A study of the use of psycho-educational group techniques to improve perceptions of body image in Bulimia

Lisa Marie Valentino
Clark Atlanta University

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ABSTRACT

SOCIAL WORK

VALENTINO, LISA M. B. S. JOHN CARROLL UNIVERSITY, 1991

A STUDY OF THE USE OF PSYCHO-EDUCATIONAL GROUP TECHNIQUES TO IMPROVE PERCEPTIONS OF BODY IMAGE IN BULIMIA

Advisor: Dr. Anne Fields-Ford

Thesis dated May, 1995

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THE STUDY OF THE USE OF PSYCHO-EDUCATIONAL GROUP
TECHNIQUES TO IMPROVE PERCEPTIONS OF BODY IMAGE IN BULIMIA

A THESIS
SUBMITTED TO THE FACULTY OF CLARK ATLANTA UNIVERSITY
IN PARTIAL FULFILLMENT OF THE REQUIREMENTS FOR
THE DEGREE OF MASTER OF SOCIAL WORK

BY
LISA MARIE VALENTINO

SCHOOL OF SOCIAL WORK

ATLANTA, GEORGIA
MAY 1995
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ACKNOWLEDGEMENTS

I would like to thank my advisor, Dr. Anne Fields-Ford for her encouragement and support through out my research and the motivation to seek for the answers that are not always easily found. I dedicate this research to my father who has been my building block and support system for me all these years. Thank you for encouraging me to excel and always believing in me.
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CHAPTER ONE

INTRODUCTION

The Diagnostic Statistical Manual - IV (DSM-IV) characterizes bulimia as having both physiological and psychological attributes. Its physiological manifestations are such things as repeated episodes of binge eating followed by inappropriate compensatory behaviors such as self-induced vomiting; misuse of laxatives, diuretics, or other medications; fasting; or excessive exercise. The psychological manifestations are characterized by the perception of body shape and weight as an essential feature to the bulimic. Garner, Rockert, Olmsted, Johnson and Coscine (1985) describe bulimia as a rigid, extreme pattern of thinking, feeling, and relating to others. It is a self-image and a life orientation that develops in certain family and sociocultural contexts at many different levels. Bingeing, which is both physiological and psychological, is described as eating in a specific, discrete amount of time a large amount of food that is larger than most individuals would eat. According to the DSM-IV binge eating is typically triggered by dysphoric mood states, interpersonal stressors, intense hunger following dietary restraint or feelings related to body weight, body shape, and food. Binge eating may transiently reduce dysphoria, but disparaging self-criticism and depressed mood often follow.

While there has been a lack of consensus among investigators on the etiology behind bulimia, the emerging agreement is developing whereby bulimia is considered a multi-determined disorder with a number of contributing factors including personality traits, family characteristics, and

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society and environment. Grissett and Norvell (1992) found a correlation between bulimics and social impairments such as dissatisfaction with their social support and relationships. 5

Previous research indicates that bulimics report less support from family and friends, more negative interactions and less social competence. 6 Other research has indicated that bulimics have a preoccupation with their appearance and what others perceive their physical image to be. Still other research reports suggest that bulimics experience difficulties in social adjustment, social anxiety, poor relationships and social isolation. Persons suffering from bulimia are concerned with fulfilling others expectations at the expense of acknowledging their own needs which prevents them from developing a stable self-definition and leaves them feeling fraudulent. 7

According to the American Psychiatric Association bulimia nervosa has been reported to occur in most industrialized countries such as the United States, Canada, Europe and Australia, with the same frequency. In the United States bulimic individuals are primarily caucasian the greatest percentage of which are female between adolescence and their thirties who are in a higher socioeconomic group. 8 The prevalence of bulimia among adolescent and young adult females is approximately 1% - 3%. 9 Kerr, Skok & McLaughlin (1991) also reported that bulimia is less common among males and African-Americans in general.

Bulimia itself is multi-faceted including pressures from the individual, culture, family and society. Kerr et. al. (1991) in their research literature noted that bulimics typically are products of


6 Ibid., 293.


single-parent homes more so than anorexics or non-eating disordered individuals. Additional findings regarding the demographic profile of bulimics is that their parents were described as non-supportive with a high incidence of substance abuse among family members including the bulimic. Use of other amphetamines was also noted.\textsuperscript{10} Kerr et. al. (1991) also noted a significant link between bulimia and depression. They found low self-esteem paralleling with poor self-image, which in turn contributes to depression. Another factor found to be related to bulimia is high anxiety, which commonly leads to an increase in purging behavior. This purging behavior parallels with the bulimics "obsession" for thinness. This "obsession" for thinness supports the view that bulimics have some impulse-control difficulties.\textsuperscript{11}

Within the past two decades the prevalence of bulimia has increased. While bulimia is reported as affecting a large percentage of young women the prevalence is often difficult to determine due to the secretiveness of the disorder and the fact that many females do not realize that they are affected by the disorder. Treatment of bulimia is not reported as being particularly successful due by in large to a need for a better understanding of the disorder.

\textbf{Statement of the Problem}

In 1980 the DSM-III recognized bulimia as a diagnostic category. For social workers, psychologists, psychiatrists and general practitioners it brought about a physiological and psychological disorder in which they had limited knowledge and training.

The recovery rate for eating disorders is not high which indicates a need for a better understanding of the disorder as well as researching various interventions to treat bulimia nervosa


According to Garner et al. (1985) research has shown that most bulimic patients have a misconception about dieting, weight, regulation, nutrition and the social context of their disorder. Garner et al. (1985) also found that through psycho-education and cognitive-behavioral therapy many bulimics recover due to a better understanding of the complications and factors associated with the disorder. This is most effectively done by using a treatment intervention that includes using both individual counseling as well as group counseling. Both are becoming a growing approach to the treatment of bulimia.  

CHAPTER TWO
REVIEW OF THE LITERATURE

The bulimic syndrome consists of powerful urges to binge eating while attempting to avoid the "fattening" effects of food by induced vomiting, abusing purgatives, excessive exercising, starving, or some combination, coupled with the psychological disorder characterized by a morbid fear of becoming fat. The bulimic is most often a young, well-educated white female who expresses significant distress and the self-awareness typically associated with the motivation to benefit from treatment. Johnson and Larson (1982) have emphasized that this disorder is notoriously difficult to treat.  

According to Garner (1991) eating disorders are common problems affecting, in particular, a growing number of adolescent and young adult women. Recent research has found that there is a significant proportion of obese individuals who are seeking weight loss and engaging in binge eating, which warrants a diagnosis of bulimia nervosa. Garner (1991) also found eating disorders to be less common in males. Recent evidence suggests that these eating disorders, which were once only believed to affect higher socioeconomic classes, are becoming more common in middle and lower social classes.  

The trend to eating disorders may have many explanations but it may be partially related to the social pressures that are placed on women to diet so that they conform to unrealistic thin standards of physical attractiveness. Women are bombarded with messages from the media that beauty, success, personal happiness and self-worth are based on having a thin shape. The fashion industry, movies, magazines and television all promote the view that one can only be

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15 Ibid., 1.
loved and respected when slender. This suggests that thinness is associated with favorable personality traits.\textsuperscript{16}

There are serious limitations in estimating the prevalence of eating disorders because most are reported through self-report instruments and on samples that may not reflect important demographic differences in their basic rates. A number of studies do agree that both anorexia nervosa and bulimia nervosa may occur in as many as 1\% to 4\% of female high school and college students. The rate may occur as high as 12\% - 15\% of female medical students and other graduate students. Suspected cases of eating disorders are even more common among groups that have a heightened pressure to diet or maintain a thin shape such as ballet students, professional dancers, wrestlers, swimmers and gymnasts.\textsuperscript{17}

Stein (1991) reported that there have been studies where there was a 19\% prevalence rate of bulimia while another study reported only a 1\% rate. Both studies used female college students. Books aimed at audiences on eating disorders cite a much higher prevalence of eating disorders, claiming that 20\% of all women between the ages of 13 and 40 are affected by an eating disorder. A recent study reviewed 15 prevalence studies and concluded that approximately 8\% of all women and 1\% of all males meet the DSM-III definition of bulimia.\textsuperscript{18}

Recent reports have identified binge eating patterns in 20\% to 55\% of overweight individuals that were seeking treatment. A study of 112 overweight men and women who were seeking treatment for obesity found that 55\% were reported as having moderate binge eating problems and 23\% were reported as having a very serious problem with binge eating. In a similar study of 432 overweight women seeking treatment for weight loss, 46\% were described as having


serious problems with binge eating. In a study of 70 obese subjects who were not involved in a weight loss program 33% met the DSM-III criteria for binge eating patterns.\textsuperscript{19}

A study surveyed a sample of 247 psychology students and found 79% of the females and 49% of the males reported binge eating episodes. 10% of the females also admitted to self-induced vomiting. Another study of 1,000 freshman college students done in 1983, found a small percentage of students who met the criteria for bulimia; 8% of females and 1.4% of males. However, the report failed to show the high percentages of weekly binge eating episodes reported by 41% of the males surveyed and 57.4% of the females. 47% of the females also reported using weight control measures such as vomiting, laxative abuse and fasting. These alone are not sufficient to be diagnosed as bulimic but they do show very disturbed eating patterns.\textsuperscript{20}

Research investigators note that approximately 10% of the bulimics reported laxative use and self-induced vomiting. In another recent study they found that 21% of women attending a family planning clinic reported binge eating episodes, 2.9% reported using vomiting to control weight, and 4.9% reported using laxatives.\textsuperscript{21}

Kerr, Skok and McLaughlin (1991) also report bulimics as being dichotomous thinkers. Many studies describe them as having irrational cognitive thinking styles. Many bulimics are avoidant, believing that situations can cause emotional reactions over which they have no control over. According to many bulimics, what has happened to them in the past and the effect it has had on them cannot be overcome. A study done in 1988 of 50 eating disordered females found


bulimics to be passive, avoidant and filled with self-doubt which tended to make them feel helpless over situations.\textsuperscript{22}

Further research examining the psychosocial characteristics of bulimics indicate that these women were highly adaptive to the demands and expectations of others and appeared to maintain a deficient sense of self-sufficiency and self-control.\textsuperscript{23} Garfinkel (1980) suggested that bulimic females in comparison with anorexics, maintained a persistent sense of being out of control. This sense of being out of control was manifested in impulsive related problems ranging from stealing to suicidal gestures.\textsuperscript{24} Compulsive shoplifting was seen in one-third of the bulimic patients in Pope, Hudson, Jonas and Yurgelum's (1984) study. They also reported that 47 out of their first 136 bulimic subjects had made at least one major suicide attempt during their lifetime. Another characteristic of the bulimic was that they experienced more depression and low self-esteem than asymptomatic women. Pope et. al. (1983) also reported that major depression was found to be the single most common psychiatric disorder (66\%) associated with bulimia.\textsuperscript{25}

Kerr et. al. (1991) reported a high correlation between depression and bulimia. They found that the more severe the bulimia the higher degree of depression the bulimic was suffering.\textsuperscript{26}


Garner (1991) reports in his Eating Disorder Inventory-2 (EDI-2) manual that depression has been described as a common theme in eating disorders. Some claim that eating disorders are “depressive variants”, while others suggest that depression plays an important predisposing role in eating disorders. Other research indicates that depression may be a secondary factor to the binge eating because there is marked improvement in mood when bulimic symptoms are under control.27

Kerr et. al. (1991) reported bulimics as having a higher incident of family substance abuse. Generally, this abuse takes the form of alcohol, but other drugs frequently mentioned are marijuana, amphetamines, diet pills and barbiturates. They also reported bulimics with family histories of affective disorders.28

Kerr et. al. (1991) also reported bulimics as having difficulties with their interpersonal relationships. Bulimics come from families which many times have conflict resolution problems. Bulimics are more likely than anorexics or non-eating disordered individuals to have divorced parents. Most bulimics describe their parents as non-nurturing and unsupportive.29 The attitudes and behaviors of parents, the relationship they have with their child, and the style of family organization have been thought to play an important role in precipitating or perpetuating bulimia.30

While in treatment, bulimics compared to non-bulimic women, reported poorer family adjustment and more problems with their parents. When comparing the families of bulimics to other families, the families of bulimics have been found to be less caring, less cohesive and to


29Ibid., 849-851.

have higher levels of conflict and hostility. Literature on family environment supports the significance of familial factors in the development and maintenance of eating disorders. A study reported by Kantz, Groze and Yates (1992) compared mothers of six bulimic females and six mothers of control subjects. They found the mothers of the bulimic subjects to be more domineering and controlling. The bulimic subjects mothers also held higher expectations for their daughters. The fathers of the bulimic subjects were reported as more emotionally distant from their daughters. Overall, the bulimic patients parents were perceived to be more judgmental with a higher level of parent-daughter stress.

Bulimic subjects reported perceiving their families as having a great deal of anger conflict that was unexpressed. A study reported in Kantz et. al. (1992) used 20 anorexics, 13 bulimic anorexics, 24 normal weight bulimics and 57 control subjects found that the eating disordered families were less supportive and less expressive than families in the control group.

In 1986, Humphrey found that bulimic subjects families experienced greater conflict, detachment and isolation as well as providing less support and involvement than the control groups family. Family history can also be important in evaluating the potential for eating disorders. Among 364 first-degree relatives of 24 bulimics and anorexics compared to 43 normal control subjects their was a significantly higher incidence of eating disorders.

31 Ibid., 281.


33 Ibid., 605.


In 1987, Bulik found that depression was significantly greater in bulimic patients as opposed to control subjects. A follow up study was done using 35 bulimics, 35 controls and their first and second relatives. The results showed a significantly higher incidence of depression and alcohol abuse in the bulimics. The family members of the bulimics also reported experiencing greater depression than the control group.36

Another area of research has found bulimics to have demonstrated social impairments and dissatisfaction with their social support and relationships. This lack of adequate perceived social support and the distressed interpersonal relationships could be important risk factors for the development and maintenance of bulimia.37

Feminist and psychodynamic theorists have suggested that difficulties with intimate relationships, especially with men, are a central problem in bulimia. Boskind-Lodahl (1976) stated that these difficulties arise from several sources. First, the bulimic has a tremendous desire to please others and bases her sense of self-worth on the approval of others. Second, bulimics expect to be rewarded by men for their strivings to fit the perfect feminine role and, thus, are very vulnerable to rejection. Third, because the bulimic gains her sense of self-worth through others, her resultant over-dependence on others creates a self-perpetuating pattern of rejection. Fourth, bulimics fear men because although they seek self-validation from men, such dependence gives men the power to reject. Finally, bingeing itself distances the bulimic from others, both through anxiety about eating with others and through the secretive nature of this behavior.38

Another important symptom of eating disorders is their preoccupation with their appearance, their constant concern with how their physical self is perceived by others. Research suggests that eating disorder patients experience difficulties in areas of social adjustment, characterized by social anxiety, impoverished relationships and social isolation. Others suggest

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that eating disorders are linked to poor self-confidence and a preoccupation with self-presentation.\textsuperscript{39}

A study done in 1993, by Striegel-Moore, Silberstein & Rodin, strongly supported the hypothesis that "social self" concerns are strongly linked to body dissatisfaction and eating disorders. Along with the preoccupation with the self-presentation the study also found that these social self-deficits were reinforced and/or amplified by the consequences of the eating disorder, which increases the psychological sense of not fitting in, which in turn isolates the woman further. Bulimics also tend to have low self-esteem. Bulimics score significantly lower on scales which measure social desirability.\textsuperscript{40} Bulimics have also been found to have higher anxiety levels. Studies found anxiety levels raised with an increase in purging behaviors.\textsuperscript{41}

For women, their bodies become "social objects" constantly accessible to the gaze of others. Far surpassing that of men's bodies, women's bodies are scrutinized by men and women alike. Bulimic women are concerned with fulfilling others expectations at the expense of their own needs which prevents them from developing a stable self-definition of themselves. Hence, the heightened public self-consciousness both results and serves from the need to please others and build a false sense of self.\textsuperscript{42} In 1986, a study found that 81% of their subjects were within the range of ideal weight but 78% reported that they would prefer to lose weight.\textsuperscript{43} Because bulimics

\begin{itemize}
\item \textsuperscript{41}Ibid., 297.
\item \textsuperscript{42}Ibid., 298.
\item \textsuperscript{43}J. Eisele, D. Hertsgaard and H. K. Light, "Factors Related to Eating Disorders in Young Adolescent Girls," \textit{Adolescence} 21 (1986): 283-290.
\end{itemize}
may distort their body image, an important therapeutic goal may be to correct these distorted self-perceptions as well as reduce the overall importance of weight as a self-evaluating dimension.44

Psycho-educational material has become an integral component of a growing number of individual and group approaches to bulimia. Many have found that conventional treatment programs have placed a disproportionate or exclusive emphasis on either the emotional or physical aspects of the disorder. Treatment for bulimia must emphasize the interdependence between the mental and physical aspects of experience. Failing to integrate those could further the conflict between the mind and body that is already too often experienced by patients with bulimia. By using psycho-education many bulimic patients can benefit from and often recover because of an improved understanding of complications and factors perpetuating the disorder.45

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CHAPTER THREE

METHODOLOGY

This methodology section is organized in the following manner: (1) Research Design, (2) Treatment Hypothesis, (3) Case Information and (4) Intervention Strategy and Implementation.

Research Design

A single - system design was used in this research. Grinnell, Jr. (1993) describes the use of a single - system design by social workers as a way of monitoring and evaluating a clients outcome in the interventions with which they address the clients main problem. Bloom an Fischer refer to the A - B design as the simplest logical structure permitting a planned comparison between two elements.

The Eating Disorder Inventory-2 (EDI-2) was implemented by using an A - B subject design. An intervention designed to improve the subjects perception of their body image was implemented after the baseline was established.

The original Eating Disorder Inventory (EDI) was introduced in 1983 and was comprised of three subscales; Drive for Thinness, Bulimia and Body Dissatisfaction, which assessed attitudes and behaviors concerning eating, weight and shape. Five subscales (Ineffectiveness, Perfectionism, Interpersonal Distrust, Interoceptive Awareness and Maturity Fears) were added which looked at more general organizing constructs or psychological traits clinically relevant to eating disorders.

Also added to the original 64 items on the EDI were 27 items which added three new constructs (Asceticism, Impulse Regulation and Social Insecurity) to the earlier EDI.

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49 Ibid., 1.
When used in a clinical setting the EDI can provide information helpful in understanding the patient, planning treatment and in assessing progress. The EDI provides individual patient profiles which are helpful in comparing against the norms in eating disordered patients and comparison samples. This descriptive information is relevant in individual cases due to the emerging consensus that there is remarkable heterogeneity in the psychopathology associated with eating disorders. If the EDI-2 is administered at several points during treatment it can provide valuable information about clinical status and response to treatment.  

The EDI-2 can also be helpful in nonclinical settings by identifying individuals who may be at risk for developing eating disorders. Many researchers indicate that the EDI-2 is a valuable research instrument. It provides descriptive information allowing comparison of samples in one research setting to those from other sites. It has also been used both as an outcome measure and a prognostic indicator in treatment studies.  

Body satisfaction in bulimia has been used in several studies (Davis, Olmsted & Rockert, 1990; Fabian & Thompson, 1989). Subscales of the EDI have been used to select or define criterion groups in studies of body satisfaction / dissatisfaction and weight preoccupation.  

Treatment Hypothesis  

Bulimia itself is multi-faceted including pressures from the individual, culture, family and society. Social workers are needed to have a full understanding of how each of these areas impact the individual before successful treatment can be established. The hypothesis and intervention in this research is based on a cognitive-behavioral theory. Derived from the cognitive-behavioral theory is psycho-education which is the focus of the intervention in this
research. It is hypothesized that body image can become increasingly positive when one is more educated about eating disorders and where the eating disorder began. Psycho-education is defined as the process of disseminating information about the nature of a specific disorder for the purpose of fostering attitudinal and behavioral change in the client. The process is used by the practitioner to summarize relevant scientific information about a disorder and to address questions the client may have such as, "Why did I develop this problem? What can I do to get better?"53

This intervention is commonly used as the initial component in the cognitive-behavioral treatment of bulimia nervosa due to its conceptual rationale for the cognitive and behavioral strategies that make up the multifaceted package. 54

Case Information

For anonymity in this research the client will be referred to as Susan. Susan is a single, white female. Susan was diagnosed with bulimia in 1992, shortly after graduating from college. In the past, Susan had participated in counseling due to a history of "family problems". Susan described herself as having very low self-esteem, poor self-image and continually battling with depression. A family fallout with her mother and brother at the end of 1991 was what Susan describes as "triggering" the bulimia.

During the worst of her bulimia, Susan describes her days as planning every meal, clock watching until she could leave work and have her meal and then immediately purging. After seeing a counselor for several months Susan was diagnosed with bulimia and placed on a drug called Anaphranil. Anaphranil is a drug commonly given to bulimics for obsessive-compulsive behavior.

Susan continues to struggle with bulimia and poor self-image. Having not been in counseling for approximately two years, she agreed to take the Eating Disorder Inventory-2 (EDI-


54 Ibid., 882.
2) and participate in eight sessions of Overeaters Anonymous (OA).
Intervention Strategy and Implementation

The Eating Disorder Inventory-2 (EDI-2) was given at the first meeting with Susan before any intervention began and the end of the eighth session of Overeaters Anonymous.

The EDI-2 is a widely used self-report used to measure symptoms commonly associated to anorexia nervosa and bulimia nervosa. The self-report consists of 91 questions which the respondent answers whether or not the question "always", "usually", "often", "sometimes", "rarely" or "never" applies to them. The practitioner has the ability to look at eight subscales; Drive for Thinness, Bulimia, Body Dissatisfaction, Ineffectiveness, Perfectionism, Interpersonal Distrust, Interoceptive Awareness and Maturity Fears. The EDI-2 also provides three new provisional subscales; Asceticism, Impulse Regulation and Social Insecurity.  

For the purpose of this research four subscales were the focus of this study; Drive for Thinness, Bulimia, Body Dissatisfaction and Perfectionism.

The Drive for Thinness subscale looks at "the relentless pursuit for thinness", which is considered the cardinal feature of any eating disorder. This subscale assesses any excessive concerns with dieting, preoccupation with weight and fear of weight gain.  

The Bulimia subscale looks at the tendency to think about and participate in bouts of bingeing. Binge eating is a primary characteristic of bulimia nervosa and the feature that differentiates bulimia from the restricted types of anorexia nervosa. 

The Body Dissatisfaction subscale measures dissatisfaction with the overall shape and size of the body. This focuses mainly on specific regions such as the stomach, hips, thighs and

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57 Ibid., 5.
buttocks. Body image disturbances are commonly viewed as the major factor that initiates and sustains the weight controlling behaviors associated with eating disorders.\textsuperscript{58}

The Perfectionism subscale looks at the extent to which one believes that their personal achievements should be superior. The items on this subscale measure the belief that only the highest standards of personal performance are acceptable and that others also expect outstanding achievement.\textsuperscript{59}

Three studies have looked at the test-retest reliability of the original Eating Disorder Inventory. In 1988, Welch retested 70 students and nurses one week later and found a coefficient ranging from .79 to .95 for all subscales except Interoceptive Awareness (.67). In 1987, Wear and Pratz retested 70 nonpatient university undergraduates after three weeks and found reliability's ranging from .77 to .96. High scores were shown in the Drive for Thinness, Bulimia and Body Dissatisfaction subscales. In 1990 Crowther, Lilly, Crawford, Shepard and Oliver found after one year the highest retest reliability in the Drive for Thinness, Body Dissatisfaction, Ineffectiveness, Perfectionism and Interpersonal Distrust subscales.\textsuperscript{60}

Susan attended a serious of eight one hour meetings at Overeaters Anonymous (OA). The meetings were held at various churches or psychiatric institutes. All groups were held in the same 12-step format as Alcoholics Anonymous meetings. Members share experiences while offering acceptance, understanding, communication, relief, power and hope to others. The hope is that the disease can be "arrested" due to the belief that it cannot be cured, so that the compulsive eater can feel comfortable with who they are no matter if they can reach and maintain their desired weight or not. The goal is to abstain from compulsive eating one day at a time by daily personal contracts, meetings, sponsors, phone calls and the 12-step program of Alcoholics Anonymous replaces alcoholic and alcohol with compulsive overeater and food.

\textsuperscript{58} Ibid., 5.
\textsuperscript{60} Ibid., 5.
Susan described the meetings as “very different” than she expected. The people were warm, friendly and reassuring. As the other group members shared their stories Susan realized she was not alone and was able to identify with the other feelings other group members were describing. Even after the very first meeting Susan left feeling that there may be hope after all.
CHAPTER FOUR

PRESENTATION OF THE FINDINGS

The graphs presented on the following pages present the Eating Disorder Inventory-2 (EDI-2) raw score subscales for the four target areas in this research; Drive for Thinness, Bulimia, Body Dissatisfaction and Perfectionism. The answer to a question is assigned a number between 0-3, depending on how the question is answered. Determination of how high the score is would be based on how many questions on the Eating Disorder Inventory-2 pertain to that particular subscale. The interpretation is only a tool in helping assess a diagnosis and what some possible problem areas may be with the subject. The interpretations should in no way be used as the only tool in diagnosing clients.

Figure I is the pre-intervention raw subscale scores, which was completed in a one day assessment when the initial application of the Eating Disorder Inventory-2 (EDI-2) was given and the participant was interviewed to be sure that they had been assessed and clinically diagnosed by a licensed psychologist as bulimic before the intervention began. The initial test results indicate moderately high scores to high scores in all four subscales. The interpretations of the Drive for Thinness score suggest preoccupation with weight, body shape, excessive concern with exercise and dieting and a morbid fear of weight gain.

The Bulimia score was considered moderately high and suggests a tendency to binge eating which may be followed by laxative use, vomiting or other weight control practices.

The Body Dissatisfaction score was within the elevated range and may suggest that the participant feels extreme dissatisfaction with their overall shape especially certain regions of their body such as; hips, stomach, thighs and buttocks. This level of dissatisfaction may sustain an eating disorder once developed.

The participants score on the on the Perfectionism subscale was interpreted as moderately high and suggests a somewhat moderate expectation for personal achievement and/or the belief that others expect superior achievement of them.
Figure II depicts the four subscale scores following eight hour long sessions at Overeaters Anonymous (OA). Score within the Drive for Thinness, Bulimia, and Perfectionism subscales increased by 2 - 3 points. The Body Dissatisfaction subscale score decreased by 3 points. Neither the increase nor the decrease in subscale scores were significant enough to change the Eating Disorder Inventory-2 (EDI-2) computer interpretation of the scores.
Figure 1

Categories of Bulimia

Subscale Scores of the Categories of Bulimia

- Drive for Thinness
- Bulimia
- Body Dissatisfaction
- Perfectionism

Categories of Bulimia
Figure 2

Subscale Scores of the Categories of Bulimia

Categories of Bulimia

- Drive for Thinness
- Bulimia
- Body Dissatisfaction
- Perfectionism
Limitations of the Study

The pretest - posttest outcome of the intervention showed a positive change in only one area; Body Dissatisfaction. However this change was not significant to the outcome of the study. In the Drive for Thinness, Bulimia and Perfectionism subscales there was no significant change although the scores did increase by 2 points each. Bloom and Fischer noted that the A - B design has its limitations in that it does not provide strong changes nor can the design permit control over the many possible alternative explanations for why the results occurred as they did. They also noted that the A - B design can not pinpoint which aspect of the intervention was the most influential in changing behaviors within the participant.61

The Eating Disorder Inventory-2 (EDI-2) has questions that focus on feelings about oneself. One possible drawback to this type of questioning could be that the answers which are given may reflect the mood or frame of mind the participant is in when they are taking the test. This "mood change" could also be true when taking the test after an Overeaters Anonymous. The participant described the meetings as "bringing up a lot of old hidden feelings", other times the participant left the Overeaters Anonymous meetings feeling that there was hope and that she was not alone in here feelings and emotions. These different moods could affect how the test questions were answered thus effecting the results. This brings us to the limitations of time. Starting a group and listening to many different people speak about their experiences can stir up many emotions making the beginning of the group experience like an emotional rollercoaster. Until there has been enough time for the participant to sort through all the old and new feelings and emotions that they are going through they will experience many mood changes. After time, the participant, if successful, will have worked through their feelings and learned to change their behavior so that they can integrate the good and bad parts of their lives. The participant of this research noted that most group members stated that it had taken them six months or better before

they committed themselves to the program and started to see a change in themselves. This knowledge helped the participant not to be discouraged when she did not see immediate changes in her behavior.
CHAPTER FIVE

CONCLUSION

The goal of this study was to improve the participants perception of their body image through the use of cognitive-behavioral therapy and psycho-education. More specifically, through attending Overeaters Anonymous meetings.

The intervention was shown to improve in only one out of four subscales on the Eating Disorder Inventory-2 (EDI-2). The scores in the other three subscales all increased by two points. Neither the increase nor the decrease in subscale points were significant to any change in behavior. It is reasonable to assume that this type of research needs to be long term to have any significant affects on the participant. This could be due in part to the complexity of eating disorders. Because of the multiple factors associated with eating disorders recovery is generally a very slow and lengthy process. Unlike other addictions where you can survive without the substance, food is necessary for survival. Managing and changing a behavior that you must use on a day to day basis can become a difficult challenge. Repeated use of the Eating Disorder Inventory-2 (EDI-2) scale over time should eventually show a gradual drop in subscale scores, possibly as issues are resolved and maintained by the participant.

Implications for Social Work

Bulimia is a complex disorder that is caused and maintained by various biological, psychological, familial and sociocultural factors, although the contribution of each factor may vary across different populations. This complexity makes treatment of eating disorders extremely difficult. Due to all the factors, complex solutions are needed to treat the disorder. Using only one approach in treating these disorders will not be helpful in addressing the many issues associated with persons suffering from eating disorders. Multiple treatments approaches such as psychotherapy, cognitive-behavioral therapy, group interventions, education on nutrition and family counseling will be much more successful in the treatment process.
Recommendations for Future Research

The Eating Disorder Inventory-2 (EDI-2) is not a treatment for eating disordered patients but an aid to use when formulating a diagnosis. If used in a clinical setting the Eating Disorder Inventory can provide useful information in several areas such as, understanding the patient, planning a treatment and assessing the patients progress.

Future research should allow for a more long-term intervention phase due to the slow recovery and complexity of the disorder. Caution should be used as to when the application of the Eating Disorder Inventory-2 is given so that there may be some consistency in the mood the participant is in when answering the questions on the test.
APPENDIX

EATING DISORDER INVENTORY-2

QUESTIONNAIRE AND ANSWER SHEET
INSTRUCTIONS

be made on the EDI-2 Answer Sheet. The items ask about your attitudes, feelings, and behavior. Some of the items relate to food or eating. Other items ask about your feelings about yourself.

SOMETIMES (S), RARELY (R), or NEVER (N). Circle the letter that corresponds to your rating on the EDI-2 Answer Sheet. For example, if your rating for an item is OFTEN, you would circle the O for that item on the Answer Sheet.

Respond to all of the items, making sure that you circle the letter of the rating that is true about you. DO NOT ERASE!
If you need to change an answer, make an "X" through the incorrect letter and then circle the correct one.

1) I eat sweets and carbohydrates without feeling nervous.
2) I think that my stomach is too big.
3) I wish that I could return to the security of childhood.
4) I eat when I am upset.
5) I stuff myself with food.
6) I wish that I could be younger.
7) I think about dieting.
8) I get frightened when my feelings are too strong.
9) I think that my thighs are too large.
10) I feel ineffective as a person.
11) I feel extremely guilty after overeating.
12) I think that my stomach is just the right size.
13) Only outstanding performance is good enough in my family.
14) The happiest time in life is when you are a child.
15) I am open about my feelings.
16) I am terrified of gaining weight.
17) I trust others.
18) I feel alone in the world.
19) I feel satisfied with the shape of my body.
20) I feel generally in control of things in my life.
21) I get confused about what emotion I am feeling.
22) I would rather be an adult than a child.
23) I can communicate with others easily.
24) I wish I were someone else.
25) I exaggerate or magnify the importance of weight.
26) I can clearly identify what emotion I am feeling.
27) I feel inadequate.
28) I have gone on eating binges where I felt that I could not stop.
29) As a child, I tried very hard to avoid disappointing my parents and teachers.
30) I have close relationships.
31) I like the shape of my buttocks.
32) I am preoccupied with the desire to be thinner.
33) I don't know what's going on inside me.
34) I have trouble expressing my emotions to others.
35) The demands of adulthood are too great.
36) I hate being less than best at things.
37) I feel secure about myself.
38) I think about bingeing (overeating).
39) I feel happy that I am not a child anymore.
40) I get confused as to whether or not I am hungry.
41) I have a low opinion of myself.
42) I feel that I can achieve my standards.
43) My parents have expected excellence of me.
44) I worry that my feelings will get out of control.
45) I think my hips are too big.
46) I eat moderately in front of others and stuff myself when they're gone.
47) I feel bloated after eating a normal meal.
48) I feel that people are happiest when they are children.
49) If I gain a pound, I worry that I will keep gaining.
50) I feel that I am a worthwhile person.
51) When I am upset, I don't know if I am sad, frightened, or angry.
52) I feel that I must do things perfectly or not do them at all.
53) I have the thought of trying to vomit in order to lose weight.
54) I need to keep people at a distance (feel uncomfortable if someone tries to get too close).
55) I think that my thighs are just the right size.
56) I feel empty inside (emotionally).
57) I can talk about personal thoughts or feelings.
58) The best years of your life are when you become an adult.
59) I think my buttocks are too large.
60) I feel that I must do things perfectly or not do them at all.
61) I eat or drink in secrecy.
62) I think that my hips are just the right size.
63) I have extremely high goals.
64) When I am upset, I worry that I will start eating.
65) People I really like end up disappointing me.
66) I am ashamed of my human weaknesses.
67) Other people would say that I am emotionally unstable.
68) I would like to be in total control of my bodily urges.
69) I feel relaxed in most group situations.
70) I say things impulsively that I regret having said.
71) I go out of my way to experience pleasure.
72) I have to be careful of my tendency to abuse drugs.
73) I am outgoing with most people.
74) I feel trapped in relationships.
75) Self-denial makes me feel stronger spiritually.
76) People understand my real problems.
77) I can't get strange thoughts out of my head.
78) Eating for pleasure is a sign of moral weakness.
79) I am prone to outbursts of anger or rage.
80) I feel that people give me the credit I deserve.
81) I have to be careful of my tendency to abuse alcohol.
82) I believe that relaxing is simply a waste of time.
83) Others would say that I get irritated easily.
84) I feel like I am losing out everywhere
85) I experience marked mood shifts.
86) I am embarrassed by my bodily urges.
87) I would rather spend time by myself than with others.
88) Suffering makes you a better person.
89) I know that people love me.
90) I feel like I must hurt myself or others.
91) I feel that I really know who I am.


