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Sex role identification in anorectic females: a reappraisal.

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SEX ROLE IDENTIFICATION IN ANORECTIC FEMALES: A REAPPRAISAL

A Thesis Presented

by

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To John, whose faith in me has always

exceeded my faith in myself,

and

To all young women who struggle

with anorexia nervosa

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It begins quietly
in certain female children;
the fear of death, taking as its form
dedication to hunger,
because a woman's body
is a grave; it will accept
anything. I remember
lying in bed at night
touching the soft, aggressive breasts
touching, at fifteen,
the interfering flesh
that I would sacrifice
until the limbs were free
of blossom and subterfuge: I felt
what I feel now, aligning these words.
It is the same need to perfect,
of which death is the mere byproduct...

-Louise Gluck

from "Dedication to Hunger"

TABLE OF CONTENTS

ILLUSTRATIONS

Figure

LIST OF TABLES

INTRODUCTION

Anorexia nervosa, a psychosomatic disturbance characterized by a stubborn refusal of nourishment, has been referred to as the "encapsulation of a piece of madness in an otherwise sane personality (Dinnage, 1979)". Observed most frequently in adolescent and post-adolescent females (Rowland, 1970; Zeigler & Sours, 1968), anorexia has the dubious distinction of being one of the few psychiatric illnesses that can result in death. Follow-up studies indicate a mortality rate of 7-15% and a morbidity rate of 34% to 65% in terms of chronic psychopathology and social dysfunction (Kay & Leigh, 1952; Kay & Schapira, 1965).

The term "anorexia" (literally, "loss of appetite") is actually a misnomer; denial, rather than absence of desire is now recognized as the critical feature in this disorder. In this respect, at least, the German appellation PUBERTATMAGERSUCHT ("compulsive pubertal emaciation") is more expressive of the true nature of the condition. Still, whether the name emphasizes the failure in food intake or the resulting emaciation, it must be kept in mind that in either case one outstanding dramatic feature is used to name a complex symptom or disease. Much of the confusion that arises in efforts to understand the condition is related to the fact that the term used to describe it is taken too literally or endowed with causal or explanatory significance. Furthermore, because of the difficulty in probing into the private

worlds of patients who become increasingly secretive and tend to dissimulate (Dally, 1969; Selvini-Palazzoli, 1978), those who have described anorexia have generally been forced to base their conclusions on the patients' own and false explanations: lack of appetite, loathing of food, stomach aches and sensations of bloating.

Sours (1968), after an extensive review of the clinical manifestations of anorexia, cites the following primary signs and symptoms: (1) the elective restriction of food, (2) the pursuit of thinness as pleasure in itself, (3) frantic efforts to establish control over the body and its functions, (4) food avoidance and preoccupation, (5) hyperactivity and increased energy output, and (6) amenorrhea.

Bruch (1965; 1973) supplements this formulation of the disorder in primarily somatic terms with her own definition of the syndrome in terms of three areas of disordered psychological functioning: (1) a disturbance of delusional proportions in the body image by which the often gruesome emaciation is defended as normal and right, (2) a disturbance in the accuracy of the perception of stimuli arising in the body, e.g., hunger, fatigue, emotional states, and (3) a paralyzing sense of ineffectiveness in which all action is experienced as being in response to demands from others.

While the pattern of self-starvation appears to be the most prevalent one, the range of eating disturbance extends from total

food avoidance, on the one hand, to gorging, vomiting, and purging, on the other. The gorging-purging group of anorexia nervosa patients makes up at least 25% of all cases of the disorder (Sours, 1980). By vomiting, the gorger-purger may keep her weight at what she considers an ideal level, or her vomiting may become uncontrollably compulsive so that after every meal, even if she has not overeaten, she must vomit (Boskind-Lodahl, 1976). In the latter case, weight loss may be considerable, to the point of cachexia and nutritional collapse.

The extensive media coverage devoted to this syndrome in recent years has tended to obscure the fact that anorexia has been a recognized clinical entity for nearly three centuries and, as such, as been the focus of a vast amount of psychological literature. A number of discrete theories of etiology may be isolated which parallel the more general trend in this literature towards locating pathology in increasingly larger social units. As a result, early formulations involving intra-psychic conflict currently exist alongside theories which implicate familial and even social structure in the ontogeny of the disorder. (For a review of this literature, see Fishman, 1979).

Unfortunately, efforts to make sense of the vastly discrepant, and often contradictory, statements found in this literature have traditionally been obscured by a number of methodological variations between independent studies. Broad differences in diagnostic criteria have contributed to a situation in which large fluctuations

in sample composition make comparisons of one investigator's work with another virtually impossible. Confusion between primary and secondary symptomatology is another fairly common feature; behavioral patterns or deficits which are best viewed as the result of physical starvation, prolonged social isolation, and/or familial interference, have been seen alternately as both "premorbid" features and as "typical" of the anorexia syndrome.

Finally, and perhaps most significantly, controlled empirical studies--either exploratory in nature or designed to test competing theoretical assumptions--have been reported only rarely in a literature dominated until relatively recently by observational methods and in which discrepancies from conclusions of other research teams are seldom addressed. In fact, only a dozen articles in the anorexia literature compare primary anorectics to normal controls on any dimensions (Garner & Garfinkel, 1978; Smart, et al., 1976). It is partly for these reasons that our understanding of the factors that may predispose an individual to embark upon a course of relentless self-starvation remains, even after three centuries, surprisingly incomplete.

PURPOSE

The present study addressed a particular area of controversy among observers of anorexia nervosa: the nature of sex-role identification in anorectic females. This debate actually involves two separate, but related, issues. The first of these, generally considered to be the core of the identification process, concerns the degree to which anorectics internalize the roles and unconscious reactions considered appropriate for their gender. A second issue addresses a more phenomenological component of this process, concerning itself with the extent to which the anorectic's self-perception is similar to, or discrepant with, her conception of an idealized feminine self.

These issues lie at the core of three current theories of anorexia: the psychoanalytic, feminist, and "role strain" perspectives. All three posit as an etiologic factor a marked real-ideal incongruency in feminine self-concept, while all but the latter hypothesize additional deviations in the nature of the identification itself. The direction of the proposed aberrations is, however, quite different for each theory.

The analytic position cites "rejection of feminine identification" and the establishment of an "asexual ego ideal" as primary features in the syndrome. A conflict is thus created between the potential anorectic's perception of herself as a developing woman and her desire to eliminate all traces of mature female sexuality.

Feminist writers, however, posit the existence of an "over-identification" with and idealization of the traditional feminine role as typical components of an anorectic constellation, suggesting an imbalance between the would-be anorectic's self-evaluation and her culturally-conditioned perception of the kind of "ultra-femininity" it will take to gain the love and attention she craves. The "role strain" perspective, while lacking a definitive response to the question of sex-role identification, does suggest the existence of an androgynous ideal as a reaction to changing societal definitions of feminine success. A conflict is thus posited between a non-androgynous "real self" and an idealized self embodying the socially valued attributes of both traditional male and female roles.

Data bearing on this controversy would have significant implications both for our understanding of the anorectic experience and for our ability to provide therapeutic assistance commensurate with that need. Perhaps of equal importance, however, would be the theoretical contribution afforded by such findings to the study of sex roles in general, and particularly to the long-standing investigation of the relationship between appropriate sex-role identification, self-concept congruency, and psychological adjustment. Nonetheless, no controlled empirical study has ever addressed this controversy. The purpose of this study will be to do just that.

A brief review of the broader literature in these areas will be presented, followed by a fuller elaboration of those theories of anorexia in which their interface is particularly prominent.

CHAPTER I

REVIEW OF THE LITERATURE

Sex-role identification and psychological adjustment.

The place of sex-role identification in the development of both normal and psychopathologic conditions has been the subject of much controversy in the psychological literature. Sex-role identification, defined as the internalization of the roles and unconscious reactions considered appropriate to a given sex (Brown & Lynn, 1966) has traditionally been considered a critical feature of personal identification and, as such, an integral part of good personal adjustment. Exponents of this position (e.g., Rutenbeck, 1971) hold that the breakdown of appropriate sex-role identification is often linked to more pervasive personality difficulties in both sexes. Consistent with this view, the list of psychopathological behaviors associated with aberrations in this process extends from schizophrenia (La Torre, 1976; McClelland & Watt, 1968) through psychiatric patients in general (Molholm & Dinitz, 1972), neurotics (Beitner, 1961; Fenischel, 1945; Freud, 1942; Kayton & Biller, 1972; Kokonis, 1972), sexual deviants (Gershman, 1970; Stoller, 1975), and female alcoholics (Lisansky, 1957; Mogar, Wilson and Helm, 1970; Wilsnack, 1973).

This view has been challenged by others (e.g., Bem, 1974; Block, 1973; Kaplan, 1974) who postulate that appropriate sex-role identification is not critical to healthy adjustment and may, in

its more restrictive forms, place limits upon the behavior of both sexes. These writers propose that a lessening of sex-role behavior would result in the development of an androgynous society, i.e., a society in which behavior could be predicated upon situational demands rather than upon stereotyped sex-role expectations. Support for this perspective has come primarily from studies of women, in whom a high degree of sex-role socialization has been found to be negatively related to such desirable qualities as autonomy (Lozoff, 1972), internal locus of control (Minnigerode, 1976), self-esteem (Connell & Johnson, 1970; Flammer, 1971), and adjustment (Deutsch & Gilbert, 1976; Heilbrun, 1968), and positively related to anxiety (Biaggio & Nielson, 1976; Cosentino & Heilbrun, 1964; Gall, 1969). Moreover, lack of traditional feminine identification is not, by any means, always associated with emotional disturbance or pathology in women. At least one group of women who are apparently coping quite successfully in our society (i.e., successful career women) tend to show such traditionally masculine characteristics as assertiveness, independence and activity, and often appear to have masculine profiles on personality tests (Helson, 1972).

The results for male subjects, although less uni-directional, are nonetheless provocative. While high masculinity in males has been correlated during adolescence with better psychological adjustment (Mussen, 1961), it has been correlated during adulthood with high anxiety, high neuroticism, and low self-acceptance (Hartford, Willis, & Deabler, 1967; Mussen, 1962). In addition,

greater intellectual development has been correlated quite consistently with cross sex-typing, i.e., with masculinity in girls and with femininity in boys. Boys and girls who are sex-typed have been found to have lower overall intelligence, lower spatial ability, and lower creativity (Maccoby, 1966).

Congruency of feminine self-concept and psychological adjustment.

The notion of a discrepancy between one's "real self-concept" and one's "ideal self" is certainly not a new one, having its roots in personality psychology. "Real self," of course, refers to the qualities and characteristics which individuals think they actually possess (Garnets & Pleck, 1979), while the "ideal self," on the other hand, is the sum total of a person's views of what s/he wishes s/he were, or of what s/he thinks s/he ought to be (Jersild, 1963). In Rogers' "self theory," for example, the accurate perception and subsequent integration of social expectations with personal values is seen as essential to adaptive development. Consequently, changes in discrepancies between real-self and ideal-self have traditionally been used as an outcome measure in "client-centered" psychotherapy research (e.g., Rogers & Dymond, 1954).

Consistent with this hypothesis, the existence of a discrepancy between real- and ideal-self has been repeatedly found to be positively associated with anxiety (Lipsitt, 1961; McCandless, Costeneda & Palermo, 1956; Roynerson, 1957), delinquency (Howard, 1957), self-rejection, self-dissatisfaction, self-distrust (Mitchell,

1959), insecurity (Puhan, 1976), and other socially less desirable traits (Kenny, 1956; Mohanty, 1965).

The applicability of this construct of real-ideal discrepancy to the study of a particular component of self-concept --sex role identity--seems relatively straightforward. Sex role stereotypes constitute social expectations for sex-appropriate behavior (Cottrell, 1942; Weisstein, 1969) to which, for a variety of reasons, many individuals of both sexes do not conform (Garnets & Pleck, 1979). The sociological theorist Komarovsky (1976) refers to this absence of conformity as a "lack of congruity or 'malfit' between idiosyncratic personality and social role"; Turner (1970) describes this type of conflict as occurring when "a relatively uniform role is ascribed arbitrarily to a set of people with highly varied potentialities." Not surprisingly, a study by Deutsch and Gilbert (1976) found poorer adjustment among "high-discrepancy" females than among those with more congruent real-ideal self-perceptions.

A considerable body of theoretical literature attests to the fact that the expectations for women in our society are unclear and diffuse (Angrist, 1969; Epstein, 1970; Goode, 1960) and may indeed create problems for large numbers of women (Cottrell, 1942; Parsons, 1942; Rose, 1951). Other writers (e.g., Bardwick, 1971; Friedan, 1963; Steinmann & Fox, 1966) have suggested that the expectations confronting women are not merely diffuse but are in fact contradictory, and that women are often consequently placed

in a serious set of double binds. In either case, a situation exists in which a comparison of one's self with one's same-sex ideal, however defined, is likely to result in marked incongruity. Nonetheless, there does not appear to be any large-scale research which systematically analyzes the negative consequences of discrepancies between individuals' characteristics and individuals' standards or ideals for themselves deriving from larger social sex role norms.

As noted earlier, the theories of anorexia under consideration in this study may be distinguished from one another on the basis of their position on these two dimensions: object of identification and nature of posited incongruity. In the next section, these theories will be set forth in greater detail.

The psychoanalytic heritage.

The psychoanalytic position, which continues to be widely held in settings in which anorectics receive treatment, posits a violent, if unconscious, hatred of the maternal figure. Within this formulation, the would-be anorectic responds to the physical changes of adolescence with horror, and a determination to eliminate any clues that might link her to the despised fellowship of adult women:

> In the symbolic action of destroying the food, she destroyed her mother and her mother's breast, but equally she destroyed her own feminine body and breasts...The gratification of the wish to incorporate the desired object would have furthered her femininity...it would make her identification with

> the hatred mother manifest.
>
> (Benedek, 1936)

> The common element seems to be a wish to kill the incorporated mother by starving her out, and to kill and remove the fat, which is associated with the female form.
>
> (Falstein, et al.,1956)

> The anorectic girl...panics over her sensuality and feminine wishes. She tries to escape into a narcissistic sexless existence and live eternally in her bony substance.
>
> (Sours, 1979)

> Torn between her inability to be a boy and her dislike of being a girl, she bolstered up her confidence with a new ideal of sexuality... By denying 'dangerous' aspects of the outside world and repressing her drives, the patient eventually attained a state of the ego that was free from anxiety.
>
> (Thoma, 1967)

> An asexual ego ideal has developed.
>
> (Thoma, 1977)

Other writers emphasize the connection made by many anorectics beteen "fat" and "pregnancy". Repudiation of pregnancy wishes and a flight from feminine identification was cited as central in four case studies by Ceaser (1977). Blitzer (1961) has also reported on two cases in which the fat-pregnancy dynamic was particularly conspicuous. One of his patients reported that she was "scared to eat, because that would make me fat and I would get a baby that way"; another was concerned that her father wanted to "make her fat", which she couldn't understand "since he liked mother best and wouldn't want to marry me." Other clinicians, notably Meyer

and Weinroth (1957), have been impressed by the extent to which modifications in clinical history coincided with pregnancies among friends and relatives. Within this formulation, then, anorexia is seen as a particularly emphatic denial of pregnancy as the personification both of the hatred maternal role and of mature feminine sexuality.

Another common theme in the psychoanalytic literature on anorexia stresses the regressive component of the disorder, the assertion of sexual immaturity as a means of (re) capturing the dependent relationship of earlier years:

> The symptom-formation, as the major transference manifestation in the treatment procedure, represents a regressive flight from the inner dangers of genital heterosexuality to earlier developmental stages, of which the oral is the most crucial.
>
> (Jessner & Abse, 1960)

Meyer and Weinroth's (1957) position is typical of this formulation; claiming that the traditional emphasis on the revival of Oedipal conflicts is unfounded, they prefer to stress the pre-oedipal genesis and content of the disorder. Within this context, the anorectic solution is understood as part of a struggle to re-establish the mother-child unity characterized by Spitz as "non-differentiation". In agreement with Meyer and Weinroth, Gifford, et al., (1970) conclude that the sexual conflict, when present, "coincided with a threatened separation from the mother, symbolically or in reality."

Consistent with this view, Thielgaard (1956), whose analysis of the TAT protocols of large numbers of anorectic patients is

unique in the literature, has noted a tendency to identify with considerably younger persons which seems to be related to a dissociation from sexual matters. He also cites several instances in which figures in themes are described impersonally as "the person in question" or simply "it", as well as numerous examples of pronominal reversal with regard to gender.

Despite the apparent contradictions between these two perspectives, particularly with relation to the positiveness of the anorectic's attitude toward the maternal object, the common element should be clear. Regression to a more primitive level of development--the oral stage--implies a regression to a period of infantile existence prior to the psychosexual differentiation believed by Freud (1935) to occur during the phallic stage (with the child's awareness of anatomical genital differences between males and females). Thus, the basic notion of a rejection of age-appropriate sex-role identification remains constant, even with this modification of emphasis.

In fact, even a shift to an ego-analytic stance such as that taken by Selvini-Palazzoli (1965; 1978) does not moderate the significance accorded to negative perceptions of traditional femininity in the etiology of anorexia. In this view, fears of pregnancy are understood as representing more primitive fears of "being invaded by the object," and self-starvation is seen as a fight against the body waged simultaneously on two planes:

> (1) Because she considers it the concrete expression of the unacceptable part of herself (passive

> receptiveness), she attacks it as the source of her impotence and anxiety.
>
> (2) Because she considers it an all-powerful invader, she attacks it as an alien force.
>
> (Selvini-Palazzoli, 1978, p. 10)

To let the body grow fat, the author concludes, means giving passivity free rein, "submitting to the demands of an arrogant usurper". Anorexia represents "a rejection of those aspects of feminine corporeality that conjure up the terrifying vista of turning into a succubus and passive vessel", i.e., what many would agree constitutes a significant element of traditional feminine identification.

The feminist position.

The feminist perspective on anorexia, represented by a small but rapidly growing literature, differs sharply from the psychoanalytic position in its emphasis on the highly sex-typed nature of the anorectic syndrome. Boskind-Lodahl (1976), the major proponent of this position, describes the condition as symptomatic of an over-identification with the feminine role, as a desperate attempt by these women to conform to what they correctly perceive to be the socially agreed-upon definition of feminine achievement: physical attractiveness and success in heterosexual relationships (Bardwick, 1970; Douvan and Adelson, 1966). Far from rejecting the stereotype of femininity--that of the accomodating, passive, dependent woman--the vast majority of the 138 women studied by Boskind-Lodahl had never questioned their assumptions that wifehood,

motherhood, and intimacy with men were the fundamental components of femininity. For them, the obsessive pursuit of thinness represented not only an acceptance of this ideal but an exaggerated striving to achieve it. Their attempts to control their physical appearances were understood as demonstrating a disproportionate concern with pleasing others, particularly men, and a reliance on others to validate their sense of worth. Their lives had been devoted to "fulfilling the feminine role rather than the individual person (Boskind-Lodahl, 1976, p. 347).

Within the femininist formulation, then, an imbalance is posited between the potential anorectic's self-evaluation as "not woman enough" to attract or even deserve the love and attention she craves and her culturally-conditioned perception of what it will take to attain that goal. Moreover, anorexia is perceived as the culmination of a process which had its roots in an inordinately rigid childhood socialization and which has been schematized as follows:

CHILDHOOD

Powerless and Controlling Mother + "Hero" Father

Suffocating Demands for Conformity

Child who Defines Herself by Perceived Reactions of Others

ADOLESCENCE

Abnormally Low Self-Esteem and Need for Validation by Men

Adolescent Girl Ill-Equipped to Socialize with Men

Real or Perceived Rejections

Excessive Preoccupation with Appearance and Body

Intensified Feelings of Inadequacy + Fear of Men

Dieting Brings No Rewards

ANOREXIA

(Boskind-Lodahl, 1976)

When the expectations of these women of being desired and pursued by men do not materialize, they believe themselves to be undesirable, unattractive, and unworthy. These perceptions reinforce an already existing, pervasive sense of inadequacy, and fear of rejection--widely held to be a key element of female psychology (e.g., Douvan, 1970; Laws, 1979)--becomes a crucial motivating force. As a consequence, the compulsive pursuit of thinness

represents both a pathetic caricature of the social emphasis on slimness as the key to acceptance and a protective screen, a "wall of (imagined) fat" (Boskind-Lodahl, 1976) behind which they are safe from any confrontation that might further shatter their expectations and plunge them once again into the vicious cycle of self-contempt and renewed dieting. Lee (1973) supports this view: "There was an overwhelming preoccupation with weight and a tendency to view others according to their weight as a way of defending against fears of inadequacy and fear of rejection by others."

The "role strain" perspective.

A third perspective on anorexia represented in the literature is primarily addressed to the issue of incongruity rather than to the question of personal identification. This position, here termed the "role strain" perspective, sees anorexia as one response to the many and often conflicting demands placed on women in our culture. The admission of women into traditionally male preserves has, claim proponents of this theory, only served to intensify the pressure by creating a new ideal for feminine success: "super-woman". In today's world, women are expected to be beautiful, smart and well-groomed, and to devote a great deal of time to their personal appearances even while competing in business and the professions. They must have a career and yet be romantic, tender, and sweet, and in marriage play the parts of the ideal wife, mistress, and mother. In a word, they are expected to be androgynous. It would seem obvious, they claim, that the conflict

between so many apparently irreconcilable demands on her time, in a world where the male spirit of competition reigns supreme, exposes the modern woman to a terrible social ordeal.

Hilde Bruch, in an interview with People magazine (June 26, 1978), stressed the changes in societal expectations for women over the last two decades:

> During the '50's, it was acceptable to be a compliant, nice, sweet girl. If she was bright enough, and from the upper class, she was supposed to go to college and meet a nice Harvard man and settle down. Now this same girl goes to college to write a Ph.D. thesis and get a job in Washington.

Bruch notes that many of her patients express feeling overwhelmed by the vast number of subjectively obligatory opportunities available to them and the fear, in the face of too many choices, that they would not choose correctly. This perception of expanded options/ expectations may include not only the educational and occupational spheres, but personal and sexual freedoms as well. With the erosion of the "double-standard" precipitated by the women's movement, girls are "expected" to have heterosexual experiences at a much earlier age than before. Significantly, anorexia often develops after a film or lecture on sex education which emphasizes what one should be doing but is not yet ready to do (Selvini-Palazzoli, 1978). A particularly apt description to the demands of this period was provided by one anorectic patient, who cited for comparison the pressures a 40-year old executive might experience before he comes down with a heart attack. Within this formulation, then, anorexia is often perceived as the ideal

solution, the "no-choice".

Selvini-Palazzoli, also the subject of a recent interview (New York Review of Books, 1979), concurs with Bruch that the pressure on women--especially middle-class women--has never been greater:

> If the Victorian girl became a hysteric because of the stifling of her energies, the contemporary anorectic may retreat because of the demands made on them. And she is found most often in middle class than in working class families; that is where social and parental demands are strongest, where food has lost its primary value as something worked hard for and become part of the good behavior game.

In the following section, an experimental design will be presented for the investigation of the three theories described above.

CHAPTER II

PROPOSED RESEARCH

As indicated by the preceding review of the literature, the nature of sex-role identification among female anorectics has been the focus of much controversy. Nonetheless, despite both the relative availability of instruments which purport to measure masculinity and femininity, and the veritable explosion, within the last decade, of research on sex roles, no empirical study has ever addressed this issue. Using selected paper-and-pencil measures of sex-role identification and self-concept congruency, this study set out to answer two general questions: Can women with anorexia nervosa indeed be differentiated from normal controls on the basis of their performance on these measures? If so, do the differences that emerge provide support for either the psychoanalytic, feminist, or "role strain" perspectives described earlier?

McClelland and Watt (1968) have suggested that sex-role identification can best be measured on three levels. The most basic level might be labelled gender identity, an unconscious schema representing pride, confidence and security in one's membership in the male or female sex. The next level is sex role style, a more or less conscious level that is composed of the sex-typed attributes and roles that are defined as components of one's self-concept or self-presentation. The third, and most conscious level of sexual identity includes sex-typed likes, interests, and attitudes that

seem likely to be the product of specific cultures at specific times. These sex-typed likes, interests, and attitudes are usually expressed in terms of behavioral preferences or inclinations, and may or may not correspond to one's more self-attributions.

Consistent with McClelland and Watt (1968), instruments for this study were chosen to correspond to each of these levels of sex-role identification.

A secondary issue which the study proposes to address concerns the degree to which the "food restrictor" and "binger-purger" sub-types of anorectics differ with regard to sex-role identification. As noted earlier, the former group are continuously restrictive with regard to food intake, while in the "binger-purgers" or "bulimarectics" (e.g., Boskind-Lodahl, 1976), episodes of binge eating--almost always followed by self-induced vomiting or purgation to prevent food absorption--co-exist with the ubiquitous pattern of chronic dieting, overvaluation of subnormal weight and body image distortion. Although none of the theories under consideration in this study predict differing constellations of identification for these two sub-types, the decision to distinguish between the two groups was based on the finding of several influential reports (Beumont, et al., 1976; Beumont, 1977; Casper, et al., 1980; Garfinkel, et al., 1980; Russell, 1979; Strober, 1981) of important differences between non-bulimic anorectics and bulimarectics in premorbid history and in terms of psychiatric symptom complex. Especially significant for the purposes of this study is

the repeated finding of greater psychosexual immaturity among non-bulimic anorectics (Beumont et al, 1976; Beumont, 1977; Strober, 1981). For this reason, findings which bear on this issue will be specifically addressed.

CHAPTER III

METHOD

Subjects.

One hundred and seventeen women served as subjects in this study. Each woman was a member of either the experimental or control group. The experimental group consisted of 55 women with anorexia nervosa, subclassified according to their general pattern of dietary regulation and consummatory behavior as "self-starvers" (N = 19) and "binger-purgers" (N = 37). Assignment of subjects to these sub-categories was made on the basis of their responses to the "medical history" component of the demographic questionnaire (see Appendix I). In this section, respondents were asked to check which, if any, of the listed symptoms applied to them, as well as the "age of onset" and "duration" of these symptoms. Subjects who checked "anorexia nervosa (self-starvation)" were classified as "self-starvers"; subjects who indicated that both "bulimia (compulsive eating)" and "frequent vomiting" were current behaviors were classified as "binger-purgers." In the few cases where all three symptoms were checked, subjects were classified according to the pattern that characterized their current mode of dietary regulation, i.e., the symptom complex with the most recent age of onset.

Experimental subjects were obtained from a file of individuals who had contacted the Anorexia Nervosa Aid Society (ANAS) of Lincoln, Massachusetts, as well as through newspaper advertising

in the Amherst area. Sixty-two (62) women reporting no history of eating disorders served as controls. These subjects were obtained through telephone solicitation of University of Massachusetts students, as well as through convassing at a local apartment complex.

The average age of the subjects was 24.6 (s.d. = 6.1, range = 15 - 52). Sixty-seven percent of the subjects had never been married, 28% were married, and 5% were divorced or separated. Sixty-one percent (61%) of the subjects' fathers, and 47% of the subjects' mothers had completed college or graduate level training. Among the symptomatic subjects, the mean age of onset of the eating disturbance was 18.7 years (s.d. = 5.4, range = 11 - 40), while the mean duration of the disorder was 6.1 years (s.d. = 4.8, range = 1 - 20). The mean weights for the control, bulimic, and restricter groups were 124.8 (s.d. = 14.6), 116.1 (s.d. = 14.4), and 107.1 (s.d. = 18.3), respectively. A comprehensive breakdown of these sociodemographic variables by group appears in Tables 1 and 2.

Instruments

The Franck Drawing Completion Test.

A short version of the Franck Drawing Completion Test (Franck & Rosen, 1949) required subjects to complete each of eleven simple line drawings in whatever manner they wished. Performance on the FDCT, which appears in Appendix I, has generally appeared to be uncorrelated with scores on standard M-F scales (Lansky, 1960; 1964;

TABLE 1

Means and Standard Deviations

of Continuous Socio-demographic Variables

by Group

Variable	Anorectics (N=19) M	SD	Bulimarectics (N=37) M	SD	Controls (N=62) M	SD
Age	24.2	5.6	25.9	7.4	24.0	5.3
Height	64.3	2.7	64.8	1.9	64.7	2.7
Weight	107.1	18.3	116.1	14.4	124.8	14.6
Age of Onset	17.2	4.0	19.4	5.8	--	--
Duration of Symptoms	6.1	5.3	6.1	4.6	--	--

TABLE 2

Percentages of Qualitative Socio-demographic Variables by Group

Variable	Anorectics (N=19)	Bulimarectics (N=37)	Controls (N=62)
Marital Status			
Single	66.7	67.6	67.2
Married	22.2	29.7	27.9
Divorced/ Separated	11.1	2.7	4.9
Father's Highest Educational Level Attained			
Elementary	5.3	5.4	10.3
High School	36.8	29.7	31.0
University	47.4	43.2	31.0
Grad./ Professional	10.5	21.6	27.6
Mother's Highest Educational Level Attained			
Elementary	5.3	--	11.9
High School	52.6	51.4	40.7
University	31.6	45.9	30.5
Grad./ Professional	10.5	2.7	16.9

Shepler, 1951); there is some evidence that the FDCT assesses latent aspects of masculinity-femininity, particularly as related to body image (Franck & Rosen, 1949). In fact, as the only existing instrument designed specifically for this purpose, the FDCT has, despite questions regarding its validity, been used in hundreds of studies in the decades since it first appeared.

The ways in which the figures are differentially completed by males and females are believed to reflect both the function and structure of sex organs and body build, as well as impulses associated with sex-role identity. Where men tend to enlarge the stimulus--often by means of upward extension--and to close off stimulus areas, women tend to leave stimulus areas open or elaborate the area within the stimulus itself rather than expand it. This dimension of "closedness" versus "openness" is also reflected in the content of the drawings; men tend to draw protruding, "closed" objects (towers, tools, instruments) while women tend to draw many "open" objects (windows, vases, doors). Thes findings are strikingly similar to those obtained by Erikson (1941) in his observation of boys' and girls' play constructions.

According to Franck and Rosen, the "body image" projected on the test will correspond to physiological reality insofar as it is not surrounded and distorted by defensive measures. It follows, then, that their instrument is a measure of degree of acceptance of the individual's sex role.

The criteria for scoring the drawings, based on male-female

differences in drawing completion, have been described by Strodtbeck, Bezdek, and Goldhammer (1970). If the drawing is representational, it is scored as masculine or feminine according to three general principles: active versus passive, male role-related versus female role-related and symbolic versus realistic. If the content is non-representational or abstract, the four scoring criteria used are internal elaboration (feminine), roundness (feminine), angularity (masculine) and closure (masculine).

The Franck Drawing Completion Test has been scored reliably; reported interrater reliabilities have ranged from .66 to .93 (Franck and Rosen, 1949; Reed, 1957; Bieliauskas, Miranda, and Lansky, 1968; Fellows and Cerbus, 1969; Lipsitt and Lelos, 1972; Grant and Domino, 1976). No information is available on test-retest reliability. Validation of the measure comes from a large number of studies in which significant differences were reported between the FDCT scores obtained by males and females (Franck and Rosen, 1949; Shepler, 1951; Cottle, 1968; Cottle, Edwards and Pleck, 1970; Lipsitt and Lelos, 1972; LeLieuvre and Wise, 1974).

All drawings were coded by myself and another rater according to the criteria set forth by Strodtbeck, et al., (1970). Using non-experimental protocols, the raters achieved an inter-rater reliability of .90 before approaching the experimental protocols. This was computed as the percentage of total drawings on which an identical classification was made by both raters. Inter-rater reliabilities of .92 were obtained on the experimental protocols. In cases of disagreement, drawings were discussed and a joint

decision about scoring was reached.

Bem Sex Role Inventory.

The Bem Sex Role Inventory (Bem, 1974; see Appendix I) measures what could presumably be called sex-role style (Beckman, 1978). The BSRI requires a person to assess, on a 7-point scale, how well each of sixty masculine, feminine, or neutral personality characteristics describes him/herself. The scale ranges from 1 ("Never or almost never true") to 7 ("Always or almost always true"). Since the BSRI was based on the conception of a sex-typed person as someone who has internalized societal standards of desirable behavior for men and women, the adjectives were initially selected as masculine or feminine on the basis of sex-typed social desirability (as judged by college students), and not on the basis of differential endorsement by males and females.

The main content themes for masculinity concern a "dominant-instrumental dimension comprised of themes of social-intellectual ascendancy, autonomy and orientation toward risk". For femininity, the themes concern "a nurturant-expressive dimension containing themes of nurturance, affiliative-expressive concerns, and self-subordination (Berzins, Welling, & Wetter, 1978)."

The BSRI is one of the few inventories that does not assume that masculinity and femininity are bipolar end points on a uni-dimensional scale. Rather it is multi-dimensional and provides indices of androgyny and masculinity, as well as the usual femininity score. Respondents may also be classified as "undiffer-

entiated", i.e., having scores below the median on both masculinity and femininity.

Test-retest reliabilities on the BSRI have been reported as: masculinity = .90; femininity = .90; androgyny = .93 and social desirability = .89 (Bem, 1974). Internal consistency, as estimated by coefficient alpha, has been obtained for two groups of college students (N = 723 and N = 194). The results for the two groups, respectively, were: Masculinity = .86 and .86; femininity = .80 and .82; androgyny = .85 and .86; and social desirability = .75 and .80 (Bem, 1974). Tetenbaum (1977) also estimated the internal consistency of the scales. Using the responses from 400 females, he calculated an alpha coefficient of .89 for the masculinity scale and .79 for the femininity scale.

Validity, as determined by significant sex differences on the masculinity and femininity BSRI scales, has been demonstrated by Bem (1974) and substantiated by other studies (e.g., Deutsch and Gilbert, 1976; Gaudreau, 1977; Hoffman and Fidell, 1977; Minnigerode, 1976). Other studies (e.g., Gaudreau, 1975; O'Leary, 1977; Nicoll and Bryson, 1977) have contributed evidence regarding the construct validity of the instrument.

In this study, the instructions accompanying the inventory were somewhat varied, from those more commonly applied, as subjects were asked to respond to forms labelled "self" and "ideal self". Precedents for this variation may be found in several prior studies (Deutsch and Gilbert, 1976; Watson, 1977) in which an "ideal self" component was introduced.

The PRF ANDRO.

The PRF Andro Scale (Berzins, Welling, and Wetter, 1978) served as the primary measure of sex-typed likes, interests and attitudes, i.e., conscious femininity. This instrument (contained in Appendix I), consists of fifty-six statements, twenty-nine items on the masculine scale and twenty-seven items on the feminine scale. Items were selected as masculine or feminine on the basis of judged social desirability, and not on the basis of differential endorsement by males and females. As is the case with the BSRI, the masculine items related to "social and intellectual ascendancy, autonomy and orientation toward risk"; the feminine items relate to "nurturance, affiliative-expressive concerns, and self-subordination". Items are phrased in terms of behaviors (e.g., "When I see someone who looks confused, I usually ask if I can be of any assiatance"), attitudes ("To love and be loved is of great importance to me") and preferences. For each statement, respondents are asked to indicate whether the statement is true or false as it applies to them.

Four sex role categories are obtained from scores on the masculinity and femininity scales. Persons who are high on both masculinity and femininity are classed as androgynous; persons who are high on masculinity and low on femininity are classified as "masculine-typed"; persons who are high on femininity and low on masculinity are classified as "feminine-typed"; and persons who are low on both scales are classified as "undifferentiated".

Internal consistency coefficients (alpha) were estimated from

seven diferent samples. For the masculinity scale, coefficients ranged from .68 to .79. For the femininity scale, coefficients ranged from .65 to .70 (Berzins, Welling and Wetter, 1977). Test-retest reliability was found to be .81 for both masculinity and femininity scales.

Correlations of the masculinity and femininity sub-scales of the PRF Andro and the BSRI (Berzins, Welling, and Wetter, 1978) yielded the following results: For women, correlations were .50 on the femininity scales and .65 for the masculinity scales. For men, the correlations were .60 on the masculinity scales and .52 on the femininity scales. These findings are consistent with those of Grayton, et al., (1977).

Demographic Questionnaire.

Variables selected for this questionnaire (See Appendix I) included those with known or potential effects on sex-typing and sex role-related attitudes and preferences. Other questions ascertained the current age of the subject, age at onset of anorexia and pattern of weight control (i.e., restriction of intake only, or bulimic episodes followed by purgation).

Procedure.

Packets containing the 7-page questionnaire (with order of presentation counterbalanced within groups) were sent, along with a cover letter, to 175 individuals whose names were obtained from the files of the Anorexia Nervosa Aid Society (See Appendix I, Form 1A). The actual percentage of anorectics and bulimarectics

among the group was unknown; unfortunately the files did not distinguish between persons having an eating disorder, and others who called the organization seeking information for friends, or for research purposes. Prospective participants were informed that the study before them was an effort to explore differences in "feelings and self-perceptions" between women who did/did not suffer from eating disorders. A stamped, self-addressed return envelope was included. Of the 175 packets sent out, 30% (53) were returned by individuals identifying themselves as anorectic or bulimarectic. Of these, 5 male respondents were discarded. An additional seven (7) individuals were recruited through an advertisement which appeared in the Valley Advocate. These individuals received an identical packet of materials with the exception of a slightly modified cover letter (See Appendix I, Form 1B).

Control subjects were obtained through telephone solicitation of University of Massachusetts students, as well as through door-to-door convassing at a local apartment complex. Of the 77 questionnaires completed by this group, 15 were discarded when a review of the personal information included on the demographic questionnaire indicated that the respondent's weight exceeded norms for her height by 25% or more. This elimination was based on the assumption that persons who are extremely overweight may accurately be classed as having an "eating disorder", and were thus ineligible for the study.

All returned questionnaires were coded by one of three coders blind to the experimental condition.

PREDICTED OUTCOMES

Each theory of anorexia being reviewed in this study has a unique set of predicted outcomes which are directly derived from the theory and which would be considered critical to its validation. A summary of these predictions follows:

The psychoanlaytic position.

The theory, with its emphasis on "rejection of feminine identification" and establishment of an "asexual ego ideal," would generate the following predictions:

(1) Anorectics will obtain significantly lower femininity scores than non-anorectics on the FDCT.

(2) Anorectics will obtain significantly lower femininity scores on the "ideal self" components than on the "real self" components of the BSRI and the PRF Andro.

(3) This discrepancy (#2) will exceed, to a significant degree, discrepancies of a similar nature obtained by the non-anorectic subjects.

(4) Anorectics will obtain significantly lower scores than non-anorectics on both masculinity and femininity sub-scales on the "ideal self"

components of the BSRI and the PRF Andro.

(Note: the combined presence of low scores on both masculinity and femininity scales would correspond to a rating as "undifferentiated").

Given the general psychoanalytic preference for measures of unconscious phenomena, those of the analytic community would probably tend to rely most heavily on findings from the FDCT.

The feminist position.

This theory, with its emphasis on overidentfication with and idealization of the traditional feminine role, would generate the following predictions:

(1) Anorectics will obtain significantly higher femininity scores than non-anorectics on the FDCT.

(2) Anorectics will obtain significantly higher femininity scores on the "ideal self" components than on the "real self" components of the BSRI and the PRF Andro.

(3) This discrepancy (#2) will exceed, to a significant degree, discrepancies of a similar nature obtained by non-anorectic subjects.

The "role strain" position.

This theory, with its emphasis on the potentially baneful effects of a perceived pressure to be androgynous, would generate the following predictions:

(1) Anorectics will obtain significantly higher androgyny scores on the "ideal self" components than on the "real self" components of the BSRI and the PRF Andro.

(2) This discrepancy (#1) will exceed, to a significant degree, discrepancies of a similar nature obtained by the non-anorectic subjects.

CHAPTER IV

RESULTS

The sample.

One-way analyses of variance were performed to detect differences between the control, non-bulimic anorectic, and bulimarectic groups on the continuous demographic variables. No significant differences were found between the three groups with respect to age (F = 1.06, d.f. = 2,113, p = .35), or height (F = .31, d.f. = 2,114, p = .73). The groups did, however, differ significantly with respect to weight (F = 10.71, d.f. = 2,111, p = .0001). Subsequent Neuman-Keuls analyses revealed that control subjects were significantly heavier than both non-bulimic anorectics and bulimarectics ($p < .05$). Moreover, bulimarectics were significantly heavier than non-bulimic anorectics ($p < .05$).

Among the symptomatic subjects, the two sub-groups did not differ with respect to age of onset (F = 2.2, d.f. = 1,53, p = .14) or duration of eating disorder (F = .004, d.f. = 1,52, p = .95). Parental income, the final continuous variable, was discarded from the analysis due to the small percentage of subjects completing this question.

Chi square tests were performed to detect differences between the three groups on the discontinuous variables. No differences were found with respect to marital status (χ^2 = 1.9, d.f. = 4,

p = .75), father's educational level (χ^2 = 4.4, d.f. = 6, p = .62), or mother's educational level (χ^2 = 11.19, d.f. = 6, p = .08). The variable corresponding to "highest educational level attained" by the respondent had to be eliminated from the analysis due to the high percentage of subjects who misinterpreted this question.

Real self concept: Masculinity, femininity, and androgyny.

Three different masculinity-femininity instruments were used in the present study because it was believed that the various scales measured different aspects or levels of masculinity and femininity. Unless otherwise noted, the appellation BSRI will be used to refer to the standard (i.e., Real Self) form of this instrument.

Correlations between the measures were obtained separately for the non-bulimic anorectic, bulimarectic and control subjects. As expected, correlations between the masculine sub-scales of the BSRI and the PRF-Andro were high, ranging from .53 ($p < .001$) to .74 ($p < .001$). Correlations between the feminine sub-scales of these two measures yielded moderate to high correlations for the control (r = .42, p .001) and bulimarectic subjects (r = .64, $p < .001$) only. No significant relationship between the measures was obtained for the non-bulimic anorectic subjects (r = -.06, p = .41). Also as expected, correlations between the masculine and feminine sub-scales were weak on both the BSRI (r = .16, p = .029) and the PRF-ANDRO (r = .02, p = .47), lending further support to the notion that masculinity and femininity exist as independent dimensions.

Correlations between the FDCT (which yields a "feminine" score) and the feminine sub-scales of the BSRI and PRF-Andro were generally low, and failed to reach statistical significance. A notable exception to this pattern, however, was the moderate correlation obtained -- for control subjects only -- between the FDCT and the feminine sub-scale of the BSRI ($r = .41$, $p < .001$).

Data regarding masculinity and femininity, which are presented in Table 3, were analyzed through analyses of variance and subsequent Neuman-Keuls post hoc comparisons. All analyses were conducted initially by group (i.e., controls vs. an "experimental" group consisting of both non-bulimic anorectic and bulimarectic subjects) and secondarily by symptom complex (controls vs. bulimarectics vs. non-bulimic anorectics) in order to elicit potential differences between subjects with varying patterns of dietary regulation.

No significant group differences were found on either scale of the PRF-ANDRO, considered to be a measure of sex-typed likes, interests and attitudes, or on the FDCT. While non-bulimic anorectics appeared somewhat more masculine on the FDCT than did the controls (as predicted by the psychoanalytic hypothesis), the two groups did not differ significantly on this assumed measure of unconscious gender identity. There was a slight, but nonsignificant, tendency for bulimarectic subjects to respond in a more feminine manner on this measure than did non-bulimic anorectics ($p < .10$).

TABLE 3

Means and Standard Deviations of Sex Role Variables by Group

	Non-bulimic Anorectics		Bulimarectics		Controls	
	M	SD	M	SD	M	SD
Unconscious Gender Identity[a]	5.24	2.08	6.47	2.00	5.86	1.56
Conscious Preferences and Attitudes[b]						
Masculinity	13.16	5.43	14.37	5.21	14.23	4.79
Femininity	17.89	2.71	17.63	3.62	16.86	3.7
Sex Role Style:[c] Real Self						
Masculinity	4.04	1.12	4.53	.91	4.80	.80
Femininity	4.86	.53	4.98	.61	5.08	.52
Sex Role Style:[c] Ideal Self						
Masculinity	5.08	1.09	5.58	.61	5.48	.56
Femininity	5.05	.58	5.05	.41	5.13	.59

[a] Franck Drawing Completion Test, femininity Score

[b] PRF-ANDRO

[c] BEM Sex Role Inventory

On the feminine sub-scale of the BSRI, no significant differences were found either by group or by symptom complex. On the masculine sub-scale, however, one-way analysis of variance revealed that the experimental group reported significantly fewer masculine characteristics on this measure of sex-role style than did the controls ($F = 6.719$, $p < .01$). Analysis by symptom further revealed that masculine scale scores were a significant source of differences between the three groups ($F = 5.32$, d.f. = , $p = .006$). Subsequent Neuman-Keuls comparisons demonstrated that the depression in masculine scale scores was especially prominent among the non-bulimic anorectics, significantly differentiating them from the controls ($p < .05$). There was a slight tendency for bulimarectic subjects to report more masculine characteristics on this measure than did non-bulimic anorectics, although this difference failed to attain statistical significance ($p < .10$).

Since it has recently been suggested that only persons high on both masculinity and femininity on the BSRI (rather than persons who fairly equally endorse masculine and feminine items) should be characterized as androgynous (Bem, 1977; Spence, Helmreich & Stapp, 1975), sex-role classifications were assigned on the basis of a full sample median split rather than by the subtractive method originally proposed by Bem (1974). This process yielded a four-fold classification of subjects as either masculine-typed (high masculine-low feminine), feminine-typed (high feminine-low masculine), and androgynous (high feminine-high masculine) or

undifferentiated (low feminine-low masculine). (See Table 4) Experimental subjects were more likely to fall into the "undifferentiated" category than were the controls ($Z = 2.42$, $p < .01$); they were also somewhat less likely to be androgynous than were the controls ($Z = 1.42$, $p < .08$). When analyzed according to symptom complex, non-bulimic anorectics were significantly more likely to fall into the "undifferentiated" category than were the controls (53% versus 18%, $Z = 3.04$, $p < .001$); they were also somewhat more likely than the bulimarectics to be undifferentiated (53% versus 31%, $Z = 1.57$, $p < .06$).

Ideal self-concept and the discrepancy score.

All subjects were asked to complete the Bem Sex Role Inventory twice, once on a form labelled "Self" and again on a form labelled "Ideal Self" (see Table 2). Correlations between "real self" scores and "ideal self" scores were .48 for masculinity ($p < .001$) and .56 for femininity ($p < .001$). No significant differences were obtained on either the "masculine" or "feminine" sub-scales of the "Ideal Self" measure when data were analyzed by group (masculine: $F = .164$, d.f. $= 1,103$, $p = .68$; feminine: $F = .592$, d.f. $= 1,103$, $p = .44$) or by symptom (masculine: $F = .290$, d.f. $= 2,102$, $p = .059$; feminine: $F = .295$, d.f. $= 2,102$, $p = .75$).

Discrepancy scores were calculated for each subject separately for the masculine and feminine dimensions. These scores were obtained by subtracting the "ideal self" rating from the "real self" rating. Thus, for example, a mean feminine discrepancy score with

TABLE 4

Sex Role Orientation (SRO) by Group

SRO	Anorectics	Percent	Bulimarectics	Percent	Controls	Percent
Feminine	3	16	10	28	13	21
Masculine	2	11	7	19	16	26
Androgynous	4	21	8	22	21	34
Undifferentiated	10	53	11	31	11	18
TOTAL	19	101	36	100	61	99

a negative valence suggests that the average respondent in that group experiences herself as having fewer "feminine" attributes than she aspires to possess. The finding of a significant negative valence among the symptomatic groups would be consistent with the feminist hypothesis of anorexia and related eating disorders. The finding of a significant positive valence among these groups, indicating that the average respondent aspires to manifest fewer "feminine" attributes than she perceives herself as having, would be consistent with the psychoanalytic hypothesis.

On the feminine sub-scales, t-tests for correlated means failed to yield a significant real-ideal discrepancy for either the controls ($\bar{X}$ = -.054, t = -.90, df = 57, p = .37) or the experimental group ($\bar{X}$ = -.163, t = -1.97, df = 46, p = .055). (See Figure 1) When the data were re-analyzed by symptom, however, non-bulimic anorectics were found to have a significant feminine discrepancy score ($\bar{X}$ = -.303, t = -.228, df = 14, p = .039), while the bulimarectic subjects failed to manifest a significant discrepancy between their real and idealized feminine selves ($\bar{X}$ = -.098, t = -.94, df = 31, p = .353). Using Cohen's (1977) "d" as a measure of effect size, the feminine discrepancy in non-bulimic anorectics was found to be .55, described by Cohen as within the range of a "medium" effect.

Having calculated the significance of real-ideal discrepancies within each group, further analyses were conducted to determine whether the groups could be differentiated from each other according

Fig. 1. Comparison of "real self" and "ideal self" BSRI femininity scores as a function of group membership.

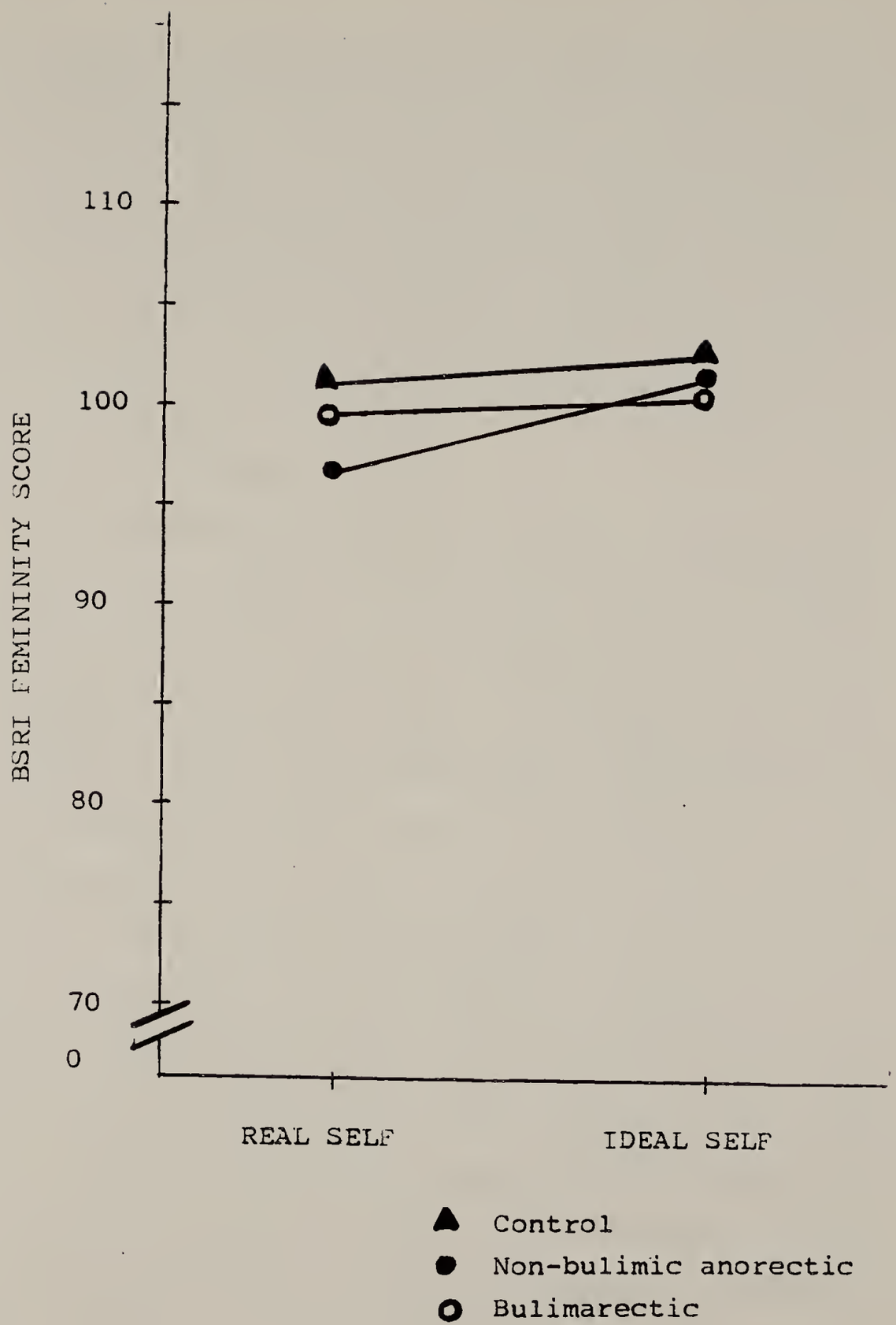
BSRI FEMININITY SCORE
110
100
90
80
70
0
REAL SELF
IDEAL SELF
Control
Non-bulimic anorectic
Bulimarectic

Figure 1

to the magnitude of those discrepancies. Magnitude of discrepancy was defined simply as the absolute value of the mean discrepancy score for each group. (As all means had a negative valence, no information about direction of discrepancy was sacrificed in this analysis). No significant differences in magnitude of feminine discrepancy were found when the data was analyzed by group ($\bar{X}$ = -1.09, t = 1.07, df = 87, p = .29), or by symptom complex (F = 1.42, df = 2,98, p = .246).

On the masculine sub-scales, t-tests for correlated means revealed highly significant real-ideal discrepancies among both control subjects ($\bar{X}$ = -.691, t = -7.32, df = 57, $p < .001$), and experimental subjects ($\bar{X}$ = 1.08, t = -7.94, df = 46, $p < .001$). See Figure 2. Analysis by symptom further demonstrated that both non-bulimic anorectics ($\bar{X}$ = -1.053, t = -4.35, df = 14, p = .001), and bulimarectics ($\bar{X}$ = -1.093, t = -6.56, df = 31, $p < .001$) manifested this highly significant discrepancy on the masculine dimension. Cohen's (1977) effect size was computed at .94 and 1.4 for the non-bulimic anorectics and bulimarectics, respectively, both significantly exceeding Cohen's cut-off point (.80) for a "large" effect size. It should be noted that, among the non-bulimic anorectics, the masculine discrepancy effect size of .94 was just less than twice the effect size obtained for the feminine discrepancy (see above).

T-tests of independent means, performed to differentiate between the control and experimental groups on the basis of magnitude

Fig. 2. Comparison of "real Self" and "ideal self" BSRI masculinity scores as a function of group membership.

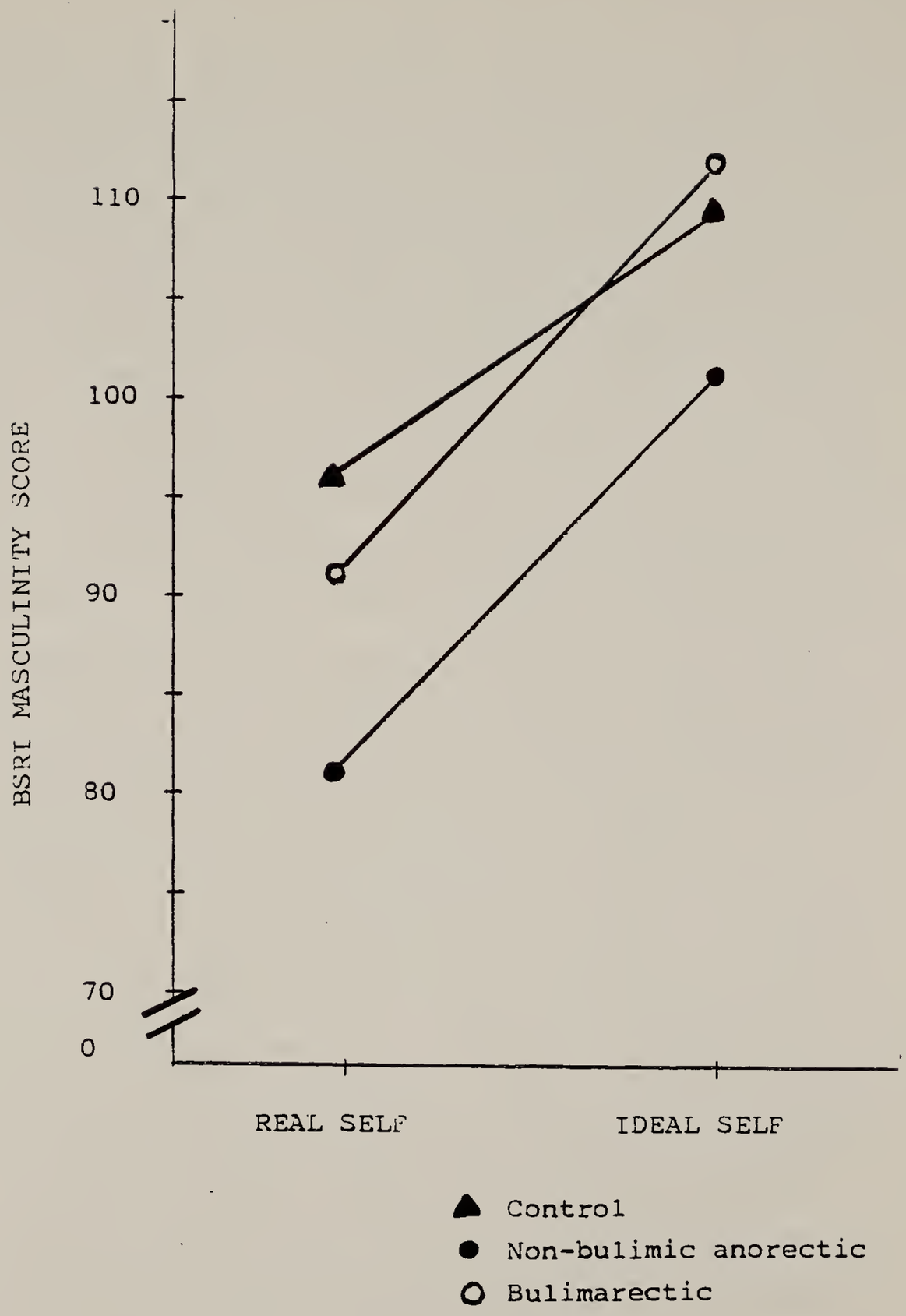
BSRI MASCULINITY SCORE
110
100
90
80
70
0
REAL SELF
IDEAL SELF
Control
Non-bulimic anorectic
Bulimarectic

Figure 2

of masculine discrepancy, revealed significantly larger discrepancies among the experimental group ($\bar{X}$ = .39, t = -2.35, df = 85, p = .02). When analyzed by symptom, differences between the controls, non-bulimic anorectics, and bulimarectics narrowly missed significance (F = 2.9, df = 2,98, p = .059). Subsequent Neuman Keuls post hoc comparisons performed at an alpha level of .05 failed to detect significant differences between the three groups. The fact that non-bulimic anorectics and bulimarectics were found to significantly surpass the controls in magnitude of masculine discrepancy when their data were collapsed together, but that such differences could not be demonstrated when their data were analyzed separately, suggests that the latter finding is an artifact of the diminished power which results from splitting the already small symptomatic sample who provided the requisite information (N = 45).

In order to clarify and supplement the results of the previous analyses (which dealt only with shifts toward greater or lesser "masculinity" and "femininity" on the "ideal self" measure, a median split was used to classify each subject as either masculine-typed, feminine-typed, androgynous, or undifferentiated on both their "real" and "ideal" selves. As in previous analyses, medians were calculated from the scores of the total population included in this study who completed the requisite information (N = 110 for "real self"; N = 105 for "ideal self"). The medians used were as follows: Masculine (real) = 92.25; Feminine (real) = 101.5, Masculine (ideal) = 111.12; Feminine (ideal) = 103.37.

After being classified in this manner, subjects were grouped into one of five categories according to the pattern of discrepancy manifested. Three of these categories corresponded to the psychoanalytic, feminist, and role strain theories, i.e., to the patterns of real-ideal classification they suggested. For example, subjects who were classified as "feminine-typed" on the basis of a median split of their "real self" scores, but whose "ideal self" scores yielded a classification of "masculine-typed" or "undifferentiated" were seen as exemplifying the rejection of feminine identification intrinsic to a psychoanalytic theory of eating disorders. The second category included subjects whose comparative classifications suggested the idealization of the feminine role cited by feminist theorists of anorexia nervosa (i.e., subjects whose "real self" classification was non-feminine, but whose "ideal self" classification was "feminine-typed). Likewise, the third category, corresponding to the role strain theory, included subjects whose non-androgynous "real self" classification was replaced by an "ideal self" classification as "androgynous". The fourth category consisted of subjects whose pattern of real-ideal classification yielded discrepancies other than those suggested by the three theories. A final category was made up of subjects who could be described as manifesting no discrepancy, i.e., they were assigned the same classification on both their real and idealized selves.

T-tests for the difference between proportions were used to determine whether symptomatic subjects significantly outnumbered

control subjects in any of these categories (notably categories 1 - 3). No significant differences were found in any category, a finding which casts serious doubt on the usefulness of any of the theoretically predicted configurations in differentiating between persons with and without an eating disorder. Moreover, symptomatic subjects appeared to be randomly distributed across the five categories (the proportions were .12, .16, .20, .22, and .29 for categories one through five, respectively), suggesting that none of the patterns of real-ideal discrepancy presented by the three theories may be considered a modal pattern among anorectics.

Patterns of conscious and unconscious masculinity-femininity.

Although it would appear from the initial analysis that masculine identification--either of a conscious or unconscious nature--was not significantly greater among the experimental group than among the controls, it was decided to examine the patterning of conscious and unconscious identifications within each woman in the sample in order to further assess the extent of sex-role conflict in women with anorexia nervosa. Moreover, this analysis was viewed as critical to the evaluation of psychoanalytic theories of the disorder in which an "unconscious" masculine identification is seen as a hallmark of the anorectic female. Precedence for this type of analysis may be found in Beckman's (1973) study of alcoholic women, another group in which pathology has been attributed to sex-role conflict in the form of "unconscious" masculine tendencies.

In the present study, median splits of the BSRI and the FDCT

were used to assign subjects to one of eight categories (corresponding to the number of possible combinations of 4 conscious classifications and 2 unconscious classifications). The eight categories derived were as follows: (1) consciously feminine-typed/unconsciously feminine, (2) consciously masculine-typed/unconsciously feminine, (3) consciously androgynous/unconsciously feminine, (4) consciously undifferentiated/unconsciously feminine, (5) consciously feminine-typed/unconsciously masculine, (6) consciously masculine-typed/unconsciously masculine, (7) consciously androgynous/unconsciously masculine, (8) consciously undifferentiated/unconsciously masculine.

A chi-square test was performed to determine whether the distribution of symptomatic subjects across the eight categories differed significantly from the distribution of control subjects. (The small number of subjects in each cell was the reason for combining non-bulimic anorectics with bulimarectics for this analysis). No significant difference was found between the two distributions (χ^2 = .082, $p > .05$).

T-tests for the difference between proportions were then performed to address several questions directly relevant to the psychoanlaytic hypotheses. Symptomatic subjects were found to have no more conscious-unconscious conflict of all types than did the control subjects (Z = .625, p = .26); nor was the former group over-represented in the conflict category corresponding to conscious femininity-unconscious masculinity (Z = 1.0, p = .16). The

possibility must be kept in mind, however, that the failure to detect significant differences on these variables may be an artifact of the diminished power resulting from dividing the sample into sixteen cells.

The relationship of age variables to sex-role variables.

The notion that one or another pattern of sex-role identifications and/or conflict might be uniquely associated with women who develop anorexia nervosa at a particular developmental phase is one that is conspicuously absent from the theoretical literature. To investigate this possibility, correlations were calculated between age at onset of the eating disorder and all other sex-role variables. No support was found for the existence of a systematic relationship between age of onset and sex-role identification, conscious or unconscious (all r's $\geq$ .15; all p's $\geq$ .15). Correlations between subjects' current age and other sex-role variables also failed to achieve significance (all r's $\geq$ .15; all p's $\geq$ .15), with the notable exception of the two "masculinity" variables.

The correlation between age and the BSRI "masculine" score was found to be -.303 (p = .012); the correlation between age and the PRF-Andro "masculine score" was -.304 (p = .013). The most likely explanation for the strong negative correlation between age and the perceived presence of stereotypically masculine attributes and preferences appears to be the steady liberalization over the last several decades of attitudes towards women in non-traditional

roles. Thus, the older the respondent, the less likely it is that she was socialized to express and develop aspects of herself considered inappropriate for, or disruptive of, the execution of feminine role-related activities (i.e., "masculine" qualities).

CHAPTER V

DISCUSSION

Empirical support for the hypotheses.

The absence of statistically significant differences in either feminine self-concept (conscious or unconscious) or magnitude of feminine discrepancy between the control and symptomatic groups, coupled with the finding of significant differences in masculine self-concept and discrepancy on the BSRI, calls into question the emphasis placed by both psychoanalytic and feminist theorists on deviations in feminine identification in the ontogeny of anorexia nervosa. Moreover, in suggesting that it is the perceived shortage of attributes traditionally associated with the "masculine" role that may be the more critical feature in the disorder (as evidenced by the repeated finding of larger effect sizes for all masculine variables), these results may be seen as providing at least preliminary support for a "role strain" theory in which women, responding to a new societal ideal of female success, feel obligated to acquire or demonstrate a host of "masculine" attributes for which their natural socialization had ill-prepared them. The results of this study suggest that this strain may be particularly severe for non-bulimic anorectics, for whom the combined presence of significantly lower initial (i.e., "real self") masculinity scores and somewhat depressed femininity scores means that they have a "longer way to go", so to speak, to attain the levels of masculinity and femininity commonly held as ideal by all three groups.

The unanticipated finding that "masculinity", rather than "femininity" may distinguish eating-disordered individuals from normals is, in fact, also consistent with the emphasis placed by Bruch (1973; 1979) and others (e.g., Selvini-Palazzoli, 1978; Casper et al., 1980) on the etiological significance of low self-esteem and feelings of ineffectiveness in anorexia, an emphasis which found empirical support in Garner's (1975) report of greater externality among anorectics on traditional measures of locus of control. Masculinity, as measured by such instruments as the BSRI and PRF-ANDRO, has been repeatedly correlated with general self-esteem (Antill & Cunningham, 1979; Colten, 1978; Eiseman, 1970; Garnets, 1978; Kelly & Worrell, 1977; Puglisi, 1978; Schiff & Koopman, 1978), as well as with greater internality and sense of efficacy and control over life events (Colten, 1978; Minor, 1976; Saltaformaggio, 1979). At least two authors have, in fact, suggested that the masculine sub-scale of the BSRI is basically interchangeable with traditional measures of locus of control (Gaudreau, 1975; Minor, 1976). Thus, the depressed masculinity scores found among the symptomatic subjects may be seen as reflecting what Bruch (1965, 1970, 1973) had noted long ago: an overwhelming sense of interpersonal powerlessness that is simultaneously challenged and defended against by ruthless manipulation of the body and its functions.

Finally, the fact that group differences emerged on the BSRI, but not on the more behaviorally-oriented PRF-ANDRO, suggests that

a distinctive pattern of self-attributions, rather than actual behavioral differences, may be the critical factor which differentiates eating-disordered individuals from controls. This finding is, in fact, congruent with Bruch's (1963, 1970, 1973) consistent efforts to shift the diagnostic criteria for anorexia away from those which depend on somatic or behavioral manifestations, and towards those which depend upon a constellation of disturbed psychological perceptions regarding the self (see p. 2).

Other findings.

The finding of a general pattern of psychosexual "undifferentiation" among the symptomatic groups is consistent with Beckman's (1978) suggestion that women with psychiatric disorders see themselves as lacking highly distinctive traits. It is also consistent with numerous reports linking degree of "undifferentiation" with various indices of psychological maladjustment: low self-esteem (Bem, 1977; Wetter, 1975), introversion, neuroticism (Hoffman & Fidell, 1979) and deficits in adaptive responses to social situations relevant to psychological adjustment (Kelly, O'Brien, Hosford, & Kinsinger, 1976). Moreover, the finding of a significantly greater number of "undifferentiated" individuals among the non-bulimic anorectics supports previous reports of greater psychosexual immaturity among this group when compared with bulimarectics (Beumont, George, and Smart, 1976; Beumont, 1977; Strober, 1981). Finally, the finding that non-bulimic anorectics were more likely than bulimarectics to manifest the

previously described depression in masculine scale scores is consistent with previous reports (e.g., Sours, 1980) that the latter group is less dominated by passive wishes, having exercised greater assertiveness and independence throughout their developmental history.

Issues in interpretation: Limitations of the findings and suggestions for future research.

For several reasons, the conclusions of this study must be interpreted with caution. The relatively small number of subjects in each of the symptomatic groups (and particularly among the non-bulimic anorectics) may have prevented other potentially important differences from reaching statistical significance. Moreover, the self-assignment of subjects to the two symptomatic groups may have resulted in the inclusion of individuals who might not have qualified as "anorectic" or "bulimarectic" had some objective diagnostic instrument, e.g., the Garner Eating Attitudes Test, 1979, been used to validate the presence of an eating disorder. Future studies might take advantage of this relatively new measure to correlate the degree of anorectic symptomatology (as indicated by the E.A.T. score) with sex role variables.

The fact that the participants in this study were, at least by self-description, symptomatic at the time they completed the questionnaires, limits our ability to make anything more than inferences about the causal or etiological significance of the findings. Specifically, the finding of greater perceived powerlessness among the experimental subjects may be equally interpret-

able as a consequence of a debilitating and seemingly incontrollable obsession with food and weight as it can as an antecedent of such an obsession. This is particularly true since the typical subject in this investigation, with an average of six years symptom duration, would be classified as "chronic" (Levenkron, 1982), a category reserved for individuals whose sense of desperation, cognitive and emotional rigidity have become so much a part of their personalities as to be refractory to most forms of treatment. It is even conceivable that some third variable, e.g., parenting style, was responsible for both the perceived helplessness and the anorexia.

These are, of course, frequently cited limitations of all observational designs in which a subject variable, i.e., a pre-existing (and thus uncontrolled) characteristic of the subject, is employed as an independent variable (see Wood, 1981, pp. 50-51). In the present study, subjects were divided into groups on the basis of the pre-existing presence or absence of an eating disorder; they were not, for obvious reasons, randomly assigned to "control" or "treatment" groups in which the induction of an eating disorder was an experimental manipulation. However, any time we obtain differences on the basis of a subject variable (such as pre-existing symptomatology), it is difficult, if not impossible, to reach a cause-effect conclusion because we cannot select just one subject variable. In this case, anorectics and controls may have differed on any number of characteristics which might account for differences in sex role identification.

Future research might begin to clarify the relationship

between pre-existing personality states and the evolution of psychopathological attitudes toward food/weight by developing a typology of individuals considered "at risk" for anorexia nervosa and following them longitudinally. [Cf. Chapman, et al.'s, (1980) work in identifying adolescents at risk for psychosis]. In this way, the relative strengths of numerous variables (including perceived powerlessness) in predicting the subsequent development of an eating disorder might be assessed. Other efforts to elucidate this relationship might involve in-depth interviews and personality assessment at a much earlier point in the illness than was possible in this study, before the psychological effects of chronicity became indistinguishable from pre-morbid functioning.

A further limitation of this study is its inability to claim that the results were uniquely related to victims of anorexia nervosa, differentiating this group from other individuals whose lives are impeded by any number of psychological or even physical handicaps. Beckman (1978), for example, found similar depressions in masculine scale scores in her sample of alcoholic women. Future research might explore sex role-related issues in these groups, once again with the goal of distinguishing pre-morbid and presumably pathogenic patterns of cognitions/emotions from those which are the by-products of disability.

The preponderance of subjects whose eating disorder first became manifest in middle to late adolescence further restricts the generalizability of the findings, limiting the conclusions that can be drawn about the vast numbers of girls who develop

anorexia nervosa with the onset of puberty or even before. Would their masculinity scores have indicated the same degree of perceived powerlessness as those of their older counterparts? And, even if they had, can we assume that the sense of personal inefficacy felt by a 12- or 13-year old is in response to the same set of environmental stimuli to which an older adolescent or middle-aged woman is responding? It might be hypothesized that the overwhelming sense of ineffectiveness experienced by the women who participated in this study results from the superimposition upon an already frail ego structure of the set of social and political realities governing and restricting the roles of women in contemporary society. Similarly, it might be argued that, for younger anorectics, a restrictive or psychologically oppressive familial environment is the most salient factor in inducing a sense of personal powerlessness. Future studies, potentially involving in-depth interviews, might assess the unique constellation of realities to which anorectics at varying developmental levels are responding.

The limited explanatory power of instruments, such as the PRF-ANDRO and the BSRI, which lack an open-ended component, is just one of a number of measurement issues which may limit the conclusions of this study. Another of these involves the degree to which the instruments used were able to tap into the theoretical constructs being measured. This question becomes an especially thorny one when, as in the case of this study, psychoanalytic theories involving the complex interaction of conscious and uncon-

scious processes must be translated into testable hypotheses. This process becomes even more difficult when information is gathered from subjects via self-report, a research tool which numerous investigators (e.g., Alexander, 1980; Crandall, 1974; Wylie, 1974) have shown to be influenced by subjects' conscious and unconscious motivations.

Thus, the failure to detect a real-ideal discrepancy on the feminine sub-scales of the BSRI that would support the psychoanalytic contention that anorectics aspire to eliminate or mitigate their "feminine" attributes may reflect any of several factors unrelated to the validity of the hypothesis. It is possible that this desire exists entirely on an unconscious level (although the absence of significant group differences on the FDCT tends to dispute this), or that the bias towards socially desirable responding on self-report measures made it less likely for all subjects to report that their "ideal self" was less feminine than their "real self" simply because so many of the "feminine" adjectives reflect socially valued qualities (e.g., "sympathetic", "warm", "understanding").

In fact, it might be argued that the use of the Bem Sex Role Inventory with an accompanying "ideal self" form would almost guarantee that any sample will obtain at least some minimal level of discrepancy on both feminine and masculine dimensions; it is the rare subject who would <u>not</u> report wanting to increase the degree to which he/she manifests the positively valued attributes of which this instrument is composed. Kelly and Worrell (1977)

have, in fact, questioned whether the truncation of the range of potential sex-correlated characteristics to include only socially desirable traits does not severely limit the ability of this measure to assess "functional sex roles," raher than just the positively valued components of such roles.

It might be further argued that the finding, among all groups participating in this study, of larger discrepancies on the masculine sub-scale than on the feminine sub-scale is also an artifact of the test's construction; while all of the adjectives on the masculine sub-scale denote socially valued qualities which one would presumably want to increase in oneself, at least five of the adjectives on the feminine sub-scale (gullible, shy, flatterable, childlike, and unpredictable) denote qualities that, while associated with traditional femininity, are neither particularly flattering or likely to yield much reinforcement in increased quantities. Recent factor-analytic studies have, in fact, indicated that BSRI femininity does not constitute a factorially pure dimension (Gaudreau, 1977; Moreland, Villis, Kamens, & Gulanick, 1977), and that the inclusion of items such as these artificially lower the apparent desirability of femininity. Nonetheless, while certain aspects of the BSRI may be construed as predisposing a particular pattern of <u>within-group</u> discrepancies, the finding that symptomatic subjects manifest a significantly greater degree of masculine discrepancy overall, i.e., <u>between groups</u>, cannot be explained as an artifact.

The failure of the PRF-ANDRO to differentiate between groups,

despite its significant correlation with the BSRI, is consistent with previous reports questioning whether these two measures can in fact be used interchangeably. Grayton, et al., (1977) concluded their comparison of the two measures with the warning that "investigators using these two instruments and analyzing the results by looking at between-group differences might come to very different conclusions depending upon which instrument was used (p. 621)." Kelly and Worrell (1977), in their review of the comparability of the two measures, note that while Berzins, et al. (1978) reported correlations of .50 to .65 between the PRF-ANDRO and the BSRI, these correlations represent only 25% - 42% of the common variance. Thus, it is likely that some different and nonoverlapping characteristics are being assessed by the two instruments, possibly as a result of differences in item format.

Summary and conclusions: implications for psychotherapy.

Controversy over the nature of sex-role identification in female anorectics abounds in the psychological literature, with at least three different theories purporting to define those abberrations considered unique to victims of this disorder. Nonetheless, until now, no substantive empirical research has ever addressed the question of which, if any of these formulations, is most relevant to the anorectic experience.

No support was found for the emphasis placed by both psychoanalytic and feminist theories on deviations in feminine identification among anorectics. No differences could be detected at the

unconscious level, or on either of the two indices of conscious femininity. Additionally, no support was found for the hypothesis (common to both psychoanalytic and feminist theories) that anorectics would experience a greater discrepancy than controls between their self-perceptions and their conceptions of an idealized feminine self. Finally, no support was found for the psychoanalytic hypothesis that anorectics would demonstrate a pattern of conscious femininity-unconscious masculinity to a greater extent than would controls. In an unanticipated finding, anorectics reported having fewer masculine attributes than controls, leading to a greater perceived discrepancy between their self-descriptions and the level of masculinity commonly held as ideal by all subjects.

As noted earlier, the results of this investigation may be interpreted as providing at least limited support for what appear to be two very different theories of anorexia nervosa, the sociologically oriented "role strain" theory and what might be termed the "interpersonal autonomy" theory of Hilde Bruch. A closer look at both theories, however, should reveal one very important commonality--an emphasis on the baneful effects of perceived powerlessness--which highlights the way in which social and cultural factors may become overlaid upon intra-psychic and or interpersonal factors in increasing the vulnerability of a particular group to succumb to mental disorder.

This concept of a superimposition of forces is not only important in understanding the etiology of the disorder; it is a

crucial factor in psychotherapy, as well. As therapists of female clients, we must always be acutely aware of the pressures inherent in being a woman in a society in which the expression of masculine behavior is associated with an increased capacity for social reinforcement (Saltaformaggio, 1979). As therapists of anorectics, however, we must be particularly sensitive to the impact of these pressures on individuals who may have never in their entire lives had the experience of self-determination in even the most trivial areas of existence.

In essence, the implications of these findings for the psychotherapy of anorectic clients are two-fold. Firstly, it becomes our responsibility to alleviate their sense of ineffectiveness by actively encouraging on these clients the development and expression of what Bakan (1966) has termed the "agentic" component of human experience, i.e., the urge to master, to assert one's existence as a unique and separate being. Any self-initiated behavior or expression should be recognized and reinforced, with the ultimate goal of helping them to discover that they have the right to express and pursue their own wants and needs. However, eliciting authentic feeling states must be distinguished from telling the client what she is <u>really</u> thinking or feeling. Classical psychoanalysis has often been criticized for unwittingly validating the idea that the client does not really know how she feels or what unconscious forces motivate her behavior (Chesler, 1972). Bruch (1974) has argued that psychoanalysis provides a recapitulation of previous interactions in which others have appeared to know the client's

feelings better than she does herself. On the other hand, some approaches such as Gestalt (Perls, 1969) or Encounter (Schultz, 1973) therapies which confront and implore clients to express their feelings, can often be devastating to the anorectic client as they may be well beyond her immediate capabilities (Garner, Garfinkel, and Bemis, 1982). Again, Bruch's (1973) advice is instructive: "Let the patient discover her inner feelings and 'say it first'."

Second, and perhaps equally significant, however, must be the affirmation of their right to reject societal demands to be more or less than the person they feel comfortable being. Many patients, prior to establishing successful weight control as a criterion for inferring self-worth, have relied solely on acceptance from others as the criterion for positive self-evaluation. In these instances, psychotherapy should be aimed at reinforcing the client's slow discovery of her own interests and gently challenging performance which seem to be strictly the product of others' expectations. Finally, the client's sense of helplessness and basic incompetence can be ameliorated by encouraging her efforts at mastery in areas that she had been frightened of approaching.

One of Dicken's characters once remarked: "Subdue your appetites, my dears, and you've conquered human nature." Our task as therapists must be to help these women look beyond their bodies to a more appropriate realm of conquest--if, that is, they decide to conquer at all.

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APPENDIX

Form IA

April 19, 1981

Dear Questionnaire Recipient,

I am an advanced graduate student in clinical psychology (University of Massachusetts, Amherst) with a particular interest in the causes and treatment of eating disorders.

The study you have before you is an investigation of possible differences in attitudes/self-perceptions among women who have had personal experiences with eating disorders and those who have not.

If you decide to participate in this study, you will be asked to complete and return the enclosed questionnaires. Any questions you may have concerning the procedures may be directed to me at (413) 253-5764. As you may have already noted, no space is provided for your name. ALL QUESTIONNAIRES ARE TO BE RETURNED ANONYMOUSLY.

You are, of course, under no obligation to participate in this study. Due to the anonymity of the returned forms, no one will ever know whether or not a particular individual has consented to participate. Your cooperation on this project would, however, be greatly appreciated. I have a strong personal commitment to help those individuals suffering from eating disorders. Research is an integral part of that commitment. It is hoped that an increased understanding of the factors contributing to the development of an eating disorder will enable us to formulate new and better strategies for the treatment and prevention of further suffering.

Sincerely,

Alison Fishman Gartner

Given the above description I consent to participate in this study.

[ ] Consent

Form IB

April 19, 1981

Dear Questionnaire Recipient,

I am an advanced graduate student in clinical psychology (University of Massachusetts, Amherst) with a particular interest in the causes and treatment of eating disorders. I obtained your name from a file of individuals who have contacted the Anorexia Nervosa Aid Society of Lincoln, Massachusetts.

The study you have before you is an investigation of possible differences in attitudes/self-perceptions among women who have had personal experiences with eating disorders and those who have not. This research has the full support of Mrs. Patricia Warner and the Board of Trustees of ANAS, and has been reviewed by staff members of Boston Children's Hospital.

If you decide to participate in this study, you will be asked to complete and return the enclosed questionnaires. Any questions you may have concerning the procedures may be directed to me at (413) 253-5764. As you may have already noted, no space is provided for your name. ALL QUESTIONNAIRES ARE TO BE RETURNED ANONYMOUSLY.

You are, of course, under no obligation to participate in this study. Due to the anonymity of the returned forms, no one will ever know whether or not a particular individual has consented to participate. Your cooperation on this project would, however, be greatly appreciated. I have a strong personal commitment to help those individuals suffering from eating disorders. Research is an integral part of that commitment. It is hoped that an increased understanding of the factors contributing to the development of an eating disorder will enable us to formulate new and better strategies for the treatment and prevention of further suffering.

Sincerely,

Alison Fishman Gartner

Given the above description I consent to participate in this study.

[ ] Consent

On the following pages you will find a series of statements which a person might use to describe himself or herself. Read each statement and decide whether or not it describes you. If you agree with a statement or decide that it does describe you, circle the "T" to indicate TRUE. If you disagree with a statement or feel that it is not descriptive of you, circle the "F" to indicate FALSE. Answer every statement either true or false, even if you are not completely sure of your answer.

T F 1. I like to be with people who assume a protective attitude toward me.

T F 2. I try to control others rather than permit them to control me.

T F 3. Surf-board riding would be too dangerous for me.

T F 4. If I have a problem, I like to work it out alone.

T F 5. I seldom go out of my way to do something just to make others happy.

T F 6. Adventures where I am on my own are a little frightening to me.

T F 7. I feel confident when directing the activities of others.

T F 8. I will keep working on a problem after others have given up.

T F 9. I would not like to be married to a protective person.

T F 10. I usually try to share my problems with someone who can help me.

T F 11. I don't care if my clothes are unstylish, as long as I like them.

T F 12. When I see a new invention, I attempt to find out how it works.

T F 13. People like to tell me their troubles because they know I will do everything I can to help them.

T F 14. Sometimes I let people push me around so they can feel important.

T F 15. I am only very rarely in a position where I feel a need to actively argue for a point of view I hold.

T F 16. I dislike people who are always asking me for advice.

T F 17. I seek out positions of authority.

T F 18. I believe in giving friends lots of help and advice.

T F 19. I get little satisfaction from serving others.

T F 20. I make certain that I speak softly when I am in a public place.

T F 21. I am usually the first to offer a helping hand when it is needed.

T F 22. When I see someone I know from a distance, I don't go out of my way to say "Hello."

T F 23. I would prefer to care for a sick child myself rather than hire someone to nurse him or her.

T F 24. I prefer not being dependent on anyone for assistance.

T F 25. When I am with someone else I do most of the decision-making.

T F 26. I try to get at least some sleep every night.

T F 27. I don't mind being conspicuous.

T F 28. I would never pass up something that sounded like fun just because it was a little hazardous.

T F 29. I get a kick out of seeing someone I dislike appear foolish in front of others.

T F 30. When someone opposes me on an issue, I usually find myself taking an even stronger stand than I did at first.

T F 31. When two persons are arguing, I often settle the argument for them.

T F 32. I will not go out of my way to behave in an approved way.

T F 33. I am quite independent of the people I know.

T F 34. I make all my clothes and shoes.

T F 35. If I were in politics, I would probably be seen as one of the forceful leaders of my party.

T F 36. I prefer a quiet, secure life to an adventurous one.

T F 37. I prefer to face my problems by myself.

T F 38. I try to get others to notice the way I dress.

T F 39. When I see someone who looks confused, I usually ask if I can be of any assistance.

T F 40. It is unrealistic for me to expect to do my best all the time.

T F 41. The good opinion of one's friends is one of the chief rewards for living a good life.

T F 42. If I get tired while playing a game, I generally stop playing.

T F 43. I could easily count from one to twenty-five.

T F 44. When I see a baby, I often ask to hold him or her.

T F 45. I am quite good at keeping others in line.

T F 46. I like to be with people who are less dependent than I.

T F 47. I don't want to be away from my family too much.

T F 48. I can run a mile in less than four minutes.

T F 49. Once in a while I enjoy acting as if I were tipsy.

T F 50. I feel incapable of handling many situations.

T F 51. I delight in feeling unattached.

T F 52. I would make a poor judge because I dislike telling others what to do.

T F 53. Seeing a helpless person makes me feel that I would like to take care of him or her.

T F 54. I usually make decisions without consulting others.

T F 55. It doesn't affect me one way or another to see a child being spanked.

T F 56. My goal is to do at least a little bit more than anyone else has done before.

T F 57. I usually wear something warm when I go outside on a cold day.

T F 58. To love and be loved is of great importance to me.

T F 59. I avoid some hobbies and sports because of their dangerous nature.

T F 60. One of the things which spurs me on to do my best is the realization that I will be praised for my work.

T F 61. People's tears tend to irritate me more than to arouse my sympathy.

Below you will find a large number of personality characteristics. I would like you to use those characteristics in order to describe your IDEAL SELF. That is, I would like you to indicate, on a scale of 1 to 7, how true of your IDEAL SELF these various characteristics are. Please do not leave any characteristics unmarked.

1	2	3	4
NEVER OR ALMOST NEVER TRUE	USUALLY NOT TRUE	SOMETIMES BUT INFREQUENTLY TRUE	OCCASIONALLY TRUE

5	6	7
OFTEN TRUE	USUALLY TRUE	ALWAYS OR ALMOST ALWAYS TRUE

Self-reliant ___
Yielding ___
Helpful ___
Cheerful ___
Defends own belief ___
Moody ___
Assertive ___
Independent ___
Shy ___

Conscientious ___
Athletic ___
Affectionate ___

Theatrical ___
Flatterable ___
Happy ___

Strong Personality ___
Unpredictable ___
Loyal ___
Forceful ___
Feminine ___

Reliable ___
Analytical ___
Sympathetic ___
Jealous ___
Has leadership abilities ___
Sensitive to the needs of others ___
Truthful ___
Willing to take risks ___
Understanding ___
Secretive ___
Makes decisions easily ___
Compassionate ___
Sincere ___
Self-sufficient ___

Eager to soothe hurt feelings ___
Conceited ___
Dominant ___
Soft-spoken ___
Likable ___

Likable ___
Masculine ___
Warm ___
Solemn ___
Willing to take a stand ___
Tender ___
Friendly ___
Aggressive ___
Gullible ___

Inefficient ___
Acts as a leader ___
Childlike ___

Adaptive ___
Individualistic ___
Does not use harsh language ___
Unsystematic ___

Competitive ___
Tactful ___
Ambitious ___
Loves children ___
Gentle ___
Conventional ___

Below you will find a large number of personality characteristics. I would like you to use those characteristics in order to describe YOURSELF. That is, I would like you to indicate, on a scale of 1 to 7, how true of YOURSELF these various characteristics are. Please do not leave any characteristics unmarked.

1	2	3	4
NEVER OR ALMOST NEVER TRUE	USUALLY NOT TRUE	SOMETIMES BUT INFREQUENTLY TRUE	OCCASIONALLY TRUE

5	6	7
OFTEN TRUE	USUALLY TRUE	ALWAYS OR ALMOST ALWAYS TRUE

Self-reliant ___
Yielding ___
Helpful ___
Cheerful ___
Defends own belief ___
Moody ___
Assertive ___
Independent ___
Shy ___

Conscientious ___
Athletic ___
Affectionate ___

Theatrical ___
Flatterable ___
Happy ___

Strong Personality ___
Unpredictable ___
Loyal ___
Forceful ___
Feminine ___

Reliable ___
Analytical ___
Sympathetic ___
Jealous ___
Has leadership abilities ___
Sensitive to the needs of others ___
Truthful ___
Willing to take risks ___
Understanding ___
Secretive ___
Makes decisions easily ___
Compassionate ___
Sincere ___
Self-sufficient ___

Eager to soothe hurt feelings ___
Conceited ___
Dominant ___
Soft-spoken ___
Likable ___

Likable ___
Masculine ___
Warm ___
Solemn ___
Willing to take a stand ___
Tender ___
Friendly ___
Aggressive ___
Gullible ___

Inefficient ___
Acts as a leader ___
Childlike ___

Adaptive ___
Individualistic ___
Does not use harsh language ___
Unsystematic ___

Competitive ___
Tactful ___
Ambitious ___
Loves children ___
Gentle ___
Conventional ___

DEMOGRAPHIC QUESTIONNAIRE

Code #_____

Please provide the information requested below. All information will be kept in total confidentiality.

AGE:_____ MARITAL STATUS:_____ HEIGHT_____ WEIGHT_____

HIGHEST EDUCATIONAL LEVEL ATTAINED:
Elementary School_____
High School _____
College/University____
Grad./Professional____

PRESENT OCCUPATION: _____

FATHER'S OCCUPATION: _____

HIGHEST EDUCATIONAL LEVEL ATTAINED:
Elementary School ____
High School ____
College/University____
Grad./Professional____

MOTHER'S OCCUPATION:_____

HIGHEST EDUCATIONAL LEVEL ATTAINED:
Elementary School ____
High School ____
College/University____
Grad./Professional____

APPROXIMATE INCOME (FAMILY OF ORIGIN): _____

MEDICAL HISTORY

Please indicate whether you have experienced (or are experiencing at the present) the following health problems. Also indicate, to the best of your knowledge, the age at which you first experienced the problem, and its duration.

CONDITION	AGE AT ONSET	DURATION
Asthma	_____	_____
Stomach Ulcers	_____	_____
Anorexia nervosa (self-starvation)	_____	_____
Bulimia (compulsive eating)	_____	_____
Frequent Vomiting	_____	_____
Sugar Diabetes	_____	_____
Anemia	_____	_____
Recurring Headaches	_____	_____

SEXUAL ORIENTATION:

Please rate your sexual orientation on the scale provided below:

1 2 3 4 5 6 7 8 9

Exclusively Heterosexual — Bisexual — Exclusively Homosexual

Rating for Self _____

In the following pages you will find a number of incomplete drawings; please complete them. Do it any way you like; use as many lines as you wish; do it the way it seems most fun. There is no right or wrong way of doing this.