & Hadzi-Pavlovic (1999), exploring links between early parenting experiences and personality disorders. Data analyses indicated that disordered functioning (as assessed by three independent rater groups) was most distinctly associated with paternal indifference and maternal overprotection, in agreement with results of this study.

As noted by Gilbert et al. (1994), shame is not just one affect, but is related to a variety of affects and cognitions (e.g. feelings of helplessness, anger at others, anger at self, inferiority, and self-consciousness). The Internalized Shame Scale does not assess all these factors. Thus, a more holistic observational method for detecting shame, such as suggested by Retzinger (1995, 1988), might provide additional understanding of the shame phenomena experienced by the anorectic.

Further investigation of peer attachment is needed. A closer look at social

networks may provide a clearer understanding of peer relationships. Longitudinal studies of attachment of both long- and short-term design could show changes in parental attachment as attachment to peer and self-image develops. Finding ways to strengthen peer relationships, particularly through institutional groups, should be explored to enhance adolescent development.

To better determine the anorectic's attachment style in the context of family relationships and personality, researchers may consider incorporating the Family Background Questionnaire, designed by Melchert and Sayger (1998) to comprehensively assess family-of-origin memories. Possibly, that would clear up questions, such as that raised by Parker and Gladstone (1996), as to whether family enmeshment is a causal factor for anorexia or a consequence of the family distress about the adolescent child.

The Health Belief Model, designed to predict a person's health behavior, may provide a conceptual framework for conducting further research. Although not yet directly applied to anorexia, the Health Belief Model has been recommended to raise an individual's awareness of risk for bulimia. Grodner (1991) has suggested identifying cues, or triggers, which prod a person to respond, that directly affect threat of the disease. Cues may be internal, such as feeling ill, responding physically to emotional stresses, or feeling obsessively guilty and 'out of control' around food when a diet is broken.

As this study was controlled for Caucasian race and female gender, implications to other populations were not addressed. Although research has indicated that until recently, anorexia has been rare or absent in non-Western cultures, Heesacker, Samson, and Shir (2000) reported that length of exposure to Western culture appears to influence

disordered eating in other nations. Contemporary research on health issues in Hispanic/Latino women (Zambrana & Ellis, 1995 and Espinoza, 2001); Asian/Pacific Island women (Wang, 1995); Native-American women (Tom-Orme, 1995), and African-American women (Lawson, Erma J., Malone-Hawkins, Sally, & Rodgers-Rose, LaFrancis 2001) would suggest that further research is needed on the prevalence of anorexia among minorities. Certainly, the inclusion of a more heterogeneous population could only serve to broaden the understanding of effective treatment of anorexia.

Although this research was limited to female gender, future research needs to address the differences of gender in attachment styles and levels of shame, as well as behavioral responses. Friedman (1996) found that homosexual men's fathers and mothers scored significantly lower in affectionate care and higher in overprotection. Being were more emotionally distant and critical of their sons than fathers of either heterosexual men or women. Gross & Hanson (2000) found secure attachment was negatively associated with shame for both male and female college undergraduates. "Perhaps this optimistic stance results in these individuals' interpersonal needs being sufficiently satisfied, thereby them less susceptible to the experience of shame. Conversely, the opposite relationship could also be true; perhaps individuals who experience less shame are more interpersonally available and therefore, more capable of developing and maintaining secure attachments" (Gross & Hanson, p. 903). Although women reported higher levels of shame than men, gender differences disappeared when controlling for effects of investment in relatedness. The greater the degree of personal importance of interpersonal connections (i.e. investment in relatedness), the greater the shame score.

Limitations of Study

There can be confidence in a research design, which rigorously follows the steps here described. A constant comparative method allows flexibility in formulating hypotheses. Thus, as propositions were tested and refined, ”true” contextual data were expected to give conceptual shape. Although theory, as well as related research, and my professional experience guided the investigation, there were certain limitations to this study.

With the small and somewhat homogeneous pool, findings may be representative of a limited population, considered tentative and subject to modification through subsequent research. However, the sample size was consistent with that of a qualitative case study. For example, Wechselblatt et al. (2000) investigated 11 anorectics to derive a grounded theory, and Schachtel (1988), utilizing a qualitative/phenomenological methodology examined the perspective of 5 bulimics.

Another limitation of the study was that it addressed only women who were willing to self-identify with the behavioral and cognitive symptoms of the disorder. Therefore, this anorectic group may not be representative of women who do not identify with anorexia and/or are not inclined to talk about their experiences.

Using self-report instruments is a restricted, but orderly way of allowing a subject to present recollections of her parents, as she experienced them during her first 16 years. Moreover, limited self-report instruments, such as used in this study, have the advantage of being objective, with results protected from researcher preconception. Furthermore, the multi-case, multi-method, replication design provided confirmation of the instrument

findings, while expanding the scope and richness of the data.

Regarding retrospective memories of parental/peer attachment, the view of Diehl, Elmick, Bourbeau, & Labouvie-Vief (1998) was adopted, maintaining that researchers need not be concerned with the actual parenting behavior. Rather, they can rely on individuals' cognitive representations of their family life, as perception may actually have greater impact on their emotions and behavior. Precise factual understanding, although sought, was of less concern than access to personal meanings and emotional resonance for the respondent in terms of attachment and shame. Therefore, while a parental account could add historical clarity, it would not likely alter the findings. This perspective, however, does not negate the effects of the actual family context or actual caregiver behavior on the formation of attachment styles. Rather, it acknowledges that experiences with others later in life may modify previous perceptions and the importance of the earlier family context.

Certainly, life experiences could flavor how participants remember the past. But the disparities existing between what an individual perceives to be true and what actually existed or occurred in previous years, within the reality of the parent-child relationship, may be irrelevant if the value and meaning of phenomenological experiences is respected Parker and Gladstone (1996). However, in circumstances such as where depressed respondents falsely perceive their parents as uncaring, a causal link may lie between perception and outcome, although a causal link between actual insufficiency of parental care and depression could not literally be claimed.

Relying on the assumption that participants will accurately report their feelings or

experiences, the Internalized Shame Scale may also have limitations. It is possible for the subject's view of her past to be influenced both by her present experience and by her responding to the perceived expectations of the tester. Also, assessment may be vulnerable to distorted perceptions, lapses of memory, and feelings overshadowing reality. Although it is difficult to gauge the biasing effects of denial, an effort was made to also incorporate observations of shame criteria. However, areas of unconscious conflict, which may weigh heavily upon the development of self-identity, were not explored.

Validity of narrative data from interviews rests on capturing and preserving the richness of contextual, personal meanings of events and experiences. Hence, an overall coherency was pursued for the representation of attachment and shame variables, as related to eating behavior. Thus, it is hoped that this in-depth, multi-faceted investigation will contribute new understanding and provide a plausible basis for future research.

APPENDIX A

LETTER TO PROFESSIONALS

Appendix A. Letter to professionals

To: Counselors of Eating Disorders

I am a University of North Texas doctoral student, conducting research for a case study comparing adult female restrictive anorexics to normal eaters. This study will consist of self-administered instruments, as well as a personal interview, exploring the relationship of attachment and internalized shame to restrictive eating. Matched pairs of adult (18 or older), white female restrictive anorexics (according to DSM IV criteria) and normal eaters will be selected. A "normal eater," for the purpose of this study, is defined as an individual who has an undisturbed eating pattern. In other words, eating is in response to hunger, taste and nutrition. Weight is not, nor has it ever been, an issue, nor body image a barrier to normal lifestyle.

Many clinicians have reported that their eating disordered patients are socially disconnected and have internalized shameful feelings, to the extent that their identities have become "shame-based," characterized by feelings of shamefulness, inadequacy and of experiencing themselves as never being "good enough." Thus, I believe this is a study pertinent to the clinical applicability of attachment and shame theory toward more effectively addressing the paradoxical thinking and behavioral patterns of anorexics. Therefore, I am requesting that you consider informing any patients meeting these criteria and exploring with them the possibility of volunteering for the participant pool
Strict confidentiality will be maintained. By the use of code numbers, anonymity will be guaranteed throughout the process. Results of the study will be provided for any participant upon request.

If you have knowledge of individuals who meet these criteria and would consider participation, please contact me at (405) 379-3867. I will be glad to answer any questions about the study, or you may contact my committee chair, Dr. Dale E. Yeatts at (817) 267-2238.

I shall look forward to hearing from you.

Sincerely,

Gloria Evans
L.P.C., L.M.F.T.

APPENDIX B

D.S.M. IV CRITERIA

Appendix B. DSM IV diagnostic criteria for 307.1 anorexia nervosa

Criteria

A. Refusal to maintain body weight, at or above a minimally normal weight for age and height (e.g. weight loss, leading to maintenance of body weight less than 85% of that expected; or failure to make expected weight gain during period of growth, leading to body weight less than 85% of that expected)

B. Intense fear of gaining weight or becoming fat, even though underweight

C. Disturbance in the way in which one's body weight or shape is experienced, undue influence of body weight or shape on self-evaluation, or denial of the seriousness of the current low body weight

D. In postmenarcheal females, amenorrhea, i.e., the absence of at least three consecutive menstrual cycles (A woman is considered to have amenorrhea if her periods occur only following hormone, e.g., estrogen, administration.)

Diagnostic criteria (A-D) for Anorexia Nervosa according to DSM IV are fulfilled.

Sub-typing

Restricting type: During the episode of Anorexia Nervosa, the person has not regularly engaged in binge-eating or purging behavior (i.e., self-induced vomiting or the misuse of laxatives, diuretics, or enemas).

Binge-Eating/Purging Type: During the current episode of Anorexia Nervosa the person has regularly engaged in binge-eating or purging behavior (i.e., self-induced vomiting or the misuse of laxatives, diuretics, or enemas).

American Psychiatric Association (1994). Diagnostic and statistical manual of mental disorders (4th Ed., revised), pp.544-545. Washington, DC: Author.

Exhibit 3. Are you dying to be thin?

APPENDIX C

DYING TO BE THIN INSTRUMENT

Appendix C. Are you dying to be thin?

Please answer the questions below honestly. Respond as you are now, not the way you used to be or the way you would like to be. Write the number of your answer in the space at the left. Please do not leave any questions blank unless instructed to do so.

_____1. I have eating habits that are different from those of my family and friends.
1) Often 2) Sometimes 3) Rarely 4) Never

_____2. I find myself panicking if I cannot exercise as I planned, fearing I will gain weight.
1) Often 2) Sometimes 3) Rarely 4) Never

_____3. My friends tell me I am thin, but I don't believe them, because I feel fat.
1) Often 2) Sometimes 3) Rarely 4) Never

_____4. My menstrual period has stopped or become irregular due to no known medical reasons
1) True 2) False

_____5. I think about food to the point that I cannot go through a day without worrying about what I will or will not eat.
1) Almost always 2) Sometimes 3) Rarely 4) Never

_____6. I have lost and currently weigh more than 15% of what is considered a healthy weight for my height, (e.g., female, 5'4" tall, healthy weight=122 lbs.)
1) True 2) False

_____7. I panic if I got on the scale tomorrow and find I have gained two pounds.
1) Almost always 2) Sometimes 3) Rarely 4) Never

_____8. I find that I prefer to eat alone or when I am sure no one will see me, thus making excuses so as to eat less and less with fiends and family.
1) Often 2) Sometimes 3) Rarely 4) Never

_____9. I find myself going on uncontrollable eating binges, during which I consume large amounts of food to the point that I feel sick and make myself vomit.
1) Never 2) Less than once/week 3) 1-6 times/week 4) 1 or more times/day

____10. (*NOTE: Answer only if your answer to #9 is "1"; otherwise leave blank.)* I find myself compulsively eating more than I want to, while feeling out of control and/or unaware of what I am doing.

1) Never 2) Less than one time per week 3) 1-6 times per week

4) 1 or more times per day

____11. I use laxatives or diuretics as a means of weight control.
1) Never 2) Rarely 3) Sometimes 4) On a regular basis

____12. I find myself playing games with food (e.g., cutting it up into tiny pieces hiding food so people will think I ate it, chewing it and spitting it out without swallowing it, keeping hidden stashes of food) and/or telling myself certain foods are bad.
1) Often 2) Sometimes 3) Rarely 4) Never

____13. People around me have become very interested in what I eat, and I find myself angry at them for pushing me to eat more.
1) Often 2) Sometimes 3) Rarely 4) Never

____14. I have felt more depressed and irritable recently than I used to and/or have been spending an increasing amount of time alone.
1) True 2) False

___15. I keep a lot of my fears about food and eating to myself, being afraid no one would understand.
1) Often 2) Sometimes 3) Rarely 4) Never

____16. I enjoy making gourmet and/or high calorie meals for others as long as I don't have to eat any myself.
1) Often 2) Sometimes 3) Rarely 4) Never

____17. The most powerful fear in my life is the fear of gaining weight or becoming fat.
1) Often 2) Sometimes 3) Rarely 4) Never

____18. I exercise a lot (more than 4 times per week and/or more than 4 hours per week) as a means of weight control.
1) True 2) False

____19. I find myself totally absorbed when reading books or magazines about dieting, exercising and calorie counting to the point that I spend hours studying them.
1) Often 2) Sometimes 3) Rarely 4) Never

____20. I tend to be a perfectionist and am not satisfied with myself unless I do things perfectly.
1) Almost always 2) Sometimes 3) Rarely 4) Never

____21. I go through long periods of time without eating (fasting) or eating very little as a means of weight - control.
1) Often 2) Sometimes 3) Rarely 4) Never

____22. It is important to me to try to be thinner than all of my friends.
1) Almost always 2) Sometimes 3) Rarely 4) Never

Scoring

Step 1: Add scores together. Total is _____.

Step 2: Compare score with table below.

38 or less -- Strong tendencies toward Anorexia Nervosa

39 – 50 -- Strong tendencies toward Bulimia Nervosa

50 – 60 -- Weight conscious; may or may not have tendencies toward an eating disorder (not likely to have anorexia or bulimia, but may have tendencies toward compulsive eating or obesity)

Over 60 -- Extremely unlikely to have anorexia or bulimia, however scoring over 60 does not rule out tendencies toward compulsive eating or obesity

APPENDIX D

PARTICIPANT AGREEMENT

Appendix D. Consent to participate in a research study.

You are invited to participate in a research study in which I will examine the relationship of parental bonding and social connection to eating patterns. To determine this, you will be asked for a time investment of approximately 90 minutes to complete self-administered questionnaires concerning your relationships with parent(s) and/or caretaker(s) and peers, as well as your feelings regarding various life experiences. You will also be requested to participate in a personal interview of approximately 75 minutes, where you will be asked open-ended questions, allowing you to further depict your thoughts and feelings regarding attachment and social connection.

This project has been reviewed and approved by the University of North Texas Institutional Review Board for the Protection of Human Subjects 940/565-3940. Taking part in this research is voluntary, and you are free to withdraw from the research at any time. There are no known risks associated with completing this study. As a licensed professional counselor, I assure you of providing an interview with sensitivity. You may answer only those questions with which you feel comfortable. However, it is very important to the results of this research that you answer as many questions as possible. The information you provide will be filed under a code number and remain strictly confidential. Signed consent forms will be kept separately, accessible only to the investigator. Furthermore, all records will be stored in a locked file in a locked office.

It is anticipated that your participation may help researchers and professionals toward understanding more about how attachment styles to parents and/or peers and internalized feelings regarding socialization could affect eating patterns. In addition, you may gain some helpful insights about yourself, leading to healthier interpersonal relationships.

This study is required for my completion of doctoral work at the University of North Texas. Results of the research will be available upon request. If you have any questions, you may contact me, Gloria Evans, at (972) 527-4361, or the chairman of my committee, Dr. Dale E. Yeatts, at (817) 267-2238.

I, _____, have read the above and have decided to participate in the study described above. My signature also indicates that I understand the contents of this consent form. A copy of this form will be provided to me.

_____ _____

Signed volunteer Date

_____ _____

Witness Date

APPENDIX E

QUESTIONNAIRE

Appendix E. Self-administered questionnaire (Attached letter)

1104 Gordon Oaks Dr.
Plano, TX 75023

Dear Participant,

Thank you for your willingness to be a part of this important study. You will find self-administered instruments enclosed which may be completed at your convenience. However, please either finish the questionnaire entirely at one sitting or an entire part at each sitting.

The Life-line is something you may need to think about and work on more gradually. On a scale from 1 to 10, 1 being least positive or negative, plot major positive events above and negative ones below the timeline. Then connect the dots to visualize your personal Life-line pattern. As you reflect on these events, please consider whether your eating pattern may have been related to any of these experiences. (You may choose to plot an eating pattern in a different color.) This exercise is to stimulate your remembrance and thinking about how life events may or may not have affected your eating behavior. Please bring these completed forms to the interview. The lifeline will be yours to keep, as it will perhaps be useful for further exploration with a trusted friend or therapist.

If you have any questions, please feel free to call me at (972) 527-4361. Keep in mind that self-administered instruments and interview information will be kept confidential. I trust that this will be a beneficial experience for you and the results of the study will supply valuable information for more effective clinical practice.

I shall look forward to seeing you at _____ on _____ at _____ for the interview.

Sincerely,

Gloria Evans

Enclosure

Appendix E. Self-administered questionnaire

Part I

Listed are various attitudes and behaviors of parents. As you remember your Mother/Father or the Mother/Father figure(s) which most influenced you during the first 16 years of your life. Please check the relationship you had with the person being considered for the Mother/Father role, selecting the one who influenced you most. Then check the most appropriate category next to each question using the following scale:

4 -- very like	____Mother	____Father
3 -- moderately like	____Stepmother	____ Stepfather
2 -- moderately unlike	____Grandmother	____Grandfather
1 -- very unlike	____Other _____	____Other_____

	Mother				Father			
	4	3	2	1	4	3	2	1
1. Spoke to me with a warm and friendly voice	___	___	___	___	___	___	___	___
2. Did not help me as much as I needed	___	___	___	___	___	___	___	___
3. Let me do those things I liked doing.	___	___	___	____	___	___	___	___
4. Seemed emotionally cold to me	___	___	___	___	___	___	___	___
5. Appeared to understand my problems and worries	____	____	____	____	____	____	____	___
6. Was affectionate to me	___	___	___	___	___	___	___	___
7. Liked me to make my own decisions.	___	___	___	___	___	___	___	___
8. Did not want me to grow up	___	___	___	___	___	___	___	___
9. Tried to control everything I did.	___	___	___	___	___	___	___	___
10. Invaded my privacy	___	___	___	___	___	___	___	___
11. Enjoyed talking things over with me.	___	___	___	___	___	___	___	___
12. Frequently smiled at me	___	___	___	___	___	___	___	___
13. Tended to baby me	___	___	___	___	___	___	___	___

	Mother				Father			
	4	3	2	1	4	3	2	1
14. Did not seem to understand needed or wanted	___	___	___	___	___	___	___	___
15. Let me decide things for myself	___	___	___	___	___	___	___	___
16. Made me feel I wasn't wanted	___	___	___	___	___	___	___	___
17. Could make me feel better when I was upset	___	___	___	___	___	___	___	_
18. Did not talk with me very much.	___	___	___	___	___	___	___	___
19. Tried to make me dependent on her/him	___	___	___	___	___	___	___	___
20. Felt I could not look after myself unless she/he was around	___	___	___	___	___	___	___	___
21. Gave me as much freedom as I wanted	___	___	___	___	___	___	___	___
22. Let me go out as often as I	___	___	___	___	___	___	___	___
23. Was overprotective of me	___	___	___	___	___	___	___	___
24. Did not praise me	___	___	___	___	___	___	___	___
25. Let me dress in any way I pleased	___	___	___	___	___	___	___	___

From Parker, G., Tupling H, & Brown, L.B. A parental bonding instrument. British Journal of Medical Psychology, 1979, 52, 1-10.

Part II

This section asks about your relationships with important people in your life; your mother, your father, and your close friends. Please read directions to each part carefully.

Section A.

Some of the following statements ask about your feelings concerning your mother or the person who has acted as your mother. If you had more than one person acting as your mother (e.g. a natural mother and a step-mother), answer the questions for the one you feel has most influenced you.

Please read each statement and circle the ONE number that tells how true you would have considered the statement during your first 16 years.

	Almost Never or Never True	Not Very True	Some-times True	Often True	Almost Always or Always True
1. My mother respected my feelings.	1	2	3	4	5
2. I feel my mother did a good job.	1	2	3	4	5
3. I wish I'd had a different mother.	1	2	3	4	5
4. My mother accepted me as I was.	1	2	3	4	5
5. I liked getting my mother's point of view on things of concern to me.	1	2	3	4	5
6. I felt it was no use letting my feelings show around my mother.	1	2	3	4	5
7. My mother could tell when I was feeling about something.	1	2	3	4	5
8. Talking over problems with my mother made me feel ashamed or foolish.	1	2	3	4	5
9. My mother expected too much from me.	1	2	3	4	5
10. I got upset easily around my . mother.	1	2	3	4	5
11. I got upset a lot more than she knew.	1	2	3	4	5

	Almost Never or Never True	Not Very True	Some-times True	Often True	Almost Always or Always True
12. When we discussed things, my mother cared about my point of view.	1	2	3	4	5
13. My mother trusted my judgment.	1	2	3	4	5
14. My mother had her own problems, so I didn't bother her with mine.	1	2	3	4	5
15. My mother helped me to understand myself better.	1	2	3	4	5
16. I told my mother about my problems and troubles.	1	2	3	4	5
17. I felt angry with my mother.	1	2	3	4	5
18. I didn't get much attention from my mother.	1	2	3	4	5
19. My mother helped me to talk about my difficulties.	1	2	3	4	5
20. My mother understood me.	1	2	3	4	5
21. When I was angry about something, my mother tried to be understanding.	1	2	3	4	5
22. I trusted my mother.	1	2	3	4	5
23. My mother didn't seem to understand what I was going through.	1	2	3	4	5
24. I could count on my mother when I needed to get something off my chest.	1	2	3	4	5
25. If my mother knew something was bothering me, she asked me about it.	1	2	3	4	5

Section B.

This part asks about your feelings regarding your father, or the man who acted as your father. If you had more than one person acting as your father (e.g. natural and step-father), answer the questions for the one you feel most influenced you.

Please read each statement and circle the ONE number that tells how true you would have considered the statement during your first 16 years.

	Almost Never or Never True	Not Very True	Some-times True	Often True	Almost Always or Always True
1. My father respected my feelings.	1	2	3	4	5
2. I feel my father did a good job.	1	2	3	4	5
3. I wish I'd had a different father.	1	2	3	4	5
4. My father accepted me as I was.	1	2	3	4	5
5. I liked getting my father's point of view on things of concern to me.	1	2	3	4	5
6. I felt it was no use letting my feelings show around my father.	1	2	3	4	5
7. My father could tell when I was feeling about something.	1	2	3	4	5
8. Talking over problems with my father made me feel ashamed or foolish.	1	2	3	4	5
9. My father expected too much of me.	1	2	3	4	5

	Almost Never or Never True	Not Very True	Some-times True	Often True	Almost Always or Always True
10. I got upset easily around my father.	1	2	3	4	5
11. I got upset a lot more than he knew.	1	2	3	4	5
12. When we discussed things, my father cared about my point of view.	1	2	3	4	5
13. My father trusted my judgment.	1	2	3	4	5
14. My father had his own problems, so I didn't bother with mine.	1	2	3	4	5
15. My father helped me to understand myself better.	1	2	3	4	5
16. I told my father about my problems and troubles.	1	2	3	4	5
17. I felt angry with my father.	1	2	3	4	5
18. I didn't get much attention from my father.	1	2	3	4	5
19. My father helped me to talk about my difficulties.	1	2	3	4	5
20. My father understood me.	1	2	3	4	5
21. When I was angry about something my father tried to be understanding.	1	2	3	4	5
22. I trusted my father.	1	2	3	4	5

	Almost Never or Never True	Not Very True	Some-times True	Often True	Almost Always or Always True
23. My father didn't seem to understand what I was going through.	1	2	3	4	5
24. I could count on my father to know when I needed to get something off my chest.	1	2	3	4	5
25. If my father knew something was bothering me, he asked me about it.	1	2	3	4	5

Section C.

This part asks about your feelings concerning your relationships with close friends. Please read each statement and circle the ONE number that tells how true you would have considered the statement during your first 16 years.

	Almost Never or Never True	Not Very True	Some-times True	Often True	Almost Always or Always True
1. I liked to get my friends' point of view on things about which I was concerned.	1	2	3	4	5
2. My friends could tell when I was upset about something.	1	2	3	4	5
3. When we discussed things, my friends cared about my point of view.	1	2	3	4	5
4. Talking over my problems with my friends made me feel ashamed or foolish.	1	2	3	4	5
5. I wish I'd had different friends.	1	2	3	4	5
6. My friends understood me.	1	2	3	4	5
7. My friends helped me to talk about my difficulties.	1	2	3	4	5

	Almost Never or Never True	Not Very True	Some-times True	Often True	Almost Always or Always True
8. My friends accepted me as I was.	1	2	3	4	5
9. I felt the need to be in touch with my friends more often.1	1	2	3	4	5
10. My friends didn't understand what I was going through.	1	2	3	4	5
11. I felt alone or apart when I was apart from my friends.	1	2	3	4	5
12. My friends listened to what I had to say..	1	2	3	4	5
13. I felt my friends were good friends.	1	2	3	4	5
14. My friends were fairly easy to talk to.	1	2	3	4	5
15. When I was angry about something my friends tried to be understanding.	1	2	3	4	5
16. My friends helped me to understand myself better.	1	2	3	4	5
17. My friends cared about how I was doing.	1	2	3	4	5
18. I felt angry with my friends.	1	2	3	4	5
19. I could count on my friends when I needed to get something off my chest.	1	2	3	4	5
20. I trusted my friends.	1	2	3	4	5
21. My friends respected my feelings.	1	2	3	4	5
22. I got upset a lot more than my friends knew.	1	2	3	4	5

	Almost Never or Never True	Not Very True	Some-times True	Often True	Almost Always or Always True
23. It seemed as if my friends were irritated with me for no reason.	1	2	3	4	5
24. I could tell my friends about my problems and troubles.	1	2	3	4	5
25. If my friends knew something was bothering me, they asked me about it.	1	2	3	4	5

Part III

Below is a list of statements describing feelings or experiences that you may have from time to time, or that are familiar to you, because you have had these feelings and experiences for a long time. Most of these statements describe feelings and experiences that are generally painful or negative in some way. Some people will seldom or never have many of these feelings. Everyone has had some of them at some time. But if you find that these statements describe the way you feel a good deal of the time, it can be painful just reading them. Please press through any discomfort and try to be as honest as you can in responding.

Read each statement carefully and circle the number to the left of the item that indicates the frequency with which you find yourself feeling or experiencing what is described in the statement. Use the scale below. PLEASE DO NOT OMIT ANY ITEM.

	Never	Seldom	Some-times	Often	Almost Always
1. I feel like I am never quiet good enough.	0	1	2	3	4

	Never	Seldom	Some-times	Often	Almost Always
2. I feel somehow left out	0	1	2	3	4
3. I think that people look down on me.	0	1	2	3	4
4. All in all, I am inclined to feel that I am a success.	0	1	2	3	4
5. I scold myself and put myself down.	0	1	2	3	4
6. I feel insecure about others' opinions of me.	0	1	2	3	4
7. Compared to other people, I feel like I somehow never measure up.	0	1	2	3	4
8. I see myself as being very small and insignificant.	0	1	2	3	4
9. I feel I have much to be proud of.	0	1	2	3	4
10. I feel intensely inadequate and full of self doubt.	0	1	2	3	4
11. I feel as if I am somehow defective as a person, like there is something basically wrong with me.	0	1	2	3	4
12. When I compare myself to others, I am just not as important.	0	1	2	3	4
13. I have an overpowering dread that my faults will be revealed in front of others.	0	1	2	3	4
14. I feel I have a number of good qualities.	0	1	2	3	4
15. I see myself striving for perfection, on to continually fall short.	0	1	2	3	4
16. I think others are able to see my defects.	0	1	2	3	4

	Never	Seldom	Some-times	Often	Almost Always
17. I could beat myself over the head with a club when I make a mistake.	0	1	2	3	4
18. On the whole, I am satisfied with myself.	0	1	2	3	4
19. I would like to shrink away when I make a mistake.	0	1	2	3	4
20. I replay painful events over and over in my mind until I am overwhelmed.	0	1	2	3	4
21. I feel I am a person of worth, at least on equal plane with others.	0	1	2	3	4
22. At times I feel I will break into a thousand pieces.	0	1	2	3	4
23. I feel as if I have lost control over my body functions and my feelings.	0	1	2	3	4
24. Sometimes I feel no bigger than a pea.	0	1	2	3	4
25. At times I feel so exposed that I wish the earth would open up and swallow me.	0	1	2	3	4
26. I have this painful gap within me that I have not been able to fill.	0	1	2	3	4
27. I feel empty and unfulfilled.	0	1	2	3	4
28. I take a positive attitude toward myself.	0	1	2	3	4
29. My loneliness is more like emptiness.	0	1	2	3	4
30. I feel like there is something missing.	0	1	2	3	4

There is some demographic information needed for statistical purposes in this study.

1. What is your age? _____

2. What was the last grade of school you completed?
   _____ 1. completed junior high school
   _____ 2. graduated from high school or GED
   _____ 3. some training other than college
   _____ 4. some college
   _____ 5. graduated from college
   _____ 6. some graduate work
   _____ 7. graduate degree _____
   _____ 8. currently in school working toward _____

3. In what religion were you raised? What is your current religious persuasion?
   (Indicate with R and C)
   _____ 1. None
   _____ 2. Jewish
   _____ 3. Roman Catholic
   _____ 4. Methodist
   _____ 5. Episcopalian
   _____ 6. Presbyterian
   _____ 7. Lutheran
   _____ 8. Pentecostal
   _____ 9. Lutheran
   _____ 10 Baptist
   _____ 11. Non-denominational
   _____ 12. Other _____

4. What is your marital status?
   _____ 1. single
   _____2. married
   _____ 3. divorced
   _____ 4. widowed
   _____ 5. other

5. How many children, if any, do you have? _____ What are their ages? _____

6. Do you work outside the home? ____ If so, what is your job? _____

7. Please circle the letter of the category which fits your total annual household income.
   A. $15,000 or less
   B. $15,001-$25,000
   C. $25,001-$40,000
   D. $40,001-$60,000
   E. over $60,000

8. How tall are you? _____ ft. _____ in.

9. What is your current weight? _____

10. What is the most you ever weighed, excluding pregnancy? ____ Least?_____

APPENDIX F

INTERVIEW

Appendix F. In-person interview schedule.

To supplement the instruments, which you have completed, I will be asking you some questions for describing how it was for you growing up in your environment, with your family and among your peers. I do not want to take the chance of just relying on my notes or memory, and thereby missing something relevant or somehow inadvertently changing your words. Therefore, unless you object, I will be tape recording the interview. However, at any time during the interview you may request that the tape recorder be paused or turned off.

1. By way of introduction, please tell me a little about yourself. From your perspective, what personal tastes, lifestyle, and other distinguishing characteristics comprise who you are as a unique person?

2. If you could change one thing in your life, what would it be?

Now, let's explore how you may have come to be the unique individual that you are, first as influenced by the culture or social processes, then family and peer relationships.

3. Please briefly state your view of life in the broader perspective of the world and your surroundings.

4. How so you see yourself fitting into the cultural environment and its demands?

Probes: Basically connected or disconnected? Explain. (Note identity confusion or ambivalence.)

Has there been any sense of straddling two worlds or being pulled in two directions?

Career/motherhood
Dependence/independence
Need to separate from the world/sociability
Want to withdraw/desire for intimate relationships

Any perceived transition, dislocation, social inequalities or other conflicting pressures preventing you from achieving desired goals?

5. In the American culture, what values do you see that society expects of women?

6. Irrespective of others' views, what is your personal image of an ideal woman?

Appendix F. In-person interview schedule (Cont.)

7. Please tell me about your family, as if you were telling a story. (Number of siblings, your birth order, family temperament, how members related to one another, what pleased or displeased you about your family)
Probes: What were your family roles?
Describe your home environment.
Describe some family traditions and/or rituals you recall.
Describe parents' marital relationship.

Please complete the next few sentences:

8. Family members depended upon one another to meet needs by . . .

9. I yearned for . . .

10. The values my family tended to emphasize were . . .

Probes: Beliefs about achievement and success, academics, community involvement, religion, inner qualities, connection with the world, etc.

11. If you were going to write the story of your life--which of course would begin when you were an infant--what would be the first sentence?

Adding to your story, please complete the following sentences with 4 or 5 adjectives.

12. My family could best be described as . . . . .

13. In my family, my mother was always . . . . .

14. In my family, I was always . . . . .

15. In my family, my father was always . . . . .

16. When out in public with my family, I usually. . . . .

17. The funniest thing I recall ever happening was . . .

18. If there were a topic that could not be discussed in my family, it was . . . . .

19. An emotion rarely expressed in my family was . . . . .

20. I was closest to . . . . . and most distant from . . .

Appendix F. In-person interview schedule (Cont.)

21. When there was conflict in our family . . .

22. If I could title a book about living with my family, it would be . . . . .

23. Please describe your relationship(s) with your parent(s) and/or caretaker(s) from as far back as you can remember. How have the relationship(s) changed over time?

Check: Availability
Nurturance, unconditional love
Protection, control, (expectation of perfection, structure & boundaries)
Freedom to explore own interests
Security, sense of belonging
Quality of communication
Dependability, trust
Sense of own personal and sexual identity

24. What influence do you feel these relationships had on your own personality development? On overall identification with mother/father? On your eating patterns?

25. What were family mealtimes like?
Did the atmosphere stay about the same throughout your childhood?
Which meals were eaten together?
Who prepared meals?
What are your first memories regarding eating?
What connotations did food have? (Reward or punishment, love, stuffing emotions, attention, approval, etc.)

26. How did your family react to your eating patterns? To your recovery? (restrictive eater only)

What do you think kept you from developing an eating disorder? (normal eater)

27. Please recall an instance from childhood when your parent(s) responded to an emotional situation and describe how you felt. Were you:

Comforted or pained?
Protected or left insecure?
Misunderstood or understood?
Rejected or accepted?
Respected or shamed?

28. What is your preferred body weight?

Appendix F. In-person interview schedule (Cont.)

29. According to your own standards, have you found your figure and body parts to be too fat, too thin or just right? Does your evaluation agree with others? Please explain.

30. Did anything in particular happen in your life, either positive or negative, that proceeded or coincided with the time(s) that you significantly altered your food intake and/or controlled further weight gain?

Check: Death of important person
Leaving home
Illness or self injury
Illness of family member
Problems in romantic relationship
Failure at school or work
Family problem
Teased or criticized for appearance
Shamed in some way
Marriage
Pregnancy
Difficult sexual experience

31. To what extent has your feeling good about yourself been dependent upon your body weight?

Probes: How did you generally feel about yourself when you "felt fat" vs. when you "felt thin"? Were there other areas in your life from which you could draw self worth? If yes, rank order how important body shape and weight was upon self-esteem in comparison.

32. Do you think a lot about your figure and weight and how others might perceive you?

Probes: How often do you weigh? In an average day, how much time do you spend thinking about your figure and/or weight?

33. Would you say that intense investment of thought, time and effort to maintaining weight an/or appearance increases of decreases self-satisfaction.

34. Please discuss what triggers either eating or not eating for you.

Check: Being urged to eat by someone else
Being around others when eating
Arguing or having conflict with someone
Being teased or criticized

Appendix F. In-person interview schedule (Cont.)

Being depressed
Feeling lonely
Wanting to numb out
Comparing media models to own appearance
Retreating from heavy social demands

35. Do you think you are fully in touch with your body's signals of need, such as hunger?

36. During your teens, did you have somebody whom you could trust entirely, and who was always there for you whenever you needed help, comfort or support? Was there someone with whom you could discuss just about everything? Explain.

37. In your teen relationship(s) to peers, to what extent did you feel able to:

Trust others
Make friends
Get close to others
Maintain relationships

38. How much contact did you have with friends and acquaintances? How often did you see each other and what did you do together?

39. What relationship during your teens had the greatest, long-lasting influence?

40. Thinking in terms of food as if were a person, how would you describe your relationship? (Friend, coping mechanism, etc.)

41. Thinking in terms of your body as something inanimate, how would you describe it?

Probe: Do you most often view your body as:

An object for others' perception or pleasure
A machine of labor
A project to be continually worked on
A status symbol
A robot out of control, which must be mastered
A container of my self
A means to an end
A phenomenon to be explored for finding my individuality
A bearer of societal and/or familial expectations
A barrier to contact or communication with others

Appendix F. In-person interview schedule

42. Describe yourself post high school. What pleased and frustrated you about yourself?

43. Please describe the time you felt most depressed and had the lowest opinion of yourself..

44. Have you ever felt a sense of being disconnected or detached from yourself and/or others? How old were you? Please explain what happened and how you felt. What seems to trigger that kind of experience today?

45. How do you view death?

46. Describe your greatest fear of failure to meet internalized rules of what constitutes appropriate behavior or body presentation

47. How do you generally react to perceived pressure on you to respond conflictually with your true emotions?

Probe: Do you most often:
Pretend to feel differently than you really do
Suppress and deny your true feeling
Replace or alter feelings.
Express true feelings, irregardless of expectations

48. Please describe how you envision yourself ten years from now.

Debriefing Statement (to follow interview):

Now before concluding, is there anything that you would like to add to describe who you are as a result of parental/peer relationships and how that may have affected your eating pattern? Do you have any questions you would like to ask or any comments concerning the interview?

Let me explain my interests in this study. There has been a long-standing study of infant-mother bonding or attachment. Basically, secure attachment means that a relationship satisfies needs for contact, emotional comfort and protection in situations of stress or danger. Variant patterns of this ideal have been observed and related to subsequent relationships. As a licensed counselor with a nutrition background, I have a special interest in finding keys toward the recovery of eating disorders. After three years of studying the phenomena of anorexia, I believe it is highly related to self-identity. Thus,

Appendix F. In-person interview schedule (Cont.)

this research is designed to gather narrative data for pattern-matching restrictive and normal eaters, especially illuminating the dynamics of attachment and internalized shame.

At this point, I do not know what I will find, but I will make available the results at the end of the study. If you have any further thoughts or questions, please call me.
Thank you for participating.

APPENDIX G

INTERVIEW EVALUATION FORM

Appendix G. Interview evaluation form

Respondent #_____

Personal Identity

Physical Image

Sense of Competence

Occupational success

General Life Satisfaction

Most Desired Area of Change

Cultural Orientation

Connected or Disconnected

Identity Confusion

Ambivalence

Society's Ideal Woman

Personal Ideal Woman

Eating Behavior

Appendix G. (Cont.)

Attachment Criteria	Mother	Father	*Peer
Protection			
No security			
Ambivalent security			
Weak security			
Normal security			
Overprotection/Rigidity			
Comments:			
Care			
Deprivation (Physical. or emotional)			
Low nurturance			
Ambivalent nurturance			
Normal nurturance			
High nurturance			
Comments:			
*Trust (Sensitivity, predictability, dependability, & respectfulness)			
No trust			
Low trust			
Ambivalent trust			
Normal trust			
High trust			

Appendix G. (Cont.)

	Mother	Father	*Peer
*Communication			
Open (Attuned & connected)			
Somewhat open			
Ambivalent			
Critical/teasing/conflictual			
Closed			
Comments:			

Attachment Pattern _____ _____

Secure - Optimal bonding indicates at least 4 of the following:

Secure base	Trustworthy
Nurturing	Protective under stress
Attuned to her individuality	Satisfying
Emotionally connected	

Absent or Weak Bonding--(low care, low control) with attachment deficiency in most respects, especially lacking empathic understanding. Parent(s) may be negative, harsh, critical or punitive, often impossible to please, with unrealistic expectations.

Affectionless Control - (low care, high control) with parent being emotionally cool or distant, hostile or rejecting, critical of emotionality , but protective and caring for physical needs

Overattached -- Affectionate constraint (high care, high control) with nurturance, trust and protection, but tendencies of intrusive control or overprotectiveness. Fosters neediness, dependency and fear of separation with lack of sense of individual identity.

Ambivalent -- Attachment inconsistency with respect to nurturance, protection and attunement, with personal demands of appearance and social acceptability which may be unattainable. Pattern may alternate between intense and often frustrating engagements with parent(s) and indifference or withdrawal.

Appendix G. (Cont.)

Shame

Shame-prone parental traits

- Frequent absence
- Emotional detachment
- Invoked anger
- Marital dissatisfaction
- Feelings not expressed
- Unclear, harsh or inappropriate values
- Children seen as extension of self
- Demeaned/humiliated for mistakes
- Fearful and anxious

Inferiority

- Insecure base
- Unresolved conflict
- Insufficiency
- Personal badness

Social alienation

- Limited social contact
- Poor quality of social contacts
- Social withdrawal/fear of intimacy
- Numbing out/disconnection

Appendix G. (Cont.)

Suicidal thoughts/attempt

Self-esteem

Negative identity with parent

No sense of belonging
Lack of female identity

Body image disturbance

Preoccupation with food

Self-defeating behavior

Perfectionism

Depression

Control

Emotional blocking

Obsessive-Compulsion

Polarized Thinking

Ambivalence

Peer Influence

Comments

APPENDIX H

INTERVIEW SUMMARIES

(Note: In order to maintain confidentiality, pseudo-names were used.)

AM1

Amy was a very attractive, 5'6", 35 year-old, married, mother of 3 and a realtor. She described her Protestant family of origin as "close-knit," very outgoing, and always doing things together. Her parents had a "wonderful" marriage of 44 years, showing respect for each other's needs. She expressed a special closeness to her older brother, who protected and took care of her. When he became "a bit rambunctious" for awhile, Amy tried to overcompensate for his behavior by trying to make her parents happy. Eventually, he became a very successful attorney. Amy described her father as a very accomplished engineer, continuing to climb the ladder of success. She considered herself as "daddy's little girl" and saw him as the more laid back, sensitive and emotionally accessible parent. Although Amy's mother, an "overly organized" high school administrator, handled the home discipline, she mostly engaged in surface conversation.

As Amy spoke, she displayed some overt indicators of shame. With lowered head and averted gaze, she often showed a painful self-consciousness. Sometimes her thought and speech appeared rapid, as if to avoid pain before it could be experienced. Even though Amy felt her family showed unconditional love, trustworthiness, and availability, she acknowledged having difficulty in talking openly with them and showing feelings. Rarely displayed in her family, anger could only be expressed in a normal tone of voice. So Amy learned to just "put a lid on it". In public with her family, Amy usually felt nervous, anxious and on edge. She perceived each family member as almost perfect, successful, popular, and well liked. Seeing herself as quiet, shy and not as successful put

a lot of pressure on her to fit the expected role. She said, "I just wanted to do everything perfectly, just read their minds, know what they wanted me to do, and do it." An internal tape would play over and over, "No matter what you do, you're never going to be that good. You're never going to be perfect. What are you going to do?" Year after year, Amy continued trying to achieve and beating herself down. For example, she said, "I always tried to make sure I got first year clarinet, good grades or that I won an award. She was encouraged to do a lot of things they wanted, such as playing the piano, which she did "all the way through high school." But not feeling good about her personality and lack of performance brought a lot of loneliness. Although she was always trying to please, she blamed herself for the lack of intimate connection with her parents.

Amy became a teacher, and after she married, her husband's pursuit of school and job opportunities required frequent moves. In 10 years of teaching experience, only once was she able to stay at the same school for two years. Relating to her husband the same way she had to her family, she felt "controlled." She said, "I just always had to do what everybody else wanted me to do." When her husband started a business, Amy thought, "My whole identity in the community was him. I didn't really know who I was or what my purpose was."

Amy said she just kept stuffing her anger "until the top blew off." Although not a conscious effort at first, "Starving myself was something I could do extremely well," and it was "something that was completely mine," that "none of them had done." "I could be the very best in the family at losing weight, and there was nothing that they could do about it. It was control for me, proving myself, even though in a detrimental way. It was

a way of proving my capabilities and that I was as good as them at something."

Recalling family mealtimes as pleasant experiences, Amy reported never dieting in her teens. When she developed an eating disorder, she was 31. The first year of weight consciousness, she began by exercising. She started taking Slim Fast once a day, then twice a day, and progressed to just eating once a day. By the second year, after the eating disorder kicked in, she was consumed with weight loss. Amy weighed every morning after running, and spent about 90% of the time thinking about her figure and weight. Amy avoided most social events, talking to her husband and daughters, only because she "had to." Amy spent hours alone, in the bedroom or soaking in the bathtub or Jacuzzi. She just kept thinking, "If I could get thinner, smaller, then I would feel better about myself, and other people would like me better." Amy said, "It seemed like everyone I saw was thinner than I," even though in her head she knew that wasn't true. She felt unworthy of her family. "The more negative my feelings, she said, "the fatter I looked. And I didn't even have to look. It was just a feeling of fatness."

Amy's family eventually intervened, and she went to in-patient treatment for 2 weeks and then continued with a day program. But when she "took a nose dive and became really suicidal," she checked herself into another in-patient program. After again cycling back to her disorder, she went to Remuda Ranch in Arizona, where "I first got a really good grip on recovery" when "I got back in touch with God." Although much improved, Amy continues to work on expressing feelings and thinks about weight gain. She tends toward black and white thinking. That is, something is either really good or really bad. There seems to be no middle ground or gray area. She said that she realized

the eating disorder was her way of handling emotions and stress. Amy's main goal is to have a happy family, as she felt she'd restricted a lot of happiness by being so focused on perfection.

AM2

Alice was a vivacious 5'7" sandy-haired, conflicually-married, 35 year-old mother of two girls. She was two years younger than another daughter of her biological mother. In her young adulthood, she learned that she had another sister, as well as an unknown brother, whom her mother had given up for adoption. After she was married, Alice found her biological father, only to discover that she had two more half brothers and a half sister. "So 2 became 3 became 4, and then became 7." From the age of 18 months until 4 years old, Alice and her sister were with foster parents, who had three other children. Alice said, "That was probably the only stable, safe, caring place that I have ever had." But her mom decided to take them back and soon moved from New York to Florida. She remarried when Alice was 7, and had another son when she was 10. From that point, she and her sister became "little stepsisters, like Cinderella." They were given heavy chores and required to baby-sit a lot.

Alice stated that her family of origin could best be described as "evil." She said that love was an emotion rarely expressed in her family, and crying was not allowed in her household. Her dad was an alcoholic, her mother a prescription drugs addict and rageaholic, while her stepfather was sexually abusive to Alice and her sister. She said, "Everyone 'kinda' catered to my mom, and tried not to get her angry." When, as a teen, Alice rebelled against this, her mother would "just go into fits…. got real violent and

suicidal." From age 4, she recalled her mother was involved in criminal activities, being neglectful and abusive to the girls. When their foster mother came to see them, they were filthy, wet and very, very thin. Alice told that the second time their foster mother came, she really "had it out with my mom……and my mom told her never to come back." There was only sporadic contact until after Alice was married. Once, when she was 15, Alice and her sister were able to go back to visit their foster mother. It was very traumatic, because neither wanted to leave.

Alice said that her mother "sold me and my sister into child prostitution and pornography. We lived in many places with many different people . . . so that they would feel like substitute parents." That went on for two years, and there would be severe abuse. Then they would go back with their mom and step-dad, who although more gentle, 'kinda' turned his back on us kids." He was weak against his wife's raging demands. "Mom was the only one allowed to have any needs, . . . so I guess everyone (else) denied having any needs." The depressed step-dad turned to the girls as surrogate spouse, and eventually, sexually abused them.

Alice felt she was most distant from herself. In her opinion, "Everyone was better than I was. Everyone had a better life, better parents, better everything. Everyone knew what was going on, except me." She said that although she tried on a lot of roles, she actually had no identity. She sighed, "I spent my whole childhood and adolescence trying to be the person she (mother) wanted me to be. But she never made up her mind who she wanted me to be. . . . The only time I really felt like me was probably when I was reading." Also, she said she always knew that she was very intelligent and creative.

Out in public with her family, Alice expressed that she felt very ashamed. "We were supposed to look like the perfect little family.". . . .but it was like having two different worlds." Once they walked out of church or the public image, her mother would continually put her down and "harp on my body." Also, "Dad would sit us down in from of that Miss Universe pageant every year. He would make us watch it. . . and he would say, 'If you would just lose 10 or 15 pounds, you would get to be there.'" There was always something wrong. When she was full height and curvy, she was told that she was too fat. However, as she has looked back at pictures, she discovered, "Oh my gosh! I am not this huge, incredible mega beast, like I was told I was."

Alice declared that she had spent the majority of her adult life in therapy. She has suffered from a dissociative disorder, an eating disorder, many addictions, as well as an attachment disorder and many suicide attempts. When she was 2 years old, Alice had eating problems. She was diagnosed with "failure to thrive." She said, "I just wouldn't eat. . . . I would refuse to talk. I wouldn't interact. Her foster mother took her regularly to the doctor and gave her special shakes. But at another time, when back with her mom and left alone, she could remember being starved, with only Spaghetti O's and bread and butter to find in the house to eat. She said, "Food was real controlled, . . .and mealtimes were pretty much torture. . . . If we took seconds, we were chastised for eating too much." Yet, even if they didn't like something, they "had to sit there and eat it until it was gone." When she was 12, she got to the point that she simply wouldn't eat, but just moved food around on her plate. At first, her parents were happy that she was real thin. But then they got really angry and started paying closer attention to what she was doing

at the table, when friends commented that she was too thin and looked sick.

Alice said that restricting was not so much for weight control as for emotional control. "It was like this microcosm world of perfectionism where I could feel like I could do something right. . . . No one could tell me that I wasn't doing it right, because I made the rules. . . .So I don't have to think about what is overwhelming me, I can focus on food. It just 'sorta' goes away, becomes numb. Then I have complete control . . .and that always gives me a sense of power." The control went both ways with Alice's weight. For awhile, she was even overweight, reaching 255 pounds. Yet, most of the time, she was anorectic, her lowest weight being 104. At the time of the interview, Alice said she would like to be 100. She knew that she was about health weight, and others considered her about right, or a little thin. She still felt too fat. She said that feeling good about herself had gone from 100% to about 70% dependency on body weight, that having been her whole identity. She acknowledged that she spent about 60% of the time in the course of a day thinking about food.

Alice contributed her eating disorder to a "lack of any real significant relationship that was stable for me and secure, as a child." She said, " when you have known, since a child, that your own mother can't even love you, you start going there too much. It just feels hopeless. You feel worthless. You feel like you are not even human." She said she had some friends when she was a teen that she would hang out with, just not to be at home. There was no one with whom she could discuss everything. She split up what she self-disclosed among three friends, and still left out big parts. She feared that if they knew how bad her parents were, they would not want to come visit her. Later, trying to

get her mom's approval, she was in the top 28% of her senior class of 800. Regardless, her mom would focus on any bad clubs or groups she hung out with, and never saw her accomplishments.

Alice brought her two girls to the interview. She was very patient with their frequent interruptions and very kind and gentle towards them. She said she was working on her marriage, and it was getting better. However, she separated from her husband. Her 10-year vision was raising her teenage daughters, being in a career of her choice and healthy.

AS1

Sally was a 5'11½", very slender, masculinely attired, and single speech therapist. She had a weak handshake and initially, limited eye contact, which improved as interview progressed. The youngest of 4, Sally had 2 sisters and a brother. She described her parents' relationship as unhappy. Her father, a Type A workaholic in aerospace defense, traveled a lot. He was a loner and very distant from the family. Sally's mother protected him from the household chaos, because he only intellectualized it. "He couldn't understand how people could make mistakes and errors." Her disciplinarian mother, who kept the household together, was a socialite. She and her husband went on long trips together, and she was always entertaining. Sally said that in her mother's absence, her 10-year older brother took care of her. She had a bedroom separate from her sisters, who were 6 and 7 years older. Although she desired a relationship with them, they never included her in their activities, which came to include partying and drugs. She was called a "spoiled, rotten brat."

Sally acknowledged that she couldn't remember much about her childhood prior to age 8. She described her family role as "the one who was always taken care of" and "sheltered." She depicted her relationship with her mother as enmeshed, unhealthily close, and overprotected. Sally felt her mother's nurturing was more to meet her own needs. She seemed to negate Sally's own feelings. Sally said, "She would buy me things, but there were always strings attached." She said that her mother "always came and rescued everybody." Once she left home, Sally's older sister became her "surrogate mother," and they, too, became enmeshed. When Sally attempted to individuate, her mother would buy less things for her.

Having a father available was Sally's deepest childhood yearning. She explained how she excelled in sports, because she wanted to please and connect with him. Occasionally, he would attend her sporting events and express pride in her achievement. But he was always pushing her for more. It was never enough. Once she got the MS degree, he wanted her to acquire a Ph.D.

Sally spoke freely when talking about herself, but her words seemed to be more emotion laden and to come more slowly when speaking of involvement with her family. Her face would become more solemn, sad and confused looking. For example, with crossed arms, downward gaze, and a long pause, when asked to relate the first line of her life story, she replied, "growing up one with mother." She said she would title a book about living with her family "Why Your Mother Should Not Be Your Best Friend." When asked to recall a parental response to an emotional need she had as a child, Sally could not think of any.

Sally felt the purpose of her eating disorder was "to show them how much she was hurting on the inside by separating and having problems just relating to the family." When growing up, everyone called her "beanpole," and being the thin one was "an identity thing." As a child, Sally was a picky eater, and was required to sit at the table until finishing everything on her plate. There were a lot of unhealthy dynamics around food. Her grandmother was obsessed with weight. Her mother was a social eater, while her father would leave the table and refuse to eat when he got angry or emotional. Sally's sister, with whom she had lived while in college, had dabbled with laxatives, after having an anorectic roommate.

Sally had begun recovery about 2 ½ years ago, when she admitted herself to the hospital. It was bad timing, as her father was also in the hospital with a collapsed lung. Her mother told her, "Well, I can't deal with you now. I have to deal with your father." At family therapy, from which her father was absent due to work, Sally was terrified to face her mother. She said her mother's first statement was, "You were such a perfect child, and your sisters and brother were so horrible. Now look what you've done to me!" Sally said that she never rebelled as a teen. So in the hospital, she "went through an adolescence of total rebellion." Sally was in the hospital for 3 weeks and then 2 weeks in day program. However, she experienced 3 other hospitalizations, once being suicidal, and the last time, having major heart complications. After several attempts, Sally maintained a 6-month period of no communication with her parents. Currently, she was calling them only every 2 weeks.

Sally said that she still assessed self-esteem by weight criteria, and that weight

consciousness remained a daily struggle. Even her lowest weight of 116 was not low enough. She said, "A lot of times when I wake up, I just feel like I look fat." Sally acknowledged difficulty in expressing anger and having people angry towards her. She admitted, "I am afraid of rejection." But she said, "When I don't eat, I just totally do not feel." On the otherhand, "If food is taken out of the picture, I start obsessing over my problems." Sally expressed a lot of self-hatred. She said, "I would deny myself food, because that was nurturing me, and I wasn't worthy of nurturance." She also stated that she found it difficult to have a close relationship without enmeshment. Further she stated, "My therapist says I have enough anger inside me to fill the world . . .and I'm never going to get over my eating disorder until I let myself get angry." Yet she expressed terror at allowing herself to be totally angry.

When asked to tell the funniest thing that ever happened to her, Sally could think of nothing. She said, "My lows are real low, and my highs are real high." Sally stated that she would love to be married, have two children and a good relationship with her family. But she said her wish totally differed from what she expected in reality will happen.

AS2

Saundra, a frail, single, 19 year-old, 5'7 ½" college drop-out, described her family household as "chaotic" and "very stressful." In her teens, her Catholic mom and Lutheran dad were rarely home. Busy with executive searches for United Way, her father was home only on weekends. Although he was not supportive, Saundra's mom went to work, and subsequently stopped cooking in her 4th grade. Saundra described herself as a

"latch key kid," with two brothers, 3 and 6 years older. One brother would isolate, while the other would be very angry. She said every family member was in his/her "own world," all being independent. "We had to fend for ourselves. I mean I started doing my laundry, cooking cleaning and packing my lunch." Her dad, who appeared to be the successful one, remained calm, never raising his monotone voice. On the otherhand, her mom, who was very emotional and cried a lot, appeared to be the loser. So the message was, "To succeed, just be level and calm." Hard work and college education were the most emphasized values.

From the time she could walk, Saundra sought to stay with friends, and never wanted to spend time with her mom. She said, "I always hated giving her a hug…. I felt her taking energy from me…. I never really trusted her…. There was no connection." At times, Saundra would stay away for a couple weeks, and no one seemed to even realize she had left. But her childhood yearnings were for an affectionate family, a dad to understand her and a mom to listen to her. When Saundra talked about her feelings, her dad would rationalize them, while her mom would just talk about her own problems. She always felt that maybe they would love her, if she could be "good and perfect" and "make things work." Saundra said she was embarrassed in public with her family, because her parents were always cold, tense and irritated about everything. Yet, anger was rarely expressed.

Saundra became independent to the extreme, deciding, "I didn't want anyone's help." By the time she was 13, she determined that she didn't even need food. It was a matter of self-control. She always felt that there was something wrong with her if she

weren't "perfect and pure." She said, "I would drink tons and tons of water to cleanse myself…. There's a kind of euphoria with that when your electrolytes are all off balance…. I ate a lot of fiber and I restricted…. I was scared to gain weight…. I would constantly chew gum." So by the time Saundra was 16, she used restriction to handle her emotions. She said, "I felt fat. I felt shame, embarrassed and worried." She constantly thought of her figure and body weight and sometimes, weighed 4-6 times per day. She felt she had to be perfect to go to college. In her freshman year, she exercised a lot and was down to 875 calories a day, while only sleeping about 4-5 hours. Saundra said her greatest fear was becoming a binge eater and just getting out of control. Her paternal grandmother had been bulimic, while her mom was an emotional, overweight, compulsive overeater.

Saundra became suicidal. Although she saw a nutritionist and therapist, she felt she didn't really get help until she had completed a 2-week inpatient and 6-week out-patient program. In recovery, Saundra later realized she had been "a human doing,' rather than a "human being." In the hospital, she stopped restricting, unlike other patients who remained "stuck" by refusing to eat and working through their problems. She decided, "This is a place where I can succeed, while others fail." But with normal people, she still tended to restrict and not want them to see her eating. So she would isolate. When she felt fat or ate too much, she thought everyone noticed. Saundra reported another relapse the previous fall. But determined to finish that semester, she did not go back to the hospital. Saundra said she had concluded that disordered eating had been an effort to send the message, "Look how screwed up I am! I need help!" She said

that she was the one who was always so strong and could handle everything, trying to help everybody else and "make the family smooth." And no one understood the pressure she was under and how she was hurting on the inside.

Saundra stated that in her teen relationships to peers that she made friends easily, but had limited trust in people. However, she was always there for them and could be trusted. She said, "I kept secrets good and I offered good advice. I seemed to have everything together, so people always came to me. I maintained relationships very, very well." But she said that in the 7th grade, when her parents were getting a divorce, "It made me feel worthless" and "I just wanted to stay in my own little zone." In college, Saundra dropped out of sorority rush, because it seemed like a "fantasy land." She said that being an anorectic is lonely. "You make yourself an island. You keep everyone at bay." And you do it "because it keeps you from the crap that's going on in your life. It keeps you focused on other things."

Saundra saw herself going back to school and getting her masters. She'd discovered that she was more right-brained than she had thought and may change from a business major to liberal arts. She also wanted to have a family.

AS3

Susan was a very frail, shy, 5'3 ½", 25 year-old, single pre-school teacher. She was an only child and still living with her dad and step-mom. Susan's parents divorced before she was one year old. She lived with her grandparents and mom, who remarried when Susan was 5 and divorced again when she was 8. She felt that she was somewhat enmeshed with her grandmother and mom, and never developed a personal identity. Her

step-dad sexually abused her. Her mom, who was frequently in the hospital, died when she was 12. At that time, she went to live with her estranged dad, who had been married several times. Susan described him as being "always distant and angry." Her step-mom, only 12 years older than she and only 12 years younger than her dad, "really didn't want to be a mom." Her dad worked a lot and was only home on weekends.

Susan described her grandparents as "caring, supportive, trustworthy, dependable," and giving her unconditional love. Grandfather disciplined and set the rules. With her grandmother, the problem solver, she could talk about anything. But feelings, especially sadness, were not expressed much in her family. When her mom died, only her grandmother shed any tears, and there was no discussion about it.

Susan always yearned for a mother that could do everything and not be bedridden, sick and depressed. She felt close to her mom before she got sick. But when she became her caretaker, she felt "trapped." And when her grandmother developed Alzheimer's, she was no longer there for her. Susan went back to live with grandparents for a year, so as to go to a community college and be with former school friends. She did well there. But when she transferred to Steven F. Austin, she really struggled with grades, getting along with people, not getting in a sorority and just trying to fit. Susan found living on her own and being away from family very stressful. After 3 suicide attempts and 2 hospitalizations, she moved back with her dad and step-mom.

Susan was very soft-spoken and exhibited shame mannerisms of gazing downward, sighing and pausing before answering certain questions. She said that she felt disconnected from others," that she "didn't belong or communicate, or fit in with others,"

and during the eating disorder, she had even felt disconnected from herself.

Susan said that she was never overweight and had never dieted. She said when it started, "I just lost my appetite." She attributed the eating disorder to the death of her mom, illness of her grandmother, learning of the abuse from her step-dad, and adjusting to living with dad and step-mom, all which occurred simultaneously. When with her grandparents, the family ate home-cooked meals together. But with her dad, she not only had to eat alone, but also prepare her own food, which "became a nuisance." She said she developed "a hate relationship with food." "I don't want anything to do with it. But it's something I need for nourishment and survival." She further remarked, "Nothing triggers eating. I mean I just have to force myself to eat…. When I feel like someone's angry at me or I haven't measured up, that's when I feel I shouldn't eat…The more in control and the less I weigh, the better I feel." Susan said that in college she just wouldn't eat for a couple of days, or she would purge once in a while. And then, she got to where she wouldn't eat for a week and a half. And later, she started exercising every time she would get hungry. She did not know anyone in college with an eating disorder. So it was not socially learned.

According to Susan, "Body weight was #1." Although she used to think about it from the moment she awakened until when she went to sleep, she said that she still thought about it over half of the time and weighed several times a day. Her lowest weight had been 69, and at interview, her preferred weight was 80. Currently, at 102, she felt fat, although others considered her thin to average. The family handled her eating problem with anger and tried to force her to eat.

Susan hoped to get a college degree and "have a career, instead of just a job. And then, hopefully, to be over the eating disorder, able to help others and maybe married." Being over the eating disorder would mean that all the distorted thinking would be gone and food would not be the focus. She said that reminding herself what it was like at her worst helped her realize she didn't want to go back there.

NEM 1

Nancy was a lovely 36 year-old, blue-eyed dark blond, married and in the early stages of pregnancy with their third child. With 7 sisters and 1 brother, this small town girl was the third of 8 children born to her Irish Catholic parents. Nancy's father was a well-respected veterinarian, 16 years older than her mother, who, being only 19 when they married, was looking for an escape from her bad home life. Their marital relationship was tense and conflicting. Although both parents drank heavily, and at 40, her mother took up smoking, they held very high standards for the family. The children were sheltered and discouraged from social involvement, lest they be "influenced by bad kids." But at age 8, Nancy lost trust in both parents, when she caught her mother in an affair, and both parents lied and denied it happened. That experience left her feeling she could trust no one. Even after her father was dying with Lou Gerrig's disease, her mother was running around with another man, whom later she married.

Nancy said she felt closer to her 5 older sisters than to her parents. Selfishly, her mother had said, "I don't want to get too close to my kids, because they will grow up and leave home, and then I'll get really hurt." Music seemed to be about the only enjoyment the family had together. Her father was very talented and also, wanted the children to be.

Nancy did have a good relationship with her maternal grandparents, who had a farm, where she loved to escape.

As Nancy spoke, she exhibited some indication of shame. There was occasional lowering of the head, an averted gaze, blushing, negative self-evaluation, and attempt to hide pain with over-soft speech. However, the shame seemed to be more of the family than of self. Nancy considered herself the family scapegoat, "the one always in trouble and being scolded," even though she never did anything bad. Feeling a lot of anger and rebellion, she simply spoke her feelings. Actually, she was also the spokesperson for the other children, who felt the same way, but were afraid to express it. Nancy's first day in Catholic school was a humiliating experience. So scared to interrupt the nun for permission to go to the restroom, she wet all over herself. She was scolded and shamed in front of the entire class. But unexpectedly, her mother took her side and "gave the nuns a piece of her mind" for treating her so harshly, when she was too young to understand. This was the first point of true connection that Nancy could recall with her mother.

As her parents' relationship regressed, Nancy experienced increasing tension at family mealtimes. Her mother did most all the cooking, while the girls watched. She never really taught them to take part in it. None of the family had a weight problem, although with her mother's high metabolism, "she could eat an unbelievable amount." There was a sense of freedom for the children to eat as much as they wanted. But they also were expected to eat everything on their plates. Because they would get in trouble if they didn't, it left a big impact on them. Nancy and her sisters would create ways to get

around it, such as stuffing food in their mouths and holding it, until they could spit it out. The clean plate issue was so ingrained in her that it took her a while to give herself permission not to always eat everything, realizing it was not good for her when it left her feeling stuffed.

Although a friendly person, Nancy's socialization was very limited. Her main social outlet was through her being a cheerleader. She said that she felt inferior, because of the shame that she carried about her family. And yet, in a sense, she also felt she was more in touch with reality than her peers. She often thought, "I'm living in the real world, and you're not." To broaden her cultural perspective, Nancy wanted to go to a state university, rather than the "small white college" to which other family members had gone at their parents' expense. But against their wishes and without their blessings or support, she went anyway. She felt that "I had just been too sheltered and disconnected from the world" long enough. She also decided to drop out of the Catholic Church, but waited until her father died, as that would have been too painful for him.

Nancy said she really tried to have a relationship with her father before he died. When she reached out to him with love and forgiveness, he seemingly softened. But she held a lot of anger and bitterness toward her mother for many years. When she bore her first child, she realized they had something in common. So Nancy made an effort to reach out to her mother, who subsequently suffered a stroke and nearly died. Although their relationship became more open, her mother's mental acuity and memory was somewhat deficient.

When she was 19, Nancy's mother forced her go to counseling. Being suicidal at

22, she was admitted to a psychiatric hospital. After leaving home, she took up drinking and partying for awhile, and avoided contact with her family. She said she used to think her family would help her out and "not let me go to pot." She felt no one cared, so she hired a therapist, who, she thought, "would have to care." She perceived herself at her worst at about age 25-28. She said she gained about 20 pounds then, but didn't diet to lose it.

Nancy said that after college she got interested in body building for awhile, but soon rejected that lifestyle. Then she got into running. Nancy said that she did not put a lot of emphasis on her weight, but rather on her overall person. "It's not my weight and my body, as much as it is the whole me. I want to look presentable." She said that she was concerned about her health enough to eat healthily, but not worried about eating every little thing, because it was fattening. She said she ate when hungry and saw food not as a friend or foe, but a necessity.

Nancy's future plans surrounded her family. She envisioned herself in 10 years homeschooling her children.

NEM2

Norma was a 5', 36 year-old, happily married graduate student, completing her MA thesis in family therapy. She was 8 years older than her brother, whom their parents raised, at a different stage in life, with more discipline. Norma considered herself almost a second mother to him. Her mother had to go back to work. However, she was close by, as she had a beauty shop connected to their home. Norma described her parents' relationship as "very good." She said they always showed affection. Norma remarked,

"We were a family that always did a lot of things , her dad was the principle breadwinner. After he developed severe diabetes, her mother's income became primary, although he maintained a small home business and began doing more of the housework.

Norma's paternal great grandparents had come from Sweden and built a country church with Scandinavian design and a family home across the road. Norma said she felt "good, happy," and "was always proud" to be in public with her family. She said she was never embarrassed with them. She and her mom were "best of friends." She recalled sewing doll clothes and making cookies together. Her mom managed to take off work and go to a lot of school, even college, functions. Even though married, Norma felt secure, because "I know that I am always welcome home. I know that I will always have somebody there if I need them."

Norma said she was a "big Daddy's girl." She felt that she tended toward perfectionism like her dad, and was very high strung like her maternal grandmother. As a result, she had experienced a severe adrenal dysfunction, with an excessive weight gain of 80 pounds in one month, going from a size 10 to an 18. She suffered excessive hair grown all over her face and body, very thin skin, high blood pressure, fractured ribs, severe osteoporosis, and other manifestations. She was hyper and very tired all the time. Because of the high cortisone levels, she couldn't relax. She described the experience as "a big boulder in the middle of the road" that messed up all my plans for work, career, education and life in general." She said, "I had the world by the tail, and then all of a sudden, ram!" Because Norma's family and church were very supportive, she stated that she didn't feel hopeless. Furthermore, the guy that Norma was dating stuck by and

subsequently married her. After 2 years of searching for help, she was referred to the right doctor at the National Institute of Health in Bethesda, Maryland, who performed surgery to remove a tumor on her pituitary, "just in the nick of time." Three months later, a second surgery was required to remove the rest of the tumor. This was a different surgeon, who called her at home, at the request of someone he met from their church. They made an 8-hour drive for 3 years to see him. Norma said the surgery wasn't as bad as the recovery, because of the drug withdrawal and the emotional trauma.

Norma had only good memories regarding food, which seemed to always center "around gatherings, family times, birthdays and happy stuff." She was allowed to fill her own plate, and did not remember ever being forced to try anything or eat everything on her plate. In her home "eating was not a big deal." Her mother was a good cook and she catered to the family's hunger and tastes. Except for her time of illness, Norma never had a weight problem. She said that, although she was never obsessive about her appearance, she was concerned that her clothes and appearance looked good enough for the public speaking she did for 13 years. If she could change anything about her body shape, she would be taller. But that was more important in junior high. She doesn't spend much time thinking about her figure now. Not eating was only triggered by anxiety or worry over "something coming up that's real important…. I just forget to eat or won't take time out to eat."

Norma said she didn't have any problems making friends, trusting people or maintaining relationships. However, she said that she shared her inner feelings more with her mom than any friend. She envisioned herself still being happily married in 10

years, “with a decent job and having a decent living.” She would prefer staying in her present house and taking an early retirement.

NES1

Edna was a 5’8”, very attractive 34 year-old occupational therapist, who described her family of origin as “normal.” She was the only child of happily married, respectful and mature Christian parents, and the youngest grandchild on both sides of the family. Edna said that her parents always worked together as a team, and her dad continually did nice things to make her mom feel special. Edna described her parents as quite stable and never panicked, but “took things as they came.” Edna expressed closeness to her parents and extended family. She felt they showed her unconditional love and that she could trust them. The only controversy that she could recall was in her teenage years when she was trying to separate from her mother’s directives and protection. Her mother was a teacher in the same school that Edna attended, so she kept a close watch over her.

But according to Edna, her parents did not push her in a certain way. Rather, they gave her freedom to explore and make her own decisions, starting her early toward being independent. They were patient and always available when she wanted to talk about anything. No topic was off limits, and she was always allowed to express her emotions. Edna had assigned chores and was given an allowance. She spoke fondly of her dad, who “built me a playhouse on a grand scale.” He sometimes took her to the circus, and they had time with just the two of them. She felt all that helped her become a stable person. Edna appeared very upbeat and confident, maintaining good eye contact. She considered

herself quite emotionally stable and normal. At times she seemed to even have difficulty answering the questions, addressing dysfunction. Edna said that she had always been sociable, with no problem making friends, and she had some long-lasting friendships. Very trusting of others, she displayed high self-esteem and hope. Edna acknowledged only a mild concern about "being taller than everyone" when she was in school. She placed nothing in her lifeline in the negative range, as having negatively impacted the rest of her life. Although not meeting her goal to be married by 25, Edna was not overly concerned. She said she felt everything had worked out for the best. She could not recall ever having felt socially disconnected.

Edna did not associate body weight with feeling good about herself or having a bad day. She saw food as "a good thing," and had pleasant memories of family mealtimes and southern foods. Her parents had a garden, and her mom made good homemade dishes. She was exposed to a variety of foods, and had no food allergies. Eating was never forced on her. Her dad had a sweet tooth, and her mom had lots of sweets available, but she just preferred regular food, most of the time. Edna recalled only one food ritual that she had for a short while, of not letting different kinds of food touch each other on the plate. She felt that resulted in reaction to seeing her dad pile everything together on his plate.

Edna said she enjoyed eating too much to restrict herself. She recalled only once trying a diet pill. Not having eaten, she passed out at school. So she never tried dieting again. When asked how she envisioned her future, she said, "I'll probably be a therapist. I love therapy."

Ethel was a single, 19 year-old, 5'7", bouncy brunette, who considered her family "happy" and "closely knitted." She was the second of four children. She saw her role as caretaker of her brother and currently, her grandmother, with whom she lived. Ethel's parents were divorced. She described their marriage as one in which "they were busy and "they talked about business all the time." They seemed to get "stressed out" over the cost of unexpected needs. Family mealtimes were mostly talking about business matters, school activities, and community events. She shared that when they bought a house in the country, they were told that her mom would have to work, and they'd go to a babysitter. She hated not being home with her mom as it had been.

The family tended to emphasize reputation, with academics and success being important values. They were churchgoing and considered "a really friendly family." Dad was the disciplinarian and the one who provided the finances. She felt she could trust her grandmother most, but also her dad, and considered the relationship with her mom most distant. Ethel saw her appearance more like her mom's, and her creativity and friendliness more like her dad's personality.

Ethel said that she was dad's "baby," but as she got older, they had grown somewhat apart. She sensed that love was always there for in her family, but strings were attached. However, it had nothing to do with her appearance. Although she had felt close to her mom as a little child, they had grown apart emotionally. She said, "When I needed her, she wasn't there. But when I least needed her, she was there." She saw her about 3 or 4 times per month. Ethel considered herself "the little black sheep in the middle." She

felt that she was not given the liberty that other children had. She said that she sensed being "a little crowded" with her family and needed her space.

Ethel told that she generally felt good about herself. She preferred a medium build to being thin. She considered family more important than weight or academics. Although she didn't spend much time thinking about her weight, at times, when stressed, she craved chocolate and junk food. For example, when her grandfather died, she was depressed and put on some extra pounds, but was never overweight. When she ate too much, she considered food her enemy. But most of the time, she ate well.

Ethel felt that she made friends easily and maintained relationships by helping out in time of need. She said she was "always there for them," but they didn't always think of helping her" She didn't feel she could trust them with secrets. There was a time when she withdrew from girls, due to a lot of partying, pot smoking and drinking, which made her feel out of place when she didn't participate. Ethel said her plans were to graduate from a nursing program and work for a high-paying hospital.

NES3

Earlene, a single, athletically-inclined, 24 year-old college graduate, was a leasing consultant. She had a 3-year younger brother to whom she felt quite close. Her parents had been happily married for 28 years. She considered her mom, who was the disciplinarian and a big talker, as a "Mrs. Cleaver" and "best friend." She never missed a scrimmage, trackmeet, or game from junior high through high school. Earlene's dad, on the otherhand, was quiet, reserved, involved in church leadership, and always caring. She said her personality was about 95% like his, while her brother was more like her mom.

The family values most emphasized were hard work, honesty, integrity, respect for others, etc. She did not recall any childhood yearnings, as she felt all her needs were met. Although her family was close, they were flexible. They helped their children strive for what they knew they could achieve, but they stepped back when necessary and did not push things on them. They had open communication and conflicts were dealt with, rather than ignored. She said they were free to express anger, but rarely needed to do so. She felt "comforted, secure, understood, accepted and respected" by her family.

The only sense of shame that Earlene could recall was when she broke off her engagement. Although she loved the guy, she said that she realized she was not "in love with him." She said she had started seeing him on the rebound, and felt she had not been honest with him. It was very difficult to let him know, because she didn't want to hurt him. Her family really liked him and felt she was making a mistake.

The family had home-cooked meals together. They were not given the opportunity to eat a lot of junk food. The only time her food intake had been altered was by the stress of breaking the engagement. She had contracted mononucleosis, became very ill, and lost some weight. But she had never depended upon her figure or body weight for self-esteem. She said that she seldom thought about it. Hunger was the only thing that triggered eating for her, and she saw food as "being there when needed." Except for a little pudgy stomach, she felt basically pleased with her physical appearance. Earlene had a lot of friends, including 3 very close, long-lasting friendships. She envisioned herself being happily married with children, but said, "I just take it as it comes." Then she added, "I'm just glad I turned out normal."

APPENDIX I

THE THIN COMMANDMENTS

Costin (1997) has endeavored to clarify the anorectic's incongruent thought process. She has formulated a master list of "The Thin Commandments," which encompasses the thousands of variations of the messages, rules and guidelines by which young girls live (perhaps die), and of which most are unaware.

1) Being thin is more important than being healthy—more important than anything.
2) You must buy clothes, cut your hair, take laxatives, starve yourself, do anything to make yourself be, or at least look thinner.
3) You shall earn all food and you shall not eat without feeling guilty.
4) You shall not eat fattening food without punishing yourself afterwards.
5) You shall count calories and fat and restrict intake accordingly.
6) What the scale says is the most important thing.
7) Losing weight is good—gaining weight is bad.
8) You can never be too thin.
9) Being thin and not eating are signs of true willpower and success.

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