AN ABSTRACT OF THE THESIS OF

Angela L. Pelger for the Master of Science

in Psychology presented on _____

Title: How Self-Esteem Relates to Tendencies Toward Eating Disorders and Weight Control Behaviors in 12-14 Year Old Males and Females

Abstract approved: Cooper B. Holmes

This study sought to examine the relationship between the Index of Self-Esteem and the Eating Disorder Inventory. It was composed of 112 subjects (47 male and 65 female) between the ages of 12 and 14 years of age. Both the Index of Self-Esteem and the Eating Disorder Inventory were administered to each subject in a group setting. Both instruments were scored according to specific instructions.

The scores from the Index of Self-Esteem and the eight subscales of the Eating Disorder Inventory were correlated employing a Pearson product-moment correlation. The Index of Self-Esteem correlated positively with the Drive for Thinness subscale of the Eating Disorder Inventory at .430; Ineffectiveness subscale, .309; Body Dissatisfaction subscale, .562; Interpersonal Distrust subscale, .403; and Interoceptive Awareness subscale, .365. Scores for males and females on the Index of Self-Esteem and Drive for Thinness, Ineffectiveness, Body Dissatisfaction and Interoceptive Awareness subscales of the EDI were found to differ significantly.

It was concluded that there is some relationship between

self-esteem and how an individual responds to questions designed to measure characteristics common to those with eating disorders. Clinically this could be of importance in the determination of who is more likely to develop an eating disorder. This could be done before the symptoms have manifested.

How Self-esteem Relates to Tendencies Toward Eating Disorders and Weight Control Behaviors in 12-14 Year Old Males and Females

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A Thesis

Presented to

the Division of Psychology and Special Education

Emporia State University

In Partial Fulfillment

of the Requirements for the Degree

Master of Science

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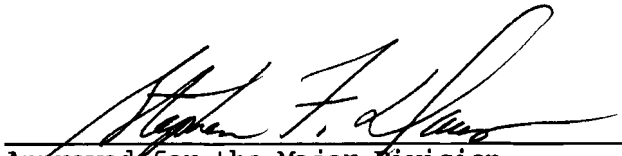
by

Angela L. Pelger

May, 1990



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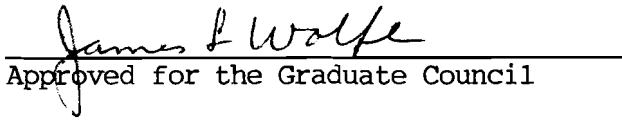

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CHAPTER 1

INTRODUCTION

Kelly and Patten (1985) described the significance that American society places on being thin. This view is supported by Garner and Garfinkel (1980) and Abraham, Mira, Beumont, Sowerbutts and Llewellyn-Jones (1983). This emphasis placed on thinness is internalized at an early age. Television programs, movies, magazine advertisements, and even radio announcements suggest that being thin is more beautiful, healthy and desirable. However, American society is preoccupied with food, serving and eating food at virtually every social function. According to Kelly and Patten (1985), this preoccupation with dieting and food has implications for the health of both adolescent and adult females because the health of adolescent females correlates positively with their health in adulthood. Also, early teenage personality traits are related to adult health. Teenagers with high self-esteem are under less stress than their peers who have a negative self-image, and this is also positively correlated with good health in adulthood. Curtis (1977) stated that high self-esteem and positive attitudes towards others are seen to be significantly related to personality adjustment and general mental health.

According to Muuss (1985), the high risk groups for anorexia nervosa are adolescent and young adult females. Garner and Garfinkel (1982) stated that 90%-95% of the cases are females, but the syndrome does appear in males. The purpose of the present research problem is to investigate the attitudes 12-14 year olds have concerning how they view themselves and how these perceptions could lead to the

development of eating disorders.

Review of the Literature

In the area of eating disorders, research has been conducted on a wide range of topics, with a broad range of instruments used to assess eating disorders. Bell, Kirkpatrick and Rinn (1986) studied the possible differences in body image perception in an anorexic group, an obese group, and a control group using a series of eight silhouette figures, ranging from emaciation to severely obese. It was hypothesized that there would be a difference among the three groups in perceived body image of: 1) the self at present weight; 2) the self at ideal weight; 3) the self at plus 10 pounds; 4) the self at minus 10 pounds; and 5) the self as expected by family members. The subjects were 24 females, aged 11-22 years. The silhouette chart was presented to each subject who then selected the image that most represented how she perceived herself according to the five conditions. Results indicated that anorexics tended to overestimate their body size, while obese underestimated their appearance.

Kalliopuska (1982) proposed that disturbed body image indirectly appears in the Draw-A-Person test. Her subjects were 32 patients, ages 16-37 years suffering from anorexia nervosa and 30 control subjects from an introductory psychology course. Subjects were asked to draw a person. Each picture was then scored according to the Machover method and two new scales constructed by Kalliopuska, one to measure the unity of the body and the other to map disturbed

image. Results indicated that the body-images of patients suffering from anorexia nervosa were significantly more disturbed than those of the control group based on Machover total scoring, the Kalliopuska and Sims unity index of body-image, and the Kalliopuska index of disturbed body-image.

Strober (1981) studied the patterns of association between Minnesota Multiphasic Personality Inventory (MMPI) scores and two different measures of body image in adolescent females in the acute stage of anorexia. The subjects were 65 adolescent females ranging in age from 14-17.5 years. Each subject was administered the MMPI. Also administered was the distorting photograph technique in which a photograph of the subject in a two-piece bathing suit is projected onto a screen through a lens capable of distorting the image bi-directionally and must be adjusted manually by the subject to correspond to her body size at that moment. The third instrument administered was the Fisher Body Distortion Questionnaire which assesses body image aberration subjectively. Strober reported that both body image scores have statistically significant positive correlation with MMPI scales Hs (Hypochondriasis), D (Depression), and Pt (Psychasthenia). The associations between the variables ranged from low to moderate, indicating that personality processes may account for only a small component of variance in body image disturbance in this particular sample.

Ben-Tovim, Whitehead and Crisp (1979) studied self-estimation of various body widths, between two moving lights, of anorexia nervosa patients and a control group of adolescent school girls matched on

socioeconomic status. Mothers of the controls and nurses were also studied to obtain a wider spread of ages. All subjects twice estimated the lateral widths of their faces, chest, waist, and hips in terms of separation between two electrically controlled mobile light sources. The mean estimates were calculated and referred to as perceived body width. The Body Perception Index (BPI) was calculated by taking the perceived width divided by actual width multiplied by 100. Results indicated that for all four body parts, the mean BPI of the anorexics was smaller than that of the controls. However, with the exception of hip measurement, it was the controls who had the smaller actual widths. This prompted investigation of the relationship between BPI and the actual width which revealed that the smaller the body part, the greater percentage of its overestimation by anorexics and controls. Ben-Tovim, Whitehead and Crisp (1979) confirmed previous studies that reported overestimation of body width to be a widespread phenomena, by no means confined to anorexic populations alone.

Previous studies have compared the body images of anorexic, overweight and normal weight adolescents and adults. Anorexics and overweight adolescents have disturbed body images; however, other groups such as normal weight adolescents and adults do too. These studies do not provide any indication as to the disposition of the subjects prior to developing an eating disorder.

One issue not mentioned in previous studies and of importance to the present research is the attitudes toward self and body exhibited by adolescent males and females not diagnosed with

an eating disorder, and the tendencies these individuals have toward developing one. Grant and Fodor (1986) explored the relationships among adolescent attitudes toward body image and tendencies toward anorexic behavior. Body image was measured by the Lerner scale which consists of separate scales measuring physical attractiveness, self-esteem and physical effectiveness, and tendencies toward anorexic behavior on the Eating Attitudes Test (EAT) and the Eating Disorder Inventory (EDI). The subjects were 55 male and 113 female high school students, ranging in age from 15-18 years and tested in their classrooms. Significant differences between males and females were shown for physical attractiveness and physical effectiveness on the Lerner scales and tendencies toward anorexic behavior as measured by the EAT. The results of the study supported contentions that self-esteem and physical attractiveness were associated with eating disorders in adolescents. The less attractive a female adolescent perceived herself, the higher the tendency toward developing an eating disorder. Self-esteem emerged as the most important predictor of tendencies toward anorexic behavior.

Baird and Sights (1986) stated that low self-esteem is a critical, pervasive problem in anorexics' and bulimics' lives. Their lack of sufficient esteem impels the maladaptive attempt to enhance esteem through self-defiance of needs and the obsessive pursuit of thinness.

Mendelson and White (1985) studied the development of self-body-esteem in overweight youngsters, focusing on the differences

between overweight and normal weight individuals and the relation between self-esteem and body-esteem. Ninety-seven children, ages 8.5-17.4, comprised the sample. Forty-eight children were overweight, defined as 112% or more of their ideal body weight; 49 children were normal weight, defined as less than 107% of their ideal body weight. The Coopersmith Self-Esteem Inventory was used to assess self-esteem, and a 24-item self-report measure of body-esteem was administered. The results indicated that at all three age groups (youngest, middle, and oldest) of normal weight youngsters, self-esteem did not undergo developmental changes. However, the pattern seems to be different in overweight children. At the youngest age, all four groups (overweight and normal weight, boys and girls) had similar self-esteem. At the middle age, being overweight adversely affected self-esteem in boys, but not in girls. At the oldest age, being overweight adversely affected self-esteem in girls, but not in boys. This research also reported that overweight youngsters had lower body-esteem than did normal weight youngsters.

A sample of adolescent cheerleaders was the focus of a study conducted by Lundholm and Littrell (1986), in which the girls' desire for thinness in relation to eating and weight control behaviors was studied. This specific group was chosen because they are often explicitly or implicitly required to attain and maintain weights that are lower than average for other adolescents of the same height; attempts to lose weight are often undertaken by these individuals. Seven-hundred-fifty-one female, high school cheerleaders ranging in age from 13-18 years were chosen. The following scales

were combined into one questionnaire and administered to the subjects: 1) a Desire for Thinness scale developed by the authors to assess adolescents' desire for thinness; 2) Cognitive Restraint, Tendency toward Disinhibition and Perceived Hunger subscales of the Restrained Eating Scale (RES); 3) Bulimia and Body Dissatisfaction subscales of the EDI; and 4) Dieting, Bulimia and Food Preoccupation, and Oral Control subscales of the EAT. The results showed that the more important the desire for thinness, the more likely the tendency toward problematic eating behaviors. Subjects with higher scores on the Desire for Thinness scale had significantly higher scores on seven of the eight eating disorder subscales: Cognitive Restraint, Tendency toward Disinhibition, Perceived Hunger, Bulimia, Body Dissatisfaction, Dieting, and Bulimia and Food Preoccupation. There was no difference on the Oral Control scale.

Fairbanks (1987) introduced a term used to describe eating disorders among athletes: anorexia athletica. Physical signs include a reduction in body weight, decline in optimal performance, fatigue, dizziness, dehydration and amenorrhea. Psychological signs include refusal to eat, a diet insufficient to maintain one's activity level, a fear of gaining weight, a preoccupation with body image and a consuming desire to be the best. Fairbanks reported that 20% of female athletes in sports that emphasize leanness (ballet, dance, aerobics, cheerleading gymnastics, figure skating and distance running) have this disorder. However, female athletes are not the only ones affected by anorexia athletica. Male wrestlers, boxers, gymnasts and body builders are also at risk of acquiring eating

disorders.

Kelly and Patten (1985) undertook their research to assess the magnitude of adolescent involvement in the high cultural value assigned to slenderness, and to discern differences that may exist between male and female adolescents. A 78-item questionnaire was administered to 2,276 high school students age 15-16 years. The questionnaire assessed attitudes associated with weight, eating and food, and physical appearance. The subjects also reported their height, weight, and ideal weight. Male and female adolescents experienced a high level of dissatisfaction with their weight. Females were much more likely than males to experience worry or concern about being overweight and relate self-attractiveness to slenderness. It was reported that they respond behaviorally to this concern by dieting; a small but significant proportion of both males and females resorted to drastic measures, such as self-induced vomiting.

The previous studies addressed the concerns adolescents have about their weight and how this concern can lead to dieting behaviors unhealthy to the individual. The topic of the current research is how the attitudes concerning self, weight, food and dieting of a population of youngsters, aged 12-14 years, relate to the possibility of developing characteristics common to those with eating disorders. In this study, an undiagnosed population is used, as opposed to other research that used medically diagnosed groups of anorexics, bulimics, and overweight subjects. The purpose of using an undiagnosed population of 12-14 year old boys and girls was to see how the self-esteem of this group relates to the development of

characteristics common to those diagnosed with an eating disorder. This writer hypothesized that children who view themselves in a negative manner and score high on a self-esteem inventory (with a high score representative of problems with self-esteem) will also score higher on an instrument designed to measure the psychological characteristics related to anorexia nervosa and bulimia than those children who have a high self-image (with a low score on the self-esteem inventory representative of minimal or no problems). This research topic is significant because of the life-threatening nature eating disorders have. It should be of importance to parents, teachers, doctors, mental health professionals and children themselves. Professionals, as well as the general public, need to be aware of the symptoms and treatments of anorexia and bulimia. There are so many aspects to these disorders that gaining knowledge about a group such as adolescent males and females and their attitudes about weight and dieting and themselves could give clues about why some adolescents develop eating disorders and others do not.

CHAPTER 2

METHOD

Subjects

The sample consisted of 112 subjects from Topeka, Kansas. Included in the sample were 47 males and 65 females ranging in age from 12 through 14 years of age, who had not been diagnosed as having an eating disorder of any type. Because of certain restrictions placed on this research by the Research Committee of the Topeka Public Schools, subjects were students in classes at the five public middle schools in the city. One class from each school was selected by the school principal for participation in the study. Subjects were tested by this writer in a group setting in the class.

Parents of the subjects were asked to sign an informed consent document prior to testing. The informed consent document described the intent and purposes of the testing as well as the testing procedure followed. This form verified their permission to allow their child to engage in the study.

Confidentiality was observed by retaining only the age, sex, school activities and parents' occupation on the testing form. An application for approval to use human subjects was approved by Emporia State University's Review Board for Treatment of Human Subjects.

Materials

The Eating Disorder Inventory, hereafter to be referred to as

the EDI, and the Index of Self-Esteem, hereinafter to be referred to as the ISE, were the test instruments employed. They were administered to each subject.

The EDI (see Appendix A) consists of 64 six-point scales, rated by the subjects as "always", "usually", "often", "sometimes", "rarely", or "never" applying to them. Items are designed to measure eight dimensions. These dimensions are: Drive for Thinness, Bulimia, Body Dissatisfaction, Ineffectiveness, Perfectionism, Interpersonal Distrust, Interoceptive Awareness, and Maturity Fears. Each of the dimensions varies in the number of questions that are designed to measure the certain anorexic or bulimic characteristics. There are six questions on the Drive for Thinness subscale; seven questions on the Bulimia subscale; nine questions on the Body Dissatisfaction subscale; 10 questions on the Ineffectiveness subscale; six questions on the Perfectionism subscale; seven questions on the Interpersonal Distrust subscale; 10 questions on the Interoceptive Awareness subscale; and eight questions on the Maturity Fears subscale. Most young people require 20 minutes or less to finish the entire questionnaire. Specific scoring instructions are given in the EDI manual and each questionnaire was scored according to those directions. Each subscale of the EDI was required by Garner and Olmsted (1984) to have a coefficient of internal consistency above .80 for the anorexia nervosa patients involved in the validation of the EDI. Item score correlation above .40 for the anorexic group was considered desirable by Garner and Olmsted, and three items with item-correlations below .40 were retained because they were conceptually important.

The average item-total correlation was .63 indicating within scale common variance among items. Criterion-related validity was established by comparing EDI patients' self-report profiles with the clinical judgements of experienced clinicians familiar with the patient's psychological presentation. All correlations between the therapist-consultant ratings and the anorexia patients' scores were significantly positive. Because several subscales of the EDI overlap conceptually with available psychological tests, convergent and discriminant validity was determined.

Hudson (1982) described a measurement package for clinical workers that includes the ISE. The ISE is a standardized scale that measures the degree or magnitude of a problem a subject has with his or her self-esteem. The scale consists of 25, five-point, choice items rated by the subject as "rarely or none of the time", "a little of the time", "some of the time", "a good part of the time", and "most or all of the time". This instrument can be used with children as young as 12. Scoring of the instrument is based on a reverse-scoring technique of the positively worded items. If a subject scored one of these positively worded items a 1, it would be rescored a 5; rescore 2 as 4; leave 3 unchanged; rescore 4 as 2; and rescore 5 as 1. All negatively worded items are left unchanged. After rescoring the positively worded items, add up all the scores and subtract a constant of 25 from the total. Scoring in this manner produces a minimum score of 0 (lower scores are interpreted as absence or minimal problems) and a maximum score of 100 (higher scores are interpreted as presence of problems), with a clinical cutting score of 30. A

modified scoring technique is used if an individual does not respond to one or more of the items on the scale. First, reverse score the appropriate items, and add up all the items reverse scored and those items that were not reverse scored. These sums are added together. Next, subtract from that figure the number of items that were completed. This figure is then multiplied by 100 and divided by the number of items completed times four. The resulting figure is the score which also has a possible range of 0 to 100. The ISE has a reliability coefficient of .9210 with a standard error of measurement of 3.5110. The discriminant validity coefficient is .5190.

Procedure

The EDI and ISE were administered as a packet to each individual in a group setting. Each EDI and ISE was numbered in order to keep the data organized. The subjects were asked to record their age, sex, school activities, and parent's occupation on the EDI test form. The instructions at the top of each instrument were read aloud for both questionnaires by this writer.

The EDI was scored by this writer according to the specific scoring instructions in the manual. Scores were obtained on eight subscales for each subject. Each ISE was also scored by this writer according to the specific instructions outlined.

Statistical Design

The above described procedures produced nine scores for each subject: one score was obtained from administration of the ISE and eight scores were obtained from administration of the EDI. Scoring

of both instruments resulted in raw scores which were correlated. Group means and standard deviations were determined for each variable.

A Pearson product-moment correlation was employed to test for the strength of relationship among the nine variables. A t-test was also employed to determine differences in male and female responses.

CHAPTER 3

RESULTS

Nine variables, which produced scorable data, composed this study. The first variable was the score attained by each subject on the Index of Self-Esteem. The other eight variables were the scores attained by each subject on the following subscales of the EDI: Drive for Thinness, Bulimia, Body Dissatisfaction, Ineffectiveness, Perfectionism, Interpersonal Distrust, Interoceptive Awareness, and Maturity Fears. These nine scores were used to obtain correlational data. The means, standard deviations, and possible ranges of the scores obtained are presented in Table 1.

Table 1

Means, Standard Deviations and Ranges of All Scores on the Index of Self-Esteem and Eating Disorder Inventory

Test Instrument	M	SD	Range
Index of Self-Esteem	33.5446	17.7495	0-80
Eating Disorder Inventory			
Drive for Thinness (DT)	3.8661	4.4872	0-15
Bulimia (B)	1.4911	2.5855	0-14
Ineffectiveness (I)	7.2768	8.6547	0-25
Body Dissatisfaction (BD)	3.3929	4.6757	0-26

Table 1 continued

Test Instrument	M	SD	Range
Perfectionism (P)	5.7411	3.8991	0-15
Interpersonal Distrust (ID)	4.0179	3.2438	0-15
Interoceptive Awareness (IA)	3.5446	4.4699	0-26
Maturity Fears (MF)	4.5367	3.6166	0-18

A Pearson product-moment correlation was computed between self-esteem scores obtained on the Index of Self-Esteem and each of the eight subscale scores of the Eating Disorder Inventory to determine the relationship between these scores. The correlations for the scores obtained are presented in Table 2.

Table 2

Pearson r Correlation Between Index of Self-Esteem Scores and Subscale Scores of the Eating Disorder Inventory

	Eating Disorder Inventory							
	DT	B	I	BD	P	ID	IA	MF
Index of Self-Esteem	.430**	.067	.309**	.562**	-.047	.403**	.365**	.022

**Statistically significant at the $p < .001$ level.

Independent t-tests were computed between male and female scores obtained on the Index of Self-Esteem and each of the eight subscales of the Eating Disorder Inventory to determine if male and female responses were truly different. The means and standard deviations and *t* values of the male and female scores are included in Table 3.

Table 3

Means, Standard Deviations and t-Values of Male and Female Scores on the Index of Self-Esteem and Eating Disorder Inventory

Test Instrument	*M*	*SD*	*t* value
Index of Self-Esteem			
Male	28.5957	15.695	-2.57*
Female	37.1231	18.395	
Eating Disorder Inventory			
Drive for Thinness			
Male	1.6383	2.698	-4.91*
Female	5.4769	4.838	
Bulimia			
Male	1.5319	2.394	.14
Female	1.4616	2.733	
Ineffectiveness			
Male	3.7447	4.919	-3.90*
Female	9.8308	9.835	

Table 3 continued

Test Instrument	M	SD	t value
Body Dissatisfaction			
Male	2.1277	4.194	-2.49*
Female	4.3077	4.822	
Perfectionism			
Male	6.0426	4.000	.69
Female	5.5231	3.841	
Interpersonal Distrust			
Male	4.1489	2.941	.36
Female	3.9231	3.465	
Interoceptive Awareness			
Male	2.2766	3.153	-2.62*
Female	4.4615	5.047	
Maturity Fears			
Male	4.4681	3.883	-.17
Female	4.5846	3.441	

*t-values are significant at the $p < .05$ level.

CHAPTER 4

DISCUSSION

Grant and Fodor (1986) explored the relationship among adolescent attitudes toward body image and tendencies toward anorexic behavior. In their study of male and female 15-18 year olds, self-esteem emerged as the most important predictor of tendencies toward anorexic behavior. Baird and Sights (1986) suggested that low self-esteem is a pervasive problem in the lives of individuals with eating disorders. Their lack of esteem impels them to enhance esteem maladaptively through self-defiance of needs and an obsessive pursuit of thinness. Mendelson and White (1985) reported that weight adversely affected self-esteem in overweight children. At the middle ages, being overweight adversely affected self-esteem in boys, but not in girls. At the oldest age, being overweight adversely affected self-esteem in girls, but not in boys. The current study attempted to correlate Index of Self-Esteem (ISE) scores with scores obtained on the subscales of the Eating Disorder Inventory (EDI) in an effort to show that there is a connection between self-esteem and scores on the subscales of the EDI.

The correlations between self-esteem score on the ISE and five of eight subscale scores on the EDI were significant. A correlation of $\underline{r}$ = .4302 was obtained between ISE and Drive for Thinness subscale. The correlation between ISE and Ineffectiveness subscale was .3094.

ISE and Body Dissatisfaction subscale correlated at .5621. ISE and Interpersonal Distrust subscale correlated at .4029. The correlation between ISE and Interoceptive Awareness subscale was .3650. All five of these scores were found to be statistically significant at the $p < .001$ level. These results seem to indicate that there is in fact a tendency for persons with self-esteem problems to score high on most of the subscales of the EDI.

According to Garner and Olmsted (1984), there are five psychological traits fundamental in the development of eating disorders, four of which are included on the EDI as subscale measures and were found to be correlated significantly with self-esteem in the present study. These psychological traits include a drive to be thinner even though emaciation occurs (Drive for Thinness subscale), a dissatisfaction with shape marked by an overestimation of body size (Body Dissatisfaction subscale), an inability to accurately respond or recognize emotions and cues indicating changes in internal state (Interoceptive Awareness subscale), and an overwhelming sense of ineffectiveness in which self-starvation is used to gain autonomy, control and self-respect (Ineffectiveness subscale). The final fundamental characteristic, maturity fears, was not found to be significantly correlated with self-esteem in this study, probably because the subjects of this study were only 12-14 years old and still considered to be children.

Results of the study also indicated differences in male and female scores. Females scored significantly higher than males on the following measures: Index of Self-Esteem; Drive for Thinness

subscale; Ineffectiveness subscale; Body Dissatisfaction subscale; and Interoceptive Awareness subscale. There was no observed difference in scores on the Bulimia, Perfectionism, Interpersonal Distrust, and Maturity Fears subscales of the EDI. These results parallel those of Grant and Fodor (1986) who found differences in male and female responses on measures of physical attractiveness, physical effectiveness, and tendencies toward anorexic behavior. The less attractive a female adolescent perceived herself, the higher the tendency toward developing an eating disorder. The fact that eating disorders are more prevalent among females than males is observed in the literature (Muuss, 1985; Garner & Garfinkel, 1982; Fairbanks, 1987; Kelly & Patten, 1985).

Results of this study indicate some relationship between self-esteem and how an individual responds to questions designed to measure characteristics common to those with eating disorders. It would be interesting to see if this would be the case in a sample of children under the age of 12. Finding out that self-esteem in the younger children is significantly correlated to the tendency to develop eating disorders could lead to insight into more precise methods of determining who is more likely to develop an eating disorder and this could be done maybe before the symptoms have manifested.

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APPENDIX A

Tell Me About Yourself

Your Age:

Your Sex:

School Activities:

Your Parent's Occupation:

Mother:

Father:

EDI

David M. Garner, Ph. D.
Marion P. Olmsted, M.A.
Janet Polivy, Ph. D.

Name _____ Date _____

Age _____ Sex _____ Marital status _____

Present weight _____ Height _____

Highest past weight (excluding pregnancy) _____ (lbs)

How long ago? _____ (months)

How long did you weigh this weight? _____ (months)

Lowest past adult weight _____ (lbs)

How long ago? _____ (months)

How long did you weigh this weight? _____ (months)

What do you consider your ideal weight? _____ (lbs)

Age at which weight problems began (if any) _____

Present occupation _____

Father's occupation _____ Mother's occupation _____

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RUCTIONS

is a scale which measures a variety of attitudes, feelings and behaviors. Some of the items relate to food eating. Others ask you about your feelings about yourself. THERE ARE NO RIGHT OR WRONG WERS SO TRY VERY HARD TO BE COMPLETELY HONEST IN YOUR ANSWERS. RESULTS ARE COM-TELY CONFIDENTIAL. Read each question and fill in the circle under the column which applies best to Please answer each question *very* carefully. Thank you.

	ALWAYS	USUALLY	OFTEN	SOMETIMES	RARELY	NEVER
eat sweets and carbohydrates without feeling nervous.	○	○	○	○	○	○
think that my stomach is too big.	○	○	○	○	○	○
wish that I could return to the security of childhood.	○	○	○	○	○	○
eat when I am upset.	○	○	○	○	○	○
stuff myself with food.	○	○	○	○	○	○
wish that I could be younger.	○	○	○	○	○	○
think about dieting.	○	○	○	○	○	○
get frightened when my feelings are too strong.	○	○	○	○	○	○
think that my thighs are too large.	○	○	○	○	○	○
feel ineffective as a person.	○	○	○	○	○	○
feel extremely guilty after overeating.	○	○	○	○	○	○
think that my stomach is just the right size.	○	○	○	○	○	○
Only outstanding performance is good enough in my family.	○	○	○	○	○	○
The happiest time in life is when you are a child.	○	○	○	○	○	○
am open about my feelings.	○	○	○	○	○	○
am terrified of gaining weight.	○	○	○	○	○	○
trust others.	○	○	○	○	○	○
feel alone in the world.	○	○	○	○	○	○
feel satisfied with the shape of my body.	○	○	○	○	○	○
feel generally in control of things in my life.	○	○	○	○	○	○
get confused about what emotion I am feeling.	○	○	○	○	○	○
would rather be an adult than a child.	○	○	○	○	○	○
can communicate with others easily.	○	○	○	○	○	○
wish I were someone else.	○	○	○	○	○	○
exaggerate or magnify the importance of weight.	○	○	○	○	○	○
can clearly identify what emotion I am feeling.	○	○	○	○	○	○
feel inadequate.	○	○	○	○	○	○
have gone on eating binges where I have felt that I could not stop.	○	○	○	○	○	○
As a child, I tried very hard to avoid disappointing my parents and teachers.	○	○	○	○	○	○
have close relationships.	○	○	○	○	○	○

	ALWAYS	USUALLY	OFTEN	SOMETIMES	RARELY	NEVER
I like the shape of my buttocks.	O	O	O	O	O	O
I am preoccupied with the desire to be thinner.	O	O	O	O	O	O
I don't know what's going on inside me.	O	O	O	O	O	O
I have trouble expressing my emotions to others.	O	O	O	O	O	O
The demands of adulthood are too great.	O	O	O	O	O	O
I hate being less than best at things.	O	O	O	O	O	O
I feel secure about myself.	O	O	O	O	O	O
I think about bingeing (over-eating).	O	O	O	O	O	O
I feel happy that I am not a child anymore.	O	O	O	O	O	O
I get confused as to whether or not I am hungry.	O	O	O	O	O	O
I have a low opinion of myself.	O	O	O	O	O	O
I feel that I can achieve my standards.	O	O	O	O	O	O
My parents have expected excellence of me.	O	O	O	O	O	O
I worry that my feelings will get out of control.	O	O	O	O	O	O
I think that my hips are too big.	O	O	O	O	O	O
I eat moderately in front of others and stuff myself when they're gone	O	O	O	O	O	O
I feel bloated after eating a normal meal.	O	O	O	O	O	O
I feel that people are happiest when they are children.	O	O	O	O	O	O
If I gain a pound, I worry that I will keep gaining.	O	O	O	O	O	O
I feel that I am a worthwhile person.	O	O	O	O	O	O
When I am upset, I don't know if I am sad, frightened, or angry.	O	O	O	O	O	O
I feel that I must do things perfectly, or not do them at all.	O	O	O	O	O	O
I have the thought of trying to vomit in order to lose weight.	O	O	O	O	O	O
I need to keep people at a certain distance (feel uncomfortable if someone tries to get too close).	O	O	O	O	O	O
I think that my thighs are just the right size.	O	O	O	O	O	O
I feel empty inside (emotionally).	O	O	O	O	O	O
I can talk about personal thoughts or feelings.	O	O	O	O	O	O
The best years of your life are when you become an adult.	O	O	O	O	O	O
I think that my buttocks are too large.	O	O	O	O	O	O
I have feelings that I can't quite identify.	O	O	O	O	O	O
I eat or drink in secrecy.	O	O	O	O	O	O
I think that my hips are just the right size.	O	O	O	O	O	O
I have extremely high goals.	O	O	O	O	O	O
When I am upset, I worry that I will start eating.	O	O	O	O	O	O

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COMMENTS:

Additional copies are available from.

PAR Psychological Assessment Resources, Inc.
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APPENDIX B

tionnaire is designed to measure how you see yourself. It is not a test, so no right or wrong answers. Please answer each item as carefully and as you can by placing a number by each one as follows:

Rarely or none of the time
A little of the time
Some of the time
A good part of the time
Most or all of the time

egin.

l that people would not like me if they really knew me well	_____
l that others get along much better than I do	_____
l that I am a beautiful person	_____
en I am with other people I feel they are glad I am with them	_____
el that people really like to talk with me	_____
el that I am a very competent person	_____
nk I make a good impression on others	_____
el that I need more self-confidence	_____
en I am with strangers I am very nervous	_____
nk that I am a dull person	_____
el ugly	_____
el that others have more fun than I do	_____
el that I bore people	_____
nk my friends find me interesting	_____
ink I have a good sense of humor	_____
el very self-conscious when I am with strangers	_____
el that if I could be more like other people I would have it de	_____
eel that people have a good time when they are with me	_____
eel like a wallflower when I go out	_____
eel I get pushed around more than others	_____
ink I am a rather nice person	_____
eel that people really like me very much	_____
eel that I am a likeable person	_____
m afraid I will appear foolish to others	_____
friends think very highly of me	_____

7,14,15,18,21,22,23,25