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Differences in Self-Perceived Family Health Between Eating Disordered and Non-Eating Disordered Individuals

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DIFFERENCES IN SELF-PERCEIVED FAMILY HEALTH BETWEEN EATING DISORDERED AND NON-EATING DISORDERED INDIVIDUALS

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An Abstract Presented to the Faculty of the Graduate School of Lindenwood University in Partial Fulfillment of the Requirements for the Degree of Master of Arts

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ABSTRACT

In this study, the constructs of autonomy and intimacy which were key concepts in the separation-individuation process were studied in relation to eating disorder symptomology. Eating disordered individuals receiving counseling were compared to a non-clinical sample of graduate and undergraduate students. The hypothesis tested was that eating disordered women will perceive their family as significantly less healthy as compared to non-eating disordered women. This was determined by the overall score of perceived family health as measured by the Family of Origin Scale. A t-test for independent samples indicated a significant difference. The researcher also hypothesized that non-eating disordered women would report their families as encouraging autonomy and intimacy more than eating disordered women. This was evaluated by the two subscales for autonomy and intimacy of the Family of Origin Scale. According to a t-test for independent samples there was a significant difference in autonomy and intimacy between the two groups. There was no relationship between body mass index and Family of Origin Scale score for either group. There was no significant difference in body mass indices between the non-eating disordered and eating disordered women.

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To my parents, Charles and Jane Wright, for their patience, support and love. Thank you for EVERYTHING.

TABLE OF CONTENTS

LIST OF TABLES

CHAPTER I

INTRODUCTION

Differences in Self-Perceived Family Health

Between Eating Disordered and Non-Eating Disordered Individuals

Eating disorders are very self-destructive and potentially life threatening. They often are symptoms of underlying problems (Smolak & Levine, 1993). In the past 10 years, researchers have focused on the separation-individuation process for understanding the etiology of eating disorders (Armstrong & Roth, 1989). Research has predominately focused on anorexia nervosa and bulimia nervosa.

According to the Diagnostic and Statistical Manual of Mental disorders, 4th edition (APA, 1994), females constitute more than 90% of both anorexia nervosa (AN) and bulimia nervosa (BN) cases. Approximately 0.5%- 1.0% of late adolescent and young adult females reach full criteria for AN. For BN it is slightly larger at 1%-3%. Frequent onset for the disorders is bimodal at 14 and 18 years old. Over 10 percent of anorexia nervosa cases end in death (APA, 1994).

According to the DSM-IV (APA, 1994), an individual must meet four criteria to be diagnosed with AN. These criteria include: (a) an inability to maintain 85% of normal weight; (b) a distorted view of one's body image, amenorrhea or ceased menstruation; and (c) an intense fear of weight. The DSM-IV divides this disorder into bulimic and restricting subtypes. The bulimic subtype maintains their below normal weight by exercise, self-induced vomiting and

laxative misuse while the restricting anorexic compensates by exercising or strict dietary control (Johnson, Tsoh & Varnado, 1996).

The crucial difference between AN and BN is that anorexics do not maintain a normal weight. To be diagnosed with BN an individual must: (a) have two binging episodes a week for the past three months; (b) compensate for caloric intake, for example by misusing laxatives or by exercising; and (c) base their worth on their body shape and weight (APA, 1994).

DSM-IV further classifies BN into purging and nonpurging subtypes. The purging type uses laxatives and vomiting while the non-purging type displays fasting or exercise to inhibit weight gain. The purgative behaviors occur in a majority of BN patients (APA, 1994; Johnson et al., 1996).

Researchers cite many different etiological factors for eating disorders. Initially researchers believed that the family's role in eating disorder development merely was their preoccupation with weight control and body image (Kalucy & Crisp, 1977). Systems theorists more extensively proposed that enmeshment, overprotectiveness, rigid boundaries and a lack of conflict resolution were evident in a patient's family (Striegel-Moore, Silberstein & Rodin,1986).

While bulimics and anorexics both come from families with poor communication, the bulimic's family is usually more hostile (Armstrong & Roth, 1989). Their families tend to have rigid boundaries with an expectation for everyone to handle their problems themselves. Consequently, clinicians have found the bulimic shows more independence and self-expression in her family of

origin as compared to the anorexic (Armstrong & Roth, 1989; Scalf-McIver & Thompson, 1989).

Other theorists such as object relation theorists, conceptualize the bulimic's purging as the violent rejection of parental nurturance. Bulimics find the nurturance they did not get from their families in food (Friedlander & Siegel, 1990; Humphrey, 1989).

Systems theorists contend that the anorexic has never been able to express conflict in her enmeshed family. Becvar and Becvar (1996, p. 193) characterize this enmeshment as "everybody is into everybody else's business and there is an extreme of hovering and providing support even when not needed". Her parents are very overprotective and overinvolved which causes the anorexic to feel inadequate. This sense of inadequacy along with a weak sense of self leads to the anorexic's complete failure to individuate from the family of origin. Although the bulimic's parents are not overprotective and overinvolved, bulimics also feel inadequate because of their family's hostile environment and inconsistent parental support (Armstrong & Roth, 1989; Humphrey, 1986; Scalf-McIver & Thompson, 1989).

In both the bulimic and anorexic families, the rigid and enmeshed boundaries along with the inconsistent expression of conflict inhibit the development of autonomy. Intimacy is also compromised in these families with the discouragement of expressing feelings, an inability to resolve conflicts and the lack of empathy and sensitivity (Humphrey, 1986; Johnson & Flach, 1985; Kog,

Vandereycken, & Vertommen, 1985; Smolak & Levine, 1993; Striegel-Moore et. al., 1986).

The struggle that eating disordered individuals have with intimacy and autonomy is closely related to the separation-individuation process. Separation-individuation is a developmental task faced by all adolescents. Although there are varying conceptualizations, this task involves maintaining intimacy with the family of origin while exercising more autonomy (Lapsley, Rice & Shadid, 1989).

Purpose

Given the serious and pervasive nature of eating disorders, research that improves the etiological assessment will also increase chances for prevention. Researchers have not previously used the Family of Origin Scale when studying eating disorders (Hovestadt, Anderson, Piercy, Cochran & Fine, 1985). Therefore, the present study was an effort to introduce another instrument for assessing family dynamics in relation to eating disorders.

Hypothesis

In support of these findings, the researcher hypothesized that eating disordered women perceive their family as less healthy than non-eating disordered women. The encouragement of autonomy and intimacy is also hypothesized to be greater in the family of origin of non-eating disordered women as compared to eating disordered women.

It was also hypothesized that a body mass index (BMI) indicating very underweight or very overweight would indicate a low health score on the Family of Origin scale. The body mass index is weight in kilograms divided by the

squared height in meters. The World Health Organization sets the standards for the analysis of a BMI taking into consideration age and sex (Shetty & James, 1994).

This study utilized the Family-of-Origin Scale (FOS) which focused on the clarity of expression, openness to others, promotion of empathy and sensitivity and several other factors as indicators of a healthy family (Hovestadt, Anderson, Piercy, Cochran & Fine, 1985).

CHAPTER II

REVIEW OF THE LITERATURE

Conceptualizations of Eating Disorders

Physiological

Stoylen and Laberg (1990) claim that Richard Morton first described AN in 1694. He identified it as "a state of nervous atrophy characterized by decreased appetite, amenorrhea, food aversion, emaciation and hyperactivity" (p. 53). At that time physicians considered it a form of hysteria, and strictly a woman's disease. Researchers attributed the prevalence of this condition to the saints' fasting rituals. Physicians were determined to demystify these worshipping connotations and find a medical etiology (Stoylen & Laberg, 1990).

In 1914, physicians classified these same symptoms as an endocrinological dysfunction. Simmonds believed the pathology of the condition was in the pituitary gland. There was no evidence to support this contention upon autopsy of the anorexic patients, and therefore it was only briefly considered a cause (as cited in Stoylen & Laberg, 1990). By the 1940's there was an appreciation of the multiple determinants of AN and BN (Stoylen & Laberg, 1990).

Cognitive

The cognitive etiological model has inspired the popular eating disorder treatment method of cognitive behavioral therapy (Johnson, Tsoh & Varnado, 1996 & Vitousek & Hollon, 1990). Greatly influenced by cognitive psychology, this model postulates that anorexics and bulimics process information using organized cognitive structures (schemata). These schemata are grounded with

issues of weight and its implications for the self. This schematic processing becomes automatic and instilled with errors (Vitousek & Hollon, 1990).

Self-schemata guide the processing of self-related information found in the individual's social experiences. These are cognitive generalizations taken from past experiences. For example, anorexics direct all their efforts toward disguising their "fundamental flaw" because they fear somehow being exposed and harshly criticized. Bulimics and anorexics give themselves the harshest criticism because they hold separate criteria for themselves (Vitousek & Hollon, 1990).

Eating disordered individuals have an elaborate code about what thin or fat implies for only them. They equate such concepts as self-control, beauty, and intelligence with thinness. This creates an associative network that automatically processes the information of self. Researchers believe these equations are from the client's learning history and the culture (Vitousek & Hollon, 1990).

The fusion of this "flawed" self and weight-related schemata results in channeling all unfulfilled goals into a focus on fatness. Anorexics may not always feel fat, but they will persistently evaluate themselves according to that measure. This is the core cognitive component through which AN and BN operate. The individual firmly holds on to this measurement of worth (Vitousek & Hollon, 1990).

Anorexics and some bulimics view their symptoms as a positive quality. Johnson et al. (1996) advises that this ego syntonic quality warrants a closer inspection of the purposes of these thoughts and behaviors. Vitousek and Hollon

(1990) outline three purposes: (a) simplify, (b) organize, and (c) stabilize their experience of the self and the environment.

Eating disordered individuals find the ambiguity and confusion of the adult world very frightening. In addition they feel bombarded by the multiple responsibilities and expectations placed on any individual in modern society. Personal and perhaps familial pressures add to this demand to excel in all realms. The eating disordered individual simplifies their view of themselves and their surroundings by reducing the determinants of self-worth to body shape and weight. If these individuals achieve thinness, then they do not feel compelled to compete in other areas. This need for simplicity supports the anorexic's choice to be thin as they often view fat as messy and unnecessary (Vitousek & Hollon, 1990).

The eating disordered individual has organized their worldview around the direct link between weight-related schemata and self schemata. In other words, the individual's perceived implications for thinness and fatness determine their self-worth and maturity. Evaluating oneself only in terms of weight and body shape is also stabilizing. While anorexics and bulimics may not always view themselves as fat, the tendency to assess oneself in these terms is consistent. Therefore, their sense of self can be stabilized without actually looking at their inner self but rather their weight and body shape (Vitousek & Hollon, 1990).

Anorexics and bulimics mistrust their perception of all experiences except their perceived worth of thinness. The thought of expressing a personal view and then being ridiculed haunts these individuals. Hence, they espouse only what is the "unquestionable truth." The quantitativeness of calorie counting and weight

measuring is the absolute truth they need (Vitousek & Hollon, 1990; Wilson, 1996).

Societal

The upper social class appears to be highly affected by eating disorders although it is unknown whether willingness and accessibility to treatment are mediating factors. Striegel-Moore, Silberstein and Rodin (1986) suspect that the differing emphasis on weight and appearance according to social classes accounts for the relationship between this disorder and social class. However, the social class representation for male anorexics is not skewed to the upper classes (Kalucy et al., 1997). The western culture also has a far greater representation of eating disorders.

The underlying belief of eating disorders is that an attractive and socially acceptable woman must be thin. Steiner-Adair (1986) believe that western culture unequivocally perpetuates this belief. This etiological model supports the prevalence of this disorder in woman and in affluent societies, but does not account for the eating disordered male (Steiner-Adair, 1986; Stoylen & Laberg, 1990). Furthermore, Steiner-Adair (1986) have suggested that society reinforces particularly female adolescents to be unaccepting of their bodily imperfections.

Steiner-Adair (1986) have found a direct correlation between a female adolescent's body weight and shape and the positive and negative relationships and feedback they receive. In contrast, society evaluates boys according to their academic success and achievement. In addition to these cultural influences, Steiner-Adair (1986) believes that any culture that supports the autonomy of its

female adolescents and ignores their relational needs will perpetuate the development of eating disorders.

Steiner-Adair (1986) found that adolescent girls who could reject the cultural ideals for women were not as susceptible to eating disorders. This is supported by the findings of Streigel-Moore, Silberstein and Rodin (1986) which suggest that bulimics are more likely to strive for the notions of femininity than a non-clinical population. However, Steiner-Adair does not believe that culture is solely to blame. Rather, society and the family can both perpetuate some pathological values. Psychological distress is manifested in eating disorders because of the sociocultural context in which people are embedded.

Systems Theory & Object Relations Theory

Systems theory and object relations theory correspond in the study of eating disorders. Theorists propose that the dynamics of the family system maintain the insufficient coping strategies seen in eating disordered individuals (Humphrey & Stern, 1988).

Humphrey and Stern (1988) contend that these ego deficits are the result of several failures in the mother-infant relationship of an eating disordered individual. One failure was in the mother's ability to consistently comfort the child and care for her needs. Without this consistency, the infant is unable to develop a strong sense of self and will have no trust in the environment. Furthermore the child cannot discriminate between a biological need for food and an emotional or interpersonal need to feel secure (Friedlander & Siegel, 1990).

The absence of this secure environment for the infant to gets her needs met inhibits the individuation process of being autonomous and expressing intimacy (Friedlander & Siegel, 1990). Johnson and Flach (1985) found that bulimics perceived their families as emphasizing most forms of achievement except recreational, intellectual or cultural. Johnson and Flach explain that in these families the bulimic has not sufficiently individuated to be able to assert or express herself in those areas. These autonomous activities also conflict with their role as the "bad child" or scapegoat.

The eating disordered individual is a scapegoat for the family (Johnson & Flach,1985). The parents project their bad selves and their sense of inadequacy on the bulimic and anorexic. The eating disordered individual has such a fear of abandonment that they will fulfill this function. Although the parents also project their good selves onto the "good child", the family may also see the eating disordered individual as the hero since they ultimately lead the family to treatment (Humphrey & Stern, 1988).

Families that maintain eating disorders are often very disorganized as well. Johnson and Flach (1985) found a direct relationship between the severity of symptomology and the severity of disorganization. This coincides with Scalf-McIver and Thompson's (1989) finding that dissatisfaction with physical appearance is related to a lack of family cohesion. Humphrey, Apple and Kirschenbaum (1986) further explain this disorganization and lack of cohesion as the "frequent use of negativistic and complex, contradictory communications" (p. 195). Humphrey et al. (1986) found that bulimic-anorexic families were ignoring

in their interactions and that the verbal content of their messages contradicted their nonverbals.

Clinicians and theorists propose that these individuals' dysfunction is in regards to food for certain reasons. The rejection of food or the purging is likened to the rejecting of the mother and is also an attempt to get the mother's attention. The eating disordered individual may also choose to restrict her caloric intake because she wants to postpone adolescence due to her lack of individuation (Beattie, 1988; Humphrey, 1986; Humphrey & Stern, 1988).

Binges are an attempt to fill the emptiness from a lack of internalized nurturance. The binging is also related to the eating disordered individual's inability to determine whether they are hungry or need to soothe their emotional tensions. This inability is a result of the inconsistent attention to their needs as a child. This care effects the quality of attachment between mother and child as well (Beattie, 1988; Humphrey, 1986; Humphrey & Stern, 1988).

The research has not significantly focused on attachment and separation theories to explain eating disorders because it did not view the theories as predictive or explanatory. However, Bowlby (as cited in Armstrong & Roth, 1989) proposes that eating disordered individuals are insecurely or anxiously attached. According to his attachment theory, an individual draws close to an attachment figure to feel secure and soothe their anxieties. Bowlby believes that the eating disordered individual diets because she thinks that will create more secure relationships which will help alleviate the tensions she cannot handle herself (Armstrong & Roth, 1989). This coincides with Humphrey and Stern's (1988)

belief that eating disorders function in varying ways to alleviate the emotional tension that they are unable to alleviate themselves. Other research has supported Bowlby's theory as well.

Becker, Bell and Billington (1987) compared eating disordered and non-eating disordered individuals on several ego deficits and found that fear of losing an attachment figure was the only ego deficit that was significantly different between the two groups. This again supports the relational nature of eating disorders. Systems theory and object relations theory also explain why this disorder occurs predominately in females.

Beattie (1988) contends that eating disorders occur much more frequently in females because the mother often projects her bad self onto the daughter. The mother frequently sees her daughter as a narcissitic extension of herself. This makes it very difficult for the mother to allow her daughter to individuate. There are several other aspects of the mother-daughter relationship that impedes individuation.

The daughter's relationship with her primary caretaker, the mother, is strained regardless of any family dysfunction. The daughter has to separate from her mother in order to develop her separate identity, but she also needs to remain close to her mother to achieve her sexual identity. Daughters also perceive themselves as having less control over their bodies because they do not have the external genitalia that lead to a sense of control over their bodies. Consequently daughters rely on their mothers more than their sons (Beattie, 1988).

Researchers have used several different strategies to collect the data of eating disordered individuals. These studies have used self-report measures and observational methods (Friedlander & Siegel, 1990; Humphrey, 1989; Humphrey, 1986; Scalf-McIver & Thompson, 1989).

Studies on eating disordered individuals have also used several different sampling procedures. Clinical populations have frequently been compared to non-clinical populations as controls. However, studies have classified female college students with three or more eating disordered symptoms as a clinical population. Researchers have studied the parents of bulimics and anorexics as well as the entire family (Friedlander & Siegel, 1990; Humphrey, 1989; Humphrey, 1986 & Scalf-McIver & Thompson, 1989).

Separation-Individuation Process and Related Psychiatric Disturbances. There are several ways that an unhealthy resolution of the separation-individuation process is manifested. The child attempts to individuate from the mother figure when the child is around two years of age and again during adolescence. Without a successful resolution as a toddler, there will be extreme difficulties when the adolescent attempts to individuate. These difficulties often lead to psychiatric disturbances (Coonerty, 1986).

Individuals with eating disorders and borderline personality disorders are very similar in their unsuccessful attempts to individuate. This is why they often present as a dual diagnosis. Before explaining their specific similarities, it is necessary to explain the stages of the first separation-individuation process (Coonerty, 1986).

The infant becomes attached to the mother figure during the first year of life, and then the separation-individuation process begins when the infant realizes that they are a separate person from the mother figure. The child then begins to feel as though the mother figure and herself are all powerful and does not rely on the mother figure for security. The final stage is rapprochement (Coonerty, 1986; Wade, 1987).

During rapprochement, the child becomes aware of her separation and vulnerabilities and seeks security again from the mother figure. Separation and individuation does not occur when the mother figure cannot be emotionally available to the child after she separated. Theorists believe this originates with the mother figure's only initial attempt at individuation which was met with emotional abandonment from her mother (Coonerty, 1986; Wade, 1987).

When the child becomes an adolescent her inability to individuate again can result in eating disorder symptomology and borderline personality disorder symptomology such as attempts at self-harm. The child felt self-hatred for wanting to separate from the mother figure; therefore, these self-destructive behaviors are ego syntonic. These acting out behaviors of adolescence are attempts to regain emotional security while exercising dysfunctional autonomy. Furthermore, both sets of symptoms result from the lack of self-soothing mechanisms that make individuation impossible (Armstrong & Roth, 1989; Coonerty, 1986; Meyer & Russell, 1998; Wade, 1987).

There is a strong connection between eating disordered individuals' and borderlines' failed separation and individuation, but other psychiatric disturbances

are related to separation-individuation difficulties as well. Researchers have found adult children of alcoholics and codependents in general to have difficulties individuating from their family of origin (Transeau & Eliot, 1990; Meyer & Russell, 1998). Coonerty (1986) found schizophrenics to have separation-individuation problems, but specifically they do not have the necessary attachment with their mother figure and they differentiate too early.

Summary

The researcher hypothesized that eating disordered women perceive their family as less healthy than non-eating disordered women. In this study the researcher used the FOS (Hovestadt, Anderson, Piercy, Cochran & Fine, 1985) which measured family health according to the concepts of autonomy and intimacy. Therefore, it is also hypothesized that the subscale scores of Autonomy and Intimacy will be greater for non-eating disordered women as compared to eating disordered women.

The research indicates that if a client presents with autonomy and intimacy issues, then clinicians should assess their weight and body shape preoccupation. Although there is strong support for a familial etiology, clinicians recommend that treatment begin with the cognitive distortions and then address the family dynamics and enmeshment (Friedlander & Siegel, 1990; Humphrey & Stern, 1988).

The research strongly indicates that eating disordered individuals believe they have a basic shortcoming. This manifests itself as an inability to individuate coupled with a fear of abandonment. In summary, the family of origin has been unable to met the child's needs in the consistent way that internalizes nurturance,

coping strategies and a separate sense of self (Armstrong & Roth, 1989; Humphrey & Stern, 1988 & Vitousek & Hollon, 1990).

CHAPTER III

METHODOLOGY

Participants

Participants were 24 eating disordered individuals receiving outpatient treatment and 25 graduate and undergraduate students at a Midwestern university. The data from one student participant was not used because she reported being previously diagnosed with an eating disorder. The researcher used a non-probability technique.

The mean age of the non-eating disordered participants was 35.71 years. For ethnicity, all participants identified themselves as White/non-Hispanic. More information on age and income is in Table 3.1. Approximately 70% reported that their mother was predominately a stay at home mom. Regarding home life, 12.5% live with their family of origin at the present time.

The mean age for the eating disordered participants was 36.04 years. Again all participants identified themselves as White/non-Hispanic. Table 3.1 has more detailed information on age and reported incomes. Seventy-five percent reported that their mother predominately stayed at home while 16.7% live with their family of origin.

The researcher also wanted to ensure that no participant in the non-eating disordered sample had a BMI that suggests being very underweight as this may indicate the existence of some eating disorder symptomology. The standard ranges for BMIs as set by the World Health Organization are in Table 3.2.

Table 3.1 Demographic Data

Non-Eating Disordered Women N = 24		Eating Disordered Women N = 24
	Age	
Mean = 35.71 SD = 10.15		Mean = 36.04 SD = 12.18
	Income	
12.5%	under $10,000	0%
25%	$10,000-25,000	12.5%
41.6%	$25,000-50,000	33.3%
4.2%	$50,000-75,000	8.3%
4.2%	$75,000-100,000	16.7%
12.5%	$100,000 or above	29.2%

The non-eating disordered sample did not consist of any very underweight participants although there were three very overweight participants as determined by their BMI. The data from one non-eating disordered participant and from four eating disordered participants were not used due to failure to report weight. Table 3.3 lists more information on the BMIs of both samples.

Table 3.2 BMI Ranges set by World Health Organization

18 & below	-> very underweight
18-20	-> underweight
20-25	-> normal weight
25-30	-> overweight
30 & above	-> very overweight

Table 3.3 BMI Data

Non-Eating Disordered Women N= 23		Eating Disordered Women N= 20
Mean = 24.68 SD = 3.42		Mean = 26.42 SD = 8.99
0%	very underweight	15%
9%	underweight	10%
52%	normal	35%
13%	overweight	10%
26%	very overweight	30%

Instruments

Family of Origin Scale.

The Family of Origin Scale (FOS), as found in Appendix A, measures the self-perceived health in one's family of origin. The FOS is a 40 item self-report inventory measuring autonomy and intimacy. Autonomy is conceptualized in terms of these factors: clarity of expression, responsibility, respect for others, openness to others, acceptance of separation and loss (Hovestadt, Anderson, Piercy, Cochran & Fine, 1985).

Intimacy is conceptualized in terms of these factors: encouraging expression of a range of feelings, creating a warm atmosphere in the home, dealing with conflict resolution without undue stress, promoting sensitivity or empathy and developing trust in humans as basically good (Hovestadt, Anderson, Piercy, Cochran & Fine, 1985).

The test was also appropriate for the study's population as it was normed on college students. It is easily scored with each responses weighted from 5 to 1 with the most healthy response receiving a 5 and the least healthy a 1. The total scores range from 40 to 200 (Hovestadt, Anderson, Piercy, Cochran & Fine, 1985).

The overall coefficient alpha for internal consistency is .75 and the standardized item alpha is .97. For autonomy, the test-retest reliability at 2 weeks ranged from .39 to .88. For intimacy, it ranged from .46 to .87. The discriminating validity indicates that the instrument can differentiate between men in alcohol-distressed marriages and those in nonalcohol-distressed marriages (Hovestadt, Anderson, Piercy, Cochran & Fine, 1985).

Demographic Data.

The Demographics Questionnaire for non-eating disordered and eating disordered individuals are in Appendix B and C respectively. The researcher obtained age, sex, approximate income, ethnicity, weight and height from all participants. The researcher also asked participants if they lived with their family of origin, both parents or one parent. Participants were asked to describe their mother as predominately a working mother or a stay at home mother.

Procedure

This research utilizes a causal-comparative design. In this research design, the two groups are different on some variable before the study begins and both are tested on the same variable. The two groups in this study differed in their eating disordered status and the perception of family health was tested for both groups.

The eating disordered participants were advised that their responses were being used for a study assessing the relationship between family of origin characteristics and eating disorders. These participants completed their questionnaires under the supervision of their therapist in a private practice setting.

The non-clinical participants completed their questionnaires in the classroom and were supervised by the researcher. They also were advised that their responses were being used for a study assessing the relationship between family of origin characteristics and eating disorders. An independent t-test was computed to determine if the two groups had significantly different means regarding family health as assessed by the FOS. The researcher also computed an independent t-test to determine if a significant difference existed between the encouragement of intimacy and autonomy in the two groups' families of origin. A correlation between the BMI and the FOS score for each group was computed. An independent t-test also was computed to determine if the two groups had significantly different BMIs.

CHAPTER IV

RESULTS

The two groups were compared on their total score of perceived family of origin health, the autonomy subscale score and intimacy subscale score. A high score indicated health, autonomy and intimacy while a low score indicated a lack of these characteristics. The mean total score for the non-eating disordered women was 123.00 and for the eating disordered women it was 97.17. For the mean scores on autonomy and intimacy, the non-eating disordered women were 58.50 and 64.50 and the eating disordered women were 45.38 and 51.79 respectively. The descriptive statistics for these scores are in Table 4.1.

Table 4.1 Family of Origin Scale Scores

Non-Eating Disordered Women N = 24	Eating Disordered Women N = 24
Total Score	
Mean = 97.17 SD = 25.44	Mean = 123.00 SD = 42.18
Scores on Autonomy Subscale	
Mean = 45.38 SD = 10.93	Mean = 58.50 SD = 21.26
Scores on Intimacy Subscale	
Mean = 51.79 SD = 15.95	Mean = 64.50 SD = 21.50

The researcher hypothesized that eating disordered women perceive their family as less healthy than non-eating disordered women. Examination of the

means and a t - test for independent samples indicated a significant difference between the perceived family health of eating disordered and non-eating disordered women. Therefore the null hypothesis was rejected, $t(46) = -2.57$, $p < .05$.

It was also hypothesized that the subscale scores of Autonomy and Intimacy will be greater for non-eating disordered women as compared to eating disordered women. The null hypothesis that there is no significant difference regarding autonomy, $t(46) = -2.69$, $p < .05$, or intimacy, $t(46) = -2.33$, $p < .05$, was rejected. Table 4.2 presents a summary of the differences found between the two groups on these three different scores.

Table 4.2 Independent t-test comparing total score

Mean difference = -25.83
SE difference = 10.05
t = -2.57 DF = 46
Prob. = .013

Independent t-test comparing scores on autonomy subscale

Mean difference = -13.13
SE difference = 4.88
t= -2.69 DF = 46
Prob. = .010

Independent t-test comparing scores on intimacy subscale

Mean difference = -12.71
SE difference = 5.47
t = -2.33 DF = 46
Prob. = .025

The researcher also hypothesized that there would be a relationship between the BMI and FOS score of the non-eating disordered women. The null

hypothesis was accepted. A Pearson product moment correlation indicates no relationship between these two variables, $r = -.019$, $p < .932$. There also was no relationship found between these two variables in the eating disordered sample, $r = -.125$, $p < .598$.

The researcher also analyzed the difference in BMI between the two groups. Examination of the means with a t-test for independent samples indicated no significant difference between the BMI of non-eating women and eating disordered women, $t(41) = -.862$, $p < .394$. The variance in BMI scores of the non-eating disordered individuals was 11.72 and for the eating disordered individuals it was 80.81. Refer to Table 4.4 for more details on the t-test. The sample contained no outliers.

CHAPTER V

DISCUSSION

The results of this study support the hypothesis that non-eating disordered women perceive their family of origin as significantly healthier than eating disordered women. Research studies that utilize self-report and observational measures corroborate this finding.

Humphrey, Apple and Kirschenbaum's (1986) use of two different interpersonal and behavioral observational systems distinguished the communication patterns of bulimic and non-eating disordered families. The FOS used in this study assessed communication patterns. The current finding that eating disordered women grew up in families with poor communication relates to Humphrey et al.'s finding that families of bulimics have significantly more complex and negative communication. The results of Scalf-McIver and Thompson (1989) and Ordman and Kirshenbaum's (1986) studies using self-report measures also agree with the current finding. In their studies, bulimics reported significant differences in their cohesion, expressiveness and conflict within the family as compared to the reports of non-eating disordered women.

This finding also corroborates the object relations and systems theories. Systems theorists contend that the bulimic's purging is an expression of conflict that cannot be expressed overtly in the family (Beattie,1988; Humphrey, 1986; Humphrey & Stern, 1988 and Ordman & Kirschenbaum,1986). According to object relations theory, dietary restriction or purging represents a rejection of the maternal figure or the bad part of themselves, and binging is seen as an attempt to

internalize the nurturance they did not receive from family (Armstrong & Roth, 1989 Becker, Bell & Billington, 1987 and Humphrey & Stern, 1988).

As hypothesized, the results also indicate that non-eating disordered women view their families as fostering significantly more autonomy than eating disordered women. Johnson and Flach's (1985) findings suggest that the families of bulimics encourage all forms of achievement except those that promote an autonomous identity. These include such activities as intellectual and social pursuits.

Although the researcher did not know which women were bulimic and which were anorexic, it is apparent by the BMIs computed that approximately 85% of the eating disordered sample would not meet the DSM-IV diagnostic criteria of having a body weight less than 85% of that expected (APA, 1994). Therefore, the eating disordered sample appears to be predominately bulimic. The literature suggests that the bulimic would have high levels of independence and assertiveness in her family although often expressed negatively (Armstrong & Roth, 1989; Scalf-McIver & Thompson, 1989). This indicates that the results could have fallen in the other direction with the eating disordered sample perceiving their family as promoting more autonomy than the non-eating disorder sample.

The eating disordered woman's perception of significantly less intimacy in her family is also supported by the literature and in particularly by Bowlby's attachment theory. Bowlby contends that the eating disordered child has never developed the trusting relationship with the primary caretaker. For various

reasons, the parents of an anorexic or bulimic were unable to provide the emotional closeness necessary to internalize their support (Armstrong & Ruth, 1989).

Furthermore, researchers contend that there is no warmth in these families with the bulimic family having a very hostile environment. The anorexic's parents may appear to be very nurturant, but actually they are detached and rejecting when the anorexic asserts her independence (Humphrey, 1986; Scalf-McIver & Thompson, 1989).

The present study does not support the hypothesis that there is a relationship between BMI and score on the FOS. Although individuals may eat excessively to soothe their tensions, they may not necessarily do so because they lacked a supportive family environment or a strong attachment to a parental figure (Humphrey & Stern, 1988). Furthermore an extremely low BMI may not always be indicative of poor relationships with the use of dieting to maintain relationships (Armstrong & Roth, 1989).

This study has supported the effectiveness of the FOS in assessing family dynamics in relation to eating disorders. The findings also reinforce the family as the treatment focus for these prevalent and at time fatal disorders. However, the cognitive distortions of these individuals play a crucial role in maintaining the disorder and more focused study could be on the integration of family therapy with cognitive-behavioral techniques.

Treatment should also address the societal component of these disorders. Clinicians should be sensitive to the body and weight conscious world that the

client lives in. Eating disordered individuals are fixated upon the culture's unrealistic beauty ideals. This crucial component of the disorder indicates the importance of consciousness raising and strategies to not fall pray to societal pressures.

Future research could compare the family of origin of individuals with borderline personality disorder and those with eating disorders. Both disorders are a manifestation of an unresolved separation-individuation process and it would be interesting to identify why one set of symptomology results and not the other.

Research on this disorder in males is increasing. A comparison of the dynamics between the eating disordered son and his parents as compared to those of the eating disordered daughter and her parents may further elucidate the etiology of this disorder.

The study is limited because its findings are generalizable to only white/Non-Hispanic subjects. The literature makes several distinctions between anorexic and bulimic families. Therefore, if the diagnosis of the eating disordered women were known, then the researcher could have drawn more substantial conclusions.

It is also likely that the fact that our eating disordered sample was in treatment had an effect on their FOS score. Depending on the focus of their treatment they may have increased awareness and insight into the dynamics of their family of origin. Also, their therapist administered the test and they may have had concerns about their therapist's intent with these scores and its effect on their treatment.

Furthermore, the non-eating disordered sample only answered the question of whether they were diagnosed with an eating disorder or not. Although the BMIs did not indicate any very underweight subjects, it is not known whether they had any eating disorder symptomology.

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APPENDIX A

FAMILY OF ORIGIN SCALE

The family of origin is the family you spent most or all of your childhood years. The scale is designed to help you recall how your family of origin functioned. Each family is unique and has its own ways of doing things. Thus, there are no right or wrong choices in this scale. What is important is that you respond as honestly as you can.

In reading the following statements, apply them to your family of origin, as you remember it. Using the following scale, circle the appropriate number. Please respond to each statement.

5 (SA) = STRONGLY AGREE THAT IT DESCRIBES MY FAMILY OF ORIGIN
4 (A) = AGREE THAT IT DESCRIBES MY FAMILY OF ORGIN
3 (N) = NEUTRAL
2 (D) = DISAGREE THAT IT DESCRIBES MY FAMILY OF ORIGIN
1 (SD) = STRONGLY DISAGREE THAT IT DESCRIBES MY FAMILY OF ORIGIN

	SA	A	N	D	SD
1. In my family, it was normal to show both positive and negative feelings.	5	4	3	2	1
2. The atmosphere in my family was usually unpleasant.	5	4	3	2	1
3. In my family, we encouraged one another to develop new friendships.	5	4	3	2	1
4. Differences of opinion in my family were discouraged.	5	4	3	2	1
5. People in my family often made excuses for their mistakes.	5	4	3	2	1
6. My parents encouraged family members to listen to one another.	5	4	3	2	1
7. Conflicts in my family never got resolved.	5	4	3	2	1
8. My family taught me that people were basically good.	5	4	3	2	1

9. I found it difficult to understand what other family members said and how they felt.	5	4	3	2	1
10. We talked about our sadness when a relative or friend died.	5	4	3	2	1
11. My parents openly admitted it when they were wrong.	5	4	3	2	1
12. In my family, I expressed just about any feeling I had.	5	4	3	2	1
13. Resolving conflicts in my family was a very stressful experience.	5	4	3	2	1
14. My family was receptive to the different ways various family members viewed life.	5	4	3	2	1
15. My parents encouraged me to express my views openly.	5	4	3	2	1
16. I often had to guess at what other family members thought or how they felt.	5	4	3	2	1
17. My attitudes and my feelings frequently were ignored or criticized in my family	5	4	3	2	1
18. My family members rarely expressed responsibility for their actions.	5	4	3	2	1
19. In my family, I felt free to express my own opinions.	5	4	3	2	1
20. We never talked about our grief when a relative or family friend died.	5	4	3	2	1
21. Sometimes in my family, I did not have to say anything, but I felt understood.	5	4	3	2	1
22. The atmosphere in my family was cold and negative.	5	4	3	2	1
23. The members of my family were not very receptive to one another's views.	5	4	3	2	1

24. I found it easy to understand what other family members said and how they felt.	5	4	3	2	1
25. If a family friend moved away, we never discussed our feelings of sadness.	5	4	3	2	1
26. In my family, I learned to be suspicious of others.	5	4	3	2	1
27. In my family, I felt that I could talk things out and settle conflicts.	5	4	3	2	1
28. I found it difficult to express my own opinions in my family.	5	4	3	2	1
29. Mealtimes in my home usually were friendly and pleasant.	5	4	3	2	1
30. In my family, no one cared about the feelings of other family members.	5	4	3	2	1
31. We usually were able to work out conflicts in my family.	5	4	3	2	1
32. In my family, certain feelings were not allowed to be expressed.	5	4	3	2	1
33. My family believed that people usually took advantage of you.	5	4	3	2	1
34. I found it easy in my family to express what I thought and how I felt.	5	4	3	2	1
35. My family members usually were sensitive to one another's feelings.	5	4	3	2	1
36. When someone important to us moved away, our family discussed our feelings of loss.	5	4	3	2	1
37. My parents discouraged us from expressing views different from theirs.	5	4	3	2	1
38. In my family, people took responsibility for what they did.	5	4	3	2	1

39. My family had an unwritten rule: Don't express your feelings.	5	4	3	2	1
40. I remember my family as being warm and supportive.	5	4	3	2	1

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APPENDIX B

DEMOGRAPHIC SHEET FOR NON-EATING DISORDERED WOMEN

Age ____

Height _____

Weight _____

Occupation _____

Ethnicity (circle one):

White/Non-Hispanic African American Hispanic American

American Indians Asian American other: _____

Yearly income of your household (circle one):

under $10,000 $10,000-$25,000 $25,000-$50,000

$50,000-$75,000 $75,000-$100,000 above $100,000

Do you live with your family of origin? If so indicate if you live with your mother, father or both parents.

_____

_____

_____

_____

While you were growing up was your mother predominately a stay at home mom?_____

_____

_____

Have you ever been diagnosed with an eating disorder?

_____

_____

_____

APPENDIX C

DEMOGRAPHIC SHEET FOR EATING DISORDERED WOMEN

Age _____

Height _____

Weight _____

Occupation _____

Ethnicity (circle one):

White/Non-Hispanic	African American	Hispanic American
American Indians	Asian American	other: _____

Yearly income of your household (circle one):

under $10,000	$10,000-$25,000	$25,000-$50,000
$50,000-$75,000	$75,000-$100,000	above $100,000

Do you live with your family of origin? If so indicate if you live with your mother, father or both parents.

_____

_____

_____

_____

While you were growing up was your mother predominately a stay at home mom?_____

_____

_____