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An analysis of Adlerian life themes of bulimic women

Axtell, Amy Ann, M.A.
The University of Arizona, 1991
AN ANALYSIS OF ADLERIAN LIFE THEMES OF
BULIMIC WOMEN

by

Amy Axtell

A Thesis Submitted to the Faculty of the
SCHOOL OF FAMILY AND CONSUMER RESOURCES
In Partial Fulfillment of the Requirements
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WITH A MAJOR IN COUNSELING AND GUIDANCE

In the Graduate College
THE UNIVERSITY OF ARIZONA

1991
STATEMENT BY AUTHOR

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This thesis is dedicated to the warm, fond, and loving memory of Dr. Richard Erickson.
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ABSTRACT

This study examines the commonality of life themes held by bulimic women, as measured by the Adlerian Lifestyle Questionnaire. Both clinically diagnosed and self-diagnosed subjects participated in this study.

The subjects participated in a structured Lifestyle interview, including the reporting of five early recollections and additional biodata information regarding their bulimia. A panel of Adlerian expert judges analyzed the interview data and summarized life themes.

Results indicate that Adlerian judges were able to identify several common Lifestyle themes and personality characteristics among the bulimic participants in this study.
CHAPTER 1

INTRODUCTION

Preface

8:00 p.m. Candy bar on the way out; I walked to the parking lot. Torn-so-torn. Cold, wet from rain, and alone. Hmmm (restaurant) or stay here? Pace, pace, pace. (A restaurant) it was. Chili, BLT, grilled cheese, fries, milk. Threw up. Pretended I was waiting for Sally; must have asked the waitress four times if she had seen her. A girl asked me to join her and her friends. "Ahhh, I really must find my friend," I lied. Pretended to have called Sally, then I left. (Another restaurant) sundae and parfait. Home; threw up.

9:30 p.m. So weak, numb.

11:45 p.m. A diet Squirt and here I am. I hope I lose weight; I hope I disintegrate.

(From the diary of a bulimic college student [Neuman & Halvorson, 1983, p. 44].)

Background

In an age of therapeutic awareness and self-recovery, interest in family dynamics, family of origin, early environmental characteristics and their developmental effects is steadily growing. The family is still the primary influential unit and the first provider of education and social development for individuals. As viewed by Adlerian theory, the family is the first place where an individual can develop social interest, a sense of belonging, acceptance, and love along with a personal hypothesis on how the world works. One of the most
prominent areas of research evolving today includes a look at family background and early family environment as related to present behavior. All society's in the world have cultural traditions for parenting, and despite variation, all hold in common the hope that the methods utilized will provide the type of adult who can best survive in that culture (Christensen, 1983). A dysfunctional family of origin can produce dysfunctional adult behaviors that may have been learned early on as coping strategies. Eating disorders, specifically bulimia for the purpose of this study, are examples of such coping mechanisms. Present research (Casper & Zachary, 1990; Scalf-McIver & Thompson, 1989; Williams & Manaster, 1990) has indicated that there is a direct relationship between family background and bulimic behavior. A growing body of research relating specific family correlates to anorexia nervosa and bulimia nervosa is emerging in the psychological and psychiatric literature (Scalf-McIver & Thompson, 1989). Historically, anorexia nervosa has received greater attention (Schlesier-Stropp, 1984) with clinical reports dating as early as 1873.

Bulimia has only been recognized as a psychiatric disorder for a brief time (APA, 1980), but it has been in existence for a long time.

In the year AD 8 in the eighth book of

Metamorphoses, the Roman poet Ovid described the
saga of the godless transgressor Erysichton, whom the goddess Ceres punished with an insatiable hunger; she forced him to eat himself out of house and home and finally to eat himself (Fichter, 1990, p. 3).

Although bulimia affects more than 10% of the female college-age population (Smith & Thelen, 1984) and roughly 2-4% of all women age 18-35 (Fichter, 1990) there have been fewer studies that focus solely on this disorder.

Bulimia, or "ox hunger", is an eating disorder characterized by:

1. Abnormal increases in hunger or in the need to eat despite the absence of subjectively experienced hunger.

2. Distinct and inconspicuous episodes of binge-eating, that is, 'rapid ingestion of large quantities of food' in secret.

3. Attempts to undo the effects of binge-eating by self-induced vomiting, restrictive dieting, excessive exercising, or use of laxatives, diuretics, and diet pills.

4. An inability to stop bingeing despite the perception that the urges, binges, and purges are unwanted and abnormal (Levine, 1987, pp. 274-275).
Eating disorders are a result of dysfunctional eating habits, which may be a reaction to certain events in an individual's personal life.

Bulimia, as a secret behavior, is a form of secret celebration, "grabbing the family substance" as one patient put it (Igoin-Apflebaum, 1985).

Hilde Bruch (1973) was the first to purport a connection between family environment and bulimic behavior. Subsequent research studies (Casper & Zachary, 1990; Chandler & Willingham, 1989; Scalf-McIver & Thompson, 1989) support this theory and indicate several areas as focal points for this population. Some research has been done concerning family environment, parent-child relationships, and behavioral manifestations, but this was the first study that administered Adlerian Lifestyle Questionnaires to bulimic women in order to examine the commonality of their subsequent life themes. Because it is the family, typically, that serves as the child's first social environment, lifestyle data focus heavily on the client's memories about family members and their interactions (Dreikurs, 1967). Although Adler stressed the uniqueness of his patients, he never-the-less recognized similarities among individuals and their lifestyles (Ansbacher & Ansbacher, 1956).
Early identification of recognizable patterns could potentially prevent the emergence of bulimic behavior in early adulthood. The Adlerian Lifestyle Questionnaire utilizes early recollections and family of origin characteristics to understand an individual's style for living and how this style is currently serving the client productively and counter-productively (Chandler & Willingham, 1984).

Purpose of the Study

The purpose of this study was to explore commonalities of life themes held by bulimic women, as measured by the Adlerian Lifestyle Questionnaire.

Statement of the Problem

This study proposes to answer the question, will there be common life themes or self-apperceptions reported by bulimic subjects, as identified by Adlerian Lifestyle Questionnaires?

Assumptions of the Study

This study is based upon the following assumptions:

1. Adlerian Lifestyle Questionnaires provide information about an individual's early experiences that can be translated into adult apperceptions.
2. The instructions and procedures given for the Lifestyle Questionnaires were appropriate for gathering information for this population.

3. The participants in this study responded honestly and competently to the Lifestyle Questionnaire items.

4. The Adlerian Lifestyle judges were competent to evaluate Lifestyle.

5. The subjects involved in this study were bulimic.

Limitations of the Study

Certain unavoidable limitations have affected the results of this study as well as the usefulness of future application of the findings. The number of participating subjects in this study was ten. Because of this small sample size, it is highly unlikely that it can be viewed as representative of the bulimic female population, or of any specified student body. The subjects ranged in age from 21 to 42, which may infer that they have a very varied set of issues that a more homogeneous sample population may not have. Other limitations include the differentiation between the self-diagnosed bulimic subjects and the clinically diagnosed bulimic subjects, and the fact that the sample used in this study was not randomly selected. These factors may have influenced the subjects' responses.
Definition of Terms

For the purpose of this study, the following terms were defined:

1. **Adlerian Psychology.** Theory of human behavior developed by Alfred Adler and Rudolf Driekurs based upon the following assumptions:
   a. Unity and self-consistency of the personality.
   b. Unique individuals behaving in relation to the changing problems of life. Decisions regarding behavior are influenced by the individual's opinion of him/herself and of the environment with which he/she has to cope.
   c. The individual's striving for success in the solution of his problems, this striving being anchored in the very structure of life. But the judgment of what constitutes success is again left to the opinion of the individual (Ansbacher & Ansbacher, 1964, p. 5).

2. **Bulimia.** A pattern of binge-eating, accompanied by awareness of disordered eating with fear of not being able to stop, depressive moods with self-deprecating thoughts following binges, and three of the following symptoms: rapid consumption of
food during a binge, consumption of easily
digested food, inconspicuous eating, termination
of binge-eating by either abdominal pain or sleep
or social interruption or self-induced vomiting,
repeated attempts to lose weight by severely
restrictive diets or vomiting, a pattern of
alternate binges and fasts, the use of cathartics
for weight control (DSM III APA, 1980).

3. **Early Recollections.** Specific events that a
person believes to have taken place within the
first few years of his life (Ackerknecht, 1976, p.
45).

4. **Family.** A group of individuals living under one
roof and under one head: household. (Webster's

5. **Lifestyle.** The organismic idea of the individual
as an actor rather than a reactor, of the
purposiveness, goal-directedness, unit, self-
consistency, and uniqueness of the individual, and
of the ultimately subjective determination of his
actions (Ansbacher, 1964, p. 6).

**Summary**

In a time where dysfunctional behavior is often viewed
as a manifestation of early experiences and family
environment, it is imperative for professionals to utilize
measures to access the relative information. This chapter has briefly explored the utility of Adlerian Lifestyle Questionnaires to obtain family history data from a bulimic population. Because, historically, bulimia is linked with familial environment, the rationale for this study is established. Chapter 2 will provide a literature review on bulimia, Adlerian Psychology, and the application of Adlerian techniques with bulimic subjects.
CHAPTER 2
REVIEW OF THE LITERATURE

This chapter will review the literature regarding (a) bulimia, (b) bulimia as a female issue, (c) Adlerian Theory and Lifestyle Questionnaires, including reliability and validity, and (d) application of Adlerian techniques with bulimic subjects. The historical data concerning bulimia will focus primarily on family environment literature and family history patterns.

Bulimia

Over the past several years, the disordered syndrome of bulimia has become recognized as a major health problem, particularly among women. Because it is both an eating disorder as well as an addictive behavior, many women are unaware that this problem has a name. It is not clear what triggers bulimia in some women, but many report a sudden weight loss. Some women report dieting on and off for several years with a period of weight loss immediately preceding the actual onset. Some have reported the weight loss was due to sickness or surgery (Goff, 1984).

Once the bulimic behavior becomes regimented, the disorder is insidious. Both the frequency of bingeing and the size of the binges tend to increase over time, though the development of the illness varies among individuals
(Mitchell, Pyle, & Eckert, 1981). One study found that the frequency of binge-eating episodes varied from once a week to as many as 46 times a week (Mitchell, Pyle, & Eckert, 1981). The actual number of calories consumed during a binge can vary as much as the length of the binge. Some studies report a binge ranging from 1,200 to 11,500 calories (Goff, 1984), while others report as many as 55,000 calories (Mitchell et al., 1981). Most binges lasted less than two hours, but some could go on for eight hours (Goff, 1984).

To properly understand bulimia, it is necessary to view it globally rather than strictly as a psychological disorder based on a fear of becoming fat (Pyle, 1981). The bulimic person becomes dependent on the binge-eating and purging behavior as a way of coping and dealing with life, and as a way of changing the way he or she feels emotionally and physically (Goff, 1984). Actual weight control becomes secondary. The binge-purge cycle becomes a response to life stressors, both positive and negative. Because s/he experiences a great deal of shame and guilt, s/he carries out the behavior with a great deal of secrecy (Goff, 1984).

The element of secrecy is what prevents many bulimics from seeking professional help (Mitchell & Pyle, 1982). Beyond the psychological and behavioral concerns, there are serious medical complications associated with bulimic behavior. The most common is a disturbance of the body's
electrolyte balance, especially potassium levels. Other symptoms that commonly occur are fatigue, weakness, chills and cold sweats, faintness, and sore muscles. Swelling of the salivary glands, extensive dental problems, frequent sore throats, minor lesions in the throat lining and mouth, diarrhea, and constipation are common problems for bulimics (Goff, 1984).

The bingeing/purging and excessive laxative use can also cause irritation to the gastrointestinal tract (Goff, 1984). Areas of concern for women that have not been researched are the effects of bulimia on the reproductive system and on the fetus development during pregnancy.

**Bulimia As Female Issue**

According to the DSM III criteria (AMA, 1980), 2-4% of all young women between 18 and 35 years suffer from bulimia (Fichter, 1990, p. 4). "Disturbances of body image, disturbances of proprio, and interoceptive perception, and an all pervasive feeling of personal ineffectiveness and worthlessness are present in all eating disorders (Fichter, 1990, p. 8).

There are anthropological perspectives on the development of bulimia, such as changes in ideal body image, pre-disposition to higher body fat content in women, and an historical positive correlation between prevalence of obesity and social class (Fichter, 1990, p. 6)."Owing to
his revolutionary history, man is poorly suited to a continuous oversupply of food" (Fichter, 1990, p. 6).

The most obvious sociocultural determinant is the "thinness ideal." Response to this societally mandated goal can have a powerful effect on women, especially younger women who are dealing with self-concept and identity issues. Deviation from the real or perceived 'thinness ideal' may precipitate a severe crisis in these insecure subjects and, in extreme cases, induce them to force their body into fasting, dieting, or bulimic behavior (vomiting, abuse of laxatives, appetite-reducing drugs, spitting out of food, and the taking of diuretics and thyroid preparations) (Fichter, 1990, p. 8).

Because there is a physical as well as psychological component to this disorder, bulimia becomes a vicious cycle. Bulimic behavior with reduced food intake and partial malnutrition causes vitamin and mineral deficiencies, endocrine dysfunctions, disorders of the vegetative nervous systems, temporarily decreased basal metabolism, and increased irritability. Physiological consequences include uncontrollable hunger and attacks of 'binge-eating' which, due to the concern to avoid weight gain, lead to anxiety, reduced self-esteem, and
social isolation. The fear of being too fat is fought by further dieting and fasting or by 'purging behavior', thus the bulimic cycle is complete (Fichter, 1990, p. 9).

During the past decade, there has been noted an increase in the incidence of eating disorders in young women, particularly bulimia (Barnett, 1986). Researchers estimate that from 4 to 19% of college-age women (average 10+%) engage in some bingeing and purging behavior (e.g., Halmi, Falk, & Schwartz, 1981; Pope & Hudson, 1984; Pyle, Mitchell, Eckert, Halverson, Neuman, & Goff, 1983).

The notion of early family environment acting as a catalyst for eating disordered behavior in early adulthood was first explored by Hilde Bruch (1973). In her developmental model, she suggests that early deficits in autonomy due to specific parental inappropriate attitudes account for the relentless battle for control which plagues these patients with a sense of inefficiency, and a total lack of differentiation between physiologic states and emotions (Igoin-Apfelbaum, 1985). According to Bruch's (1973) research, fathers tended to be perceived as distant ineffectual persons, while mothers towered over as protective over-powering images. In a study done by Igoin and Apfelbaum (1985), patients usually came up with a first version of family events which appeared to fit with a
maternal identification. Because the patient's disordered eating affected their mother (she could cause them to eat when unhappy, be made unhappy if they were overweight, guess about her eating patterns, and then demand change), patients regarded their mother as the only family member who really cared. Food and bingeing could thus perpetuate an exclusive attachment modeled on infancy in which patients described symbiotic feelings (Igoin-Apfelbaum, 1985). This study also provided evidence of paternal identification. Patients used harsh words when describing their fathers, e.g., incompetent, irresponsible, violent, tyrannical, liar, and seducer. Not unexpectedly, the patients who were most self-reproachful and depressed after binges were those who drew the worst image of their father and most violently denied their attachment to him (Igoin-Apfelbaum, 1985).

Another study that examined family correlates in college-age female bulimics found that among the family variables, the mother's perceived inconsistent expression of affection toward her daughter was the best predictor of the severity of bulimic behavior (Scalf-McIver & Thompson, 1989). Degree of bulimia was correlated negatively with family cohesion, which reflects decreasing commitment, help, and support among family members as bulimic symptomatology increases (Scalf-McIver & Thompson, 1989). According to Strober and Humphrey (1987), many bulimic women attempt to
use the binge-purge behavior to fill their needs for nurturance, and to temporarily eliminate their feelings of rejection. Though the patients consciously know that their family is beyond "patching up", bulimia may be used as a denial of this fact. The patient is overcome by her craving for the long lost love objects whom she is unable to really feel she misses (Igoin-Apfelbaum, 1985).

A relatively new area of research involves the idea of societal pressure as a contributor to disordered eating patterns. This has been seen, by some, as a direct result of the women's movement in the last decade (Barnett, 1986). Because the career opportunities for intelligent, goal-oriented women have expanded, the pressure to cope and maintain in some of the non-traditional fields is overwhelming. Instead of developing active, psychic mechanisms for coping (Vaillant, 1977), the bulimic woman eats to swallow dysphoric feelings (Barnett, 1986). As evidenced by case histories, some women believe that they really aren't bright enough, and that somehow they have fooled those around them, despite their accomplishments (Barnett, 1986). This ideation has been termed the "imposter phenomenon" by Clance and Imes (1979).

Cherin (1981) suggests that the increase of eating disorders among women in contemporary society is related to the inability of a woman to resolve the contradiction
between her need to grow and develop herself as a person and her striving for conformity (Barnett, 1986). Because our society places value on such things as competence, skill, success, and status, intelligent young women develop strong achievement motivations that may lead to dysfunctional behavior if the stress gets too intensified. The symptom of bulimia may represent a woman's ambivalence toward filling the socio-cultural stereotype of femininity and asserting her own personal power in a world which rewards hypermasculinity (Barnett, 1986).

"Most authors recognize the multidimensional and heterogeneous nature of eating disorders. There is an acceptance that not all therapies will suit all patients" (Garner & Garfinkle, 1985, p. 4).

Therapists from different schools emphasize the recognition and expression of affect; the value of exploring family interactional patterns; and the relevance of such developmental issues as separation, autonomy, sexual fears, and identity formation. The systematic application of several strategies may be preferable to operating from a unitary theoretical model.

Because of the growing awareness of risk factors and early warning signs, some training schools with high-risk activities such as ballet,
gymnastics, and figure skating, have changed policies that may have exacerbated the problem. Weekly 'weigh-ins' have been discontinued, and teachers may have been cautioned not to employ negative sanctions against those whose weight falls above the standards. Moreover, students who are beginning to display symptoms are provided with counseling and occasionally with assistance in choosing pursuits or careers that do not stress a thin image (Garner & Garfinkle, 1985, p. 514).

Adlerian Theory, Lifestyle Questionnaire

The contributing factors, whether familiar or societal, are revealed in an Adlerian life theme. The Lifestyle Questionnaire gathers information concerning family constellation, birth order, sibling relationships, achievements and deficiencies, parent-child relationships, and family climate. The goal of the projective diagnostic activity is to elicit the pattern of living, the lifestyle (Mosak, 1972).

Alfred Adler (1870-1937) was the father of Individual Psychology which sees individual lives as a whole and regards each single reaction, each movement and impulse as an articulate part of an individual's attitude toward life (Adler, 1929). Although his first ten years were closely associated with Freud (Podboy & Organist, 1975), by 1912
differences developed that were as fundamental and far-reaching as is possible within a given area (Ansbacher & Ansbacher, 1956). Adler proposed a subjectivistic point of view quite opposite of Freud's objective outlook (Brammer & Shostrom, 1968).

Social Interest

The nucleus of Adler's personality theory is the concept of a unitary, goal-directed, creative self. Individual Psychology assumes an essential, cooperative harmony between individual and society. This harmony is assumed to be based on an "innate substratum of social interest" (Ansbacher & Ansbacher, 1964, p. 6). Social Interest means "feeling with the whole sub specie aeternitatis (under the aspect of eternity)" (Ansbacher & Ansbacher, 1964, p. 34). It means striving for a community which must be thought of as everlasting. Social Interest is a normative ideal—a direction-giving goal. A movement of the individual or a movement of the masses can for us, pass as valuable only if it creates values for eternity, for the higher development of mankind. Every human being brings the disposition for social interest with him/her but then it must be developed through upbringing, especially through correct guidance of the creative power of the individual (Ansbacher & Ansbacher, 1964, p. 36).
The term social interest itself refers to the individual's awareness of being part of the human community and his/her attitudes in dealing with the social world. According to Ansbacher and Ansbacher (1964) the socialization process starts in childhood, when an individual first finds a place in society and thus acquires a sense of belonging and contribution. As an individual's social interest, specifically the ability to identify with and have empathy for others, increases, an individual's feeling of inferiority and alienation decreases (Ansbacher & Ansbacher, 1964).

People express their social interest through shared activity and mutual respect, as well as continued concern for the welfare of others. People without social interest become discouraged. Individual Psychology relies on the belief that happiness and success are largely related to this social connectedness and social interest. People begin seeking a place in the family and then in society, and have a central need to find their unique way of contributing and sharing in activities and responsibilities. According to Adler's (1964) theoretical concept of social interest, many problems people experience are a direct result of the fear of not being accepted by the groups we value. If this is not accomplished, we experience anxiety and a difficulty in dealing with these problems (Adler, 1964).
Mosak (1977) states that we must face and master five life tasks:

1. Relating to others (friendship).
2. Making a contribution (work).
3. Achieving intimacy (love and family relations).
4. Getting along with ourselves (self-acceptance).
5. Developing our spiritual dimensions (including values, meaning, life goals, and our relationship with the universe, or cosmos).

Beyond these, it is necessary to define our sex roles and learn to relate to others interdependently (Mosak, 1977).

For teaching purposes, Adler (1958) proposed four types of people to classify the attitude and behavior of individuals toward outside problems.

1. 'Ruling' type - those who express a dominant attitude from early childhood.
2. 'Getting' type - those who expect everything from others and lean on others. This is the most frequent type.
3. 'Side-Step' type - those who feel successful by avoiding the solution of problems rather than struggling with them.
4. 'Socially Useful' type - the fourth type struggles to a greater degree or lesser
degree for a solution of these problems
in a way which is useful to others.
(Adler, 1958, p. 42).

Individual Psychology has shown that the first three types
are not prepared to solve the problems of life. These
problems are always social problems. These individuals are
lacking in the ability for cooperation and contribution.
Adler (1958) sees that the clash between such a lifestyle (a
lacking in social interest) and the outside problems
(demanding social interest) results in shock. This shock
inevitably leads to what is known as neurosis, psychosis,
etc. In the fourth type we see a preparation for
cooperation and contribution and a level of activity which
is used for the benefit of others (Adler, 1958).

Adler states that the "innate potential for social
feeling (along with one's style of life) occurs early in
life and that it is first influenced by the mother-child
relationship" (Leak & Williams, 1989, p. 363). More
specifically, he believed that social interest was reflected
in attitudes toward other family members (Ansbacher &
Ansbacher, 1956, p. 435). Because Adler saw situational
factors, such as parental training, to be influential in the
development of social interest, he "attributed a large
number of failures in life to an unhappy family" (Leak &
Williams, 1989, p. 363). "If Adlerian theory is correct,
there should be a relationship between one's level of social interest and one's perception of the psycho-social environment of one's family" (Leak & Williams, 1989, p. 364). Adler assumed that people were essentially gregarious--beings whose directions were social (Podboy & Organist, 1975). Today this is called a person's lifestyle.

As early as 1907, Adler published a format of lifestyle questions designed for therapeutic interview (O'Phelen, 1977). Subsequent lifestyle questionnaires have been published by Adler (1948), Wexberg (1929/1970), and Dreikurs (1954).

**Birth Order**

One of the most important pieces of information that is uncovered through lifestyle analysis is where the subject falls in the birth order of the family. This placement is vital to the eventual interpretation because Adlerian theory states that no two children are born into the same family. "Each child, after the first, is born into a different family system" (Christensen & Shramski, 1983, p. 17). Christensen and Shramski (1983) summarize Adlerian birth order characteristics as follows:

- **Eldest Child (first born)** - Frequently become cautious, examining all risks before attempting new tasks. They may become shy and withdrawn or develop a fear of being overtaken and surpassed.
This fear results in oldest children putting severe demands on themselves for achievement, high standards of behavior, and success at all costs, which often are seemingly unattainable. These children may put themselves in a position of discouragement.

Second Child (Middle) - Frequently views everything that the oldest child can do as an indication of their own smallness and inferiority. Because of this they will try to catch up and will typically attempt to achieve superiority in areas where the oldest encounters difficulty. These children often see unfairness in life and feel cheated and abused. Despite their evident cynical attitudes toward life, they tend to be good survivors.

Youngest Child (Last Born) - Frequently develop characteristics which make it likely that others will help them shape their lives. Such characteristics as helplessness, a winning nature, and a whimsical smile are all manipulative devices used by youngest children.

Only Child - Frequently tend to be personal-comfort oriented. They are likely to be relatively demanding, somewhat self-centered,
somewhat controlling, and subtly manipulative in their approach to other people. The only child tends to have ambivalent feelings about childhood. Special Sibling - Frequently elicit an unusual amount of paternal attention. The special sibling may be weak, sickly, handicapped, retarded, adopted, or gifted and are seen as persons in need of unique attention (pp. 17-18).

If there is spacing of five or more years between children, each child will possess some of the qualities and behaviors of an only child. If there are two or more groups of children with this spacing, they will form subgroups with individual birth order placements from first born to youngest.

**Early Recollections**

Beyond the information concerning family constellation, as stated earlier, Lifestyle Questionnaires utilize early recollections as a projective technique for establishing life themes. According to Adler (1937) a person's early recollections (ERs) are found always to have a bearing on the central interests of that person's life. Early recollections give us hints and clues which are most valuable to follow when attempting the task of finding the direction of a person's striving. They are most helpful in
revealing what one regards as values to be aimed for and what one senses as dangers to be avoided. They help us to see the kind of world which a particular person feels he/she is living in, and the ways he/she really found of meeting that world. They illuminate the origins of the style of life. The basic attitudes which have guided an individual throughout his/her life and which prevail, likewise, in his/her present situation, are reflected in those fragments which he/she has selected to epitomize his/her feelings about life, and to cherish in his/her memory as reminders. He/she has preserved these as his/her early recollections (p. 287).

Later, Adler (1939) states that there are no chance memories: out of the incalculable number of impressions which meet an individual he chooses to remember only those which he feels, however darkly, to have bearing on his situation. Thus his memories represent "a story of my life"; a story he repeats to himself to warm him or comfort him, to keep him concentrated on his goal and to prepare him by means of past experiences so that he will meet the future with an already tested style of action (Adler, 1958). When asking for early recollections (ER's), in a Lifestyle interview, the clinician must insist on specificity. ER's
should include the approximate age of the event, the highlight, and the accompanying emotions. ER's are one of the most essential parts of an Adlerian Lifestyle analysis and, among other things, uncover the life fiction or goal of superiority which the individual is not totally, or not at all, aware (Ackerknecht, 1976).

Memory is an activity. It is based on the lifestyle which is determined by the selection of one single impression out of many (Ansbacher, 1964, p. 197). By eliciting several early memories or recollections, one can begin to see commonalities, and to make hypotheses about the way an individual views their world. "We may gather from them the mental, emotional, and attitudinal aspects and only after that may we arrive at an understanding of the unity of the personality" (Ansbacher, 1964, p. 95).

Reliability and Validity of Lifestyle Questionnaire and Early Recollections

"The validity of lifestyle analysis is still an open question, for there has been no direct or systematic investigation of this procedure" (Gushurst, 1971, p. 37). Because validity is a relative finding, it is necessary to view the validity of lifestyle assessment in conjunction with something else tangible. "This means that the validity of lifestyle analysis would have to be assessed in relation to either a particular use or through comparison with
another assessment procedure" (Gushurst, 1971, p. 37).
Reviewing the research by Madison (1969) and Gushurst (1971)
in these areas, "it is possible to see both an early
indication of the potential validity and utility of
lifestyle analysis and a guideline for future research in
the area" (Gushurst, 1971, p. 39).

In a published review of some recent validation studies
on early recollections as a projective technique, Taylor
(1979) summarizes the previous research and its
implications. Six articles (Ferguson, 1964; Hedvig, 1963;
Jackson & Sechrest, 1962; Lieberman, 1957, McCarter,
Tomkins, & Shiffman, 1961) that specifically deal with
attempts to establish the validity and reliability of the
diagnostic/projective use of ER's have been summarized and
the results of these articles lend support to the use of
ER's as a diagnostic projective technique in that (Taylor,
1979):

1. ER's may serve as a rapid, valuable
sample of the type of data likely to be
obtained from the longer time consuming
projective battery examinations (Hedvig,
1965; Lieberman, 1957).

2. ER's may serve as a valid method of
personality appraisal, specifically in
the areas of degree of activity,
including work and social interest
(McCarter, Tomkins, & Schiffman, 1961).

3. There appear to be some thematic
differences among ER's produced by
subjects diagnosed as belonging to
several neurotic categories (Jackson &

4. There is evidence to suggest that ER's
are not influenced by situations of
success or failure, hostility, or
friendliness, and thus are more stable
than Thematic Apperception Test stories
which do appear to be influenced by such
situations (Hedvig, 1963).

5. Lifestyle summaries based on ER's are
reliably communicable to a wide range of
professional workers (Ferguson, 1964).
On the other hand, however, information
obtained from ER's only does not appear
to be adequate for valid diagnosis of
psycho-pathology for most clinicians
(Ferguson, 1964; Hedvig, 1964) nor for
the prediction of optimism-pessimism
(McCarter, Tomkins, & Schiffman, 1961).
Ferguson's research (1964) demonstrated that "summaries of lifestyle protocols made from early recollections of 30 subjects diagnosed as psychotic, neurotic, and normal could be recognized and reliably matched to their owner's original protocols by clinicians" (Magner-Harris, Riordan, Kern, & Curlette, 1979, p. 197). Several developments, theoretical and methodological, have aided the possibility of assessing the reliability of a total lifestyle interview. Because Adler recognized the similarities among individuals as well as an individual's uniqueness, "several Adlerians have posited the existence of certain commonly observed lifestyle types and have described associated behaviors" (Kefir & Corsini, 1974; Mosak, 1971). "Thus it appears that the practical difficulty of categorizing idiographic behavior into nomothetic units has the potential of being accomplished without damaging the theoretical spirit of Adlerian thought" (Magner-Harris, Riordan, Kern, Curlette, 1979, p. 197).

Adlerian Theory on Eating Disorders

In *Cooperation Between the Sexes*, Adler (1978) discusses his position on women, their role in society, their potential predisposition for discouragement, and their issues around sexuality. He incorporates early family experiences and societal influence in his theoretical perspective. According to Adler (1978),
A girl is told at every step, so to speak, daily, and in countless variations, that girls are incapable, and are suitable only for easier and subordinated work. Obviously a little girl unable to examine such judgments for their correctness will regard female inability as woman's inevitable fate, and will ultimately herself believe in her own inability (p. 12).

The societal component is an integral part of the larger picture of a female's struggle. "It is not easy in our culture for a girl to have self-confidence and courage" (Adler, 1978, p. 13). Adler sees the childhood situation as a decisive factor in determining a woman's future role. "In childhood, matters are complicated by the psychological relations with the parents. The impressions of early childhood, the image of the father, a brother, or one's own people are often highly co-determining" (Adler, 1978, pp. 82, 86). Feminine traits can be subject to the social balance between men and women and may either be shaped or destroyed due to this force. "A bad marriage of the parents, rudeness, drunkenness, and recklessness of the father, or open unfaithfulness cause daughters to fear for the rest of their lives that they may meet the fate of their miserable and deeply humiliated mother" (Adler, 1978, p. 87).
"Awkwardness, brutality, or injuries to psychological sensitivity during the first relations may lead to permanent upset. Fear arousing experiences in childhood and prejudices regarding pain and the dangers of being a woman further increase the inferiority feeling" (Adler, 1978, p. 89).

A recent study which views eating disorders as a maladaptive conflict resolution states that "all persons with eating disorders use food and eating to communicate symbolically their sense of inadequacy in the face of life's requirements" (Casper & Zachary, 1990, p. 446). These authors propose that this sense of inadequacy is a direct result of a failure to master essential living skills and an ineffective attempt to communicate healthily with others.

Basic human needs for safety and appropriate limits, combined with a thwarted search for significance and perfection, appear to foster the ritual behaviors of eating disorders, creating an illusion of safety, limits, and significance. The evasion, repression, and denial characteristically associated with eating disorders seem related to operations (coping mechanisms) learned in the family of origin (Casper & Zachary, 1990, p. 446). Because these families typically don't address conflict, due in part to the prevailing myth that conflict infers personal
or family failure, problems, and the shattered illusion of family cohesion, they spend a great deal of time not solving conflicts (Casper & Zachary, 1990).

Bulimia, like other eating disorders, is a coping strategy where food, weight, and body image become the major focus in life. Due to the fact that it is a progressive disorder, "The bulimic has little time for work, love, social life, or social interest. Bulimic patients report a pervading sense of emptiness" (Casper & Zachary, 1990, pp. 446-447). Casper and Zachary (1990) studied the family systems with an eating disordered member and the typical elements of their styles of conflict resolution. Their findings were summarized as follows:

1. Mother was usually a woman who had put all of her energies into mothering. She needed to create a self-image in which she was loved, needed and useful. So great was her need to mother an apparently successful family, that, although she experienced conflict in and around her, she denied it to herself, to her family and to the world.

2. Father has few skills for resolving conflicts at home. He sees conflict as a red flag, challenging not only his
comfort but his adequacy as a man. His fictions tell him that he should be in control of his feelings, his family, his finances, and his future.

3. Sibling - The sibling joins the bulimic in one passionately held goal: to make her parents appear to be parenting successfully. If the parents cannot parent, the responsibility may fall on the shoulders of one of the children. The sibling's overt behavior is one of pointing her finger at the eating disordered member in order to keep her the focus of the family illness. Her methods range from hostile, underhanded criticism to the narration of the "facts" (as she sees them) of family interaction.

4. Bulimic - The unconscious goal of the bulimic is to focus the attention away from the parental/family problem by becoming the identified patient. In an attempt to resolve conflict, the bulimic focuses on food rather than issues, weight rather than judgment, and
unreality rather than decision. The eating disorder itself symbolizes the control issues, the denial, the avoidance, the rituals, the excesses, and the emptiness of the family.

Another study by Williams and Manaster (1989) looked at restrictor anorexics, bulimic anorexics, and bulimic women's early recollections and Thematic Apperception Test response. "Adlerian theory of ER's predict that negative and overdriven attitudes would be found in the more disturbed subjects" (Williams & Manaster, 1989, p. 100). Overall, eating disordered groups in this study had more negative interpersonal themes.

The bulimic's ER's reflected the achieving priority and detachment while their TAT scores indicated passivity and avoidance. Both ER's and TAT scores of the bulimics showed trends toward poor maternal empathy. "Several of the more troubled experimental subjects used the same characters and themes over and over in their ERs, for example, rejection and hostility from the mother" (Williams & Manaster, 1989, p. 100).

The TAT scores and the ERs of all three eating disordered groups, specifically the TAT responses of the bulimics, suggest a pervading sense of external locus of control among eating disordered subjects, which is
consistent with research and clinical observations of bulimics (Boskind-White & White, 1983; Caurvels, 1983; Dunn & Ondercin, 1981; Weiss & Ebert, 1983). "All three eating disordered groups showed more negative affect than the comparison group in their ERs and TAT responses, with this dysphoria more pronounced among the two anorexic groups than in the bulimic group" (Williams & Manaster, 1989, p. 101). The findings in this study suggest that bulimics base their self-worth on accomplishments and that they lack the self-esteem needed to relate well to others and attain intimacy.

The results of this study suggest that eating disordered groups may have a narrower perspective due to the narrow range of subjects in their early memories.

"The bulimics', and particularly the anorexics' projective responses see them having defective relationships with their mothers and poor interpersonal relationships generally" (Williams & Manaster, 1989, p. 105).

Lifestyle theme work with bulimic women can be an integral part of a cognitive change and can offer encouragement in general. This can be attained by uncovering and disputing their discouraging fictional beliefs.

Because these persons are particularly burdened with susceptibility to discouraging beliefs, some specific to individual scripts, some generalized
through the happenstance of being overweight in a thin-oriented culture, just a partial awareness and understanding of a theme or themes provides support for weight control (Laser, 1986, p. 128). Gaining some understanding into the whys and hows behind bulimic behavior can be significant insights.

Summary

This chapter provided a literature review that supports the utility of the study's topic. The areas of research that were discussed included a global coverage of bulimia and its effects on the female population, Adlerian theory, the Lifestyle Questionnaire as a projective tool, and the current literature combining an Adlerian approach to bulimia and eating disorders. The methodology used in this study will be discussed in Chapter 3.
CHAPTER 3

METHODOLOGY

This chapter will include a discussion of the methodology used in this study. Sub-categories that will be addressed include subjects, instrumentation, data collection, analysis, and summary.

Subjects

Originally, participants for this study were restricted to college-age women, 18-25 years old, who were recruited from a university run eating disorder support group. They were all white, female, self- and clinically-diagnosed bulimics who had not previously been administered an Adlerian Lifestyle Questionnaire. Ten subjects participated in this study as a small representation of a specific population. These subjects participated voluntarily in the study and were insured anonymity and confidentiality (see Appendix B).

Instrumentation

Lifestyle, according to Adler (1964), is the sum total of attitudes, goals, and beliefs the child develops in his/her attempt to find a place for himself/herself.

Lifestyle Questionnaire: The Adlerian Lifestyle Questionnaire (see Appendix D) was chosen because of its focus on individual traits and experiences. Based in the
school of Individual Psychology, the Lifestyle Questionnaire is a tool used for self-report and self-expression of an individual's family of origin and the subsequent environment. The application of such personal information to a life theme is the premise of the questionnaire. This instrument helps to reveal a subject's early ideation about the world and his/her role and means of interaction with it. It can provide a global picture of an individual's life philosophies and coping strategies in the world, as they see it.

Lifestyle Questionnaires refer to a format of questions used by the Adlerian counselor which enable him/her to see the client's "central convictions which, to oversimplify, describe how he/she views him/herself in relation to his/her view on life" (Mosak, 1972). Individuals differ in Lifestyle; each lifestyle is characteristic for him/her alone (O'Phelan, 1977).

The first section deals with the Family Constellation. The interviewer receives information regarding the subject's family of origin. Description, role identification, and inter-relationship questions all reveal a brief individual history that is used later as an interpretive measure. This first group of questions deals primarily with family dynamics and birth order issues.
The second section involves the extraction of Early Recollections, or memories, from the subject's past. The focus here is on feelings and emotional response. The information gathered at this point is exemplary of how the subject views life. Life themes, in the form of, "Life is . . .", "Life should be . . .", "Life can be a place where . . ." are formulated from the descriptions and information revealed in the subject's early memories. Apperceptions about self can be derived from an individual's life themes.

Data Collection

Ten bulimic, female, university students, 18 to 25 years old were recruited to voluntarily be interviewed by the researcher. The researcher initially received permission from the Student Health Office to make a small verbal presentation and distribute flyers (see Appendix A) to the Eating Disorder Support Groups there. The project was presented as a study that was looking at family environment history in bulimic women. The group was briefed on the methodology of the study and insured confidentiality and anonymity. Cards were passed out for any interested students to write their names, addresses, and telephone numbers on. The researcher collected the cards after answering further questions. After selecting the 10 most homogeneous participants, the researcher contacted each student by phone. Individual sessions (minimum one hour)
were scheduled between each subject and the researcher. The pre-interview time frame was set up and each session was taped. The participants were asked to sign a written permission slip allowing the tape-recording of the interview. The interviews were later transcribed.

The subjects were asked to answer the questions in the Lifestyle Questionnaire. Additional instructions were added to page 1, section 1, regarding the listing of all family members in the subject's family of origin, and for providing three descriptors for each member. On page 2, section 2, additional instructions were provided asking the interviewee to specify feelings associated with each early recollection.

Analysis

The Lifestyle Questionnaires and a worksheet (Appendix E) for each subject were given to a panel of three Adlerian experts for interpretation. The three expert judges were all Adlerian-trained counselors and psychologists who utilize Adlerian concepts in their related field of work. The judges were each asked to analyze the data individually and to complete the worksheets for each subject. They were then asked to collectively review the data in a group meeting, and to complete a worksheet for each subject, based on the general consensus from the questionnaires and individual worksheets. This final worksheet was a
compilation of interpretations and basic Adlerian life themes for each individual subject.

Summary

This chapter dealt solely with the methodology utilized in this study. A brief discussion of the subjects, research instrument, methods of data collection, and analysis were presented. A description of the utility of the Lifestyle Questionnaire and the panel of expert judges used further explained the methodological strategy. Chapter 4 will present the results of this study along with a discussion section.
CHAPTER 4
RESULTS AND DISCUSSION

Chapter 4 will present Lifestyle summaries for each of the 10 female bulimic participants who were interviewed in this study. These summaries are a result of the analysis by the panel of Adlerian judges. Their judgments and conclusions were derived from the Lifestyle Questionnaires and the subjects' early recollections. Each Lifestyle summary will include the subjects' apperceptions, goals, and expectations, and view of the world. An additional discussion will follow each summary based upon the judges' opinions on noticeable trends and contributing factors affecting this population. Following the results, this chapter will also present a discussion of the commonality of life themes and a global review of the 10 participants as related to the current research. The results and discussion sections will be followed by a summary.

Participants

Ten subjects participated in this study. They were all white, female, bulimic participants ranging in age from 21-42 years old. Six of these subjects were self-diagnosed, four were clinically diagnosed. They were selected from populations found in local counseling agencies, local health clubs, and local eating disorder support groups. They were
not restricted to university affiliation or student status. These subjects had not previously been administered an Adlerian Lifestyle Questionnaire and they all participated voluntarily. The subjects were all insured anonymity and confidentiality.

Data Collection

Ten bulimic, female participants, 21 to 42 years old were recruited to voluntarily be interviewed by the researcher. The researcher initially received permission from the Human Subjects Committee to distribute fliers (Appendix A) to local eating disorder support groups, local health clubs, and counseling agencies. The project was presented as a study that was looking at family environment history in bulimic women. Each subject was briefed on the methodology of the study and insured confidentiality and anonymity. Interested subjects responded to the flyer by contacting the researcher. Individual sessions (minimum one hour) were scheduled between each subject and the researcher. The pre-interview time frame was negotiated. The participants were asked to sign a written permission slip explaining the use of their personal data.

The subjects were asked to answer the items in the Lifestyle Questionnaire (OCC). Additional instructions were verbally added to page 1, Section 1, regarding the listing of all family members in the subject's family of origin, and
for providing three descriptors for each member. On page 2, Section 2, additional instructions were provided asking the interviewee to specify feelings and a focus associated with each early recollection.

Results

I. **Demographics - Subject #1**

Age - 24
Self-Diagnosed
Age at onset of bulimia - 11
Birth order - last born
Counseling - yes

Lifestyle Summary for Subject #1

A. **Apperceptions**

1. I am: unsure of myself around others, unlikable, alone, confused, unsocial, an observer, stubborn, funny, resentful, lacking in self-confidence.

2. Others are: in control, more likeable, responsible for me, the stars.

3. Men are: angry, loud, connivers, cheaters, hardworkers, supposed to take care of me, used to having their own way, admired by women, when angry they scream and then they leave.
4. Women are: helpless, weak, victims, tired and sick, don't count for much, women get the short end of the stick, don't leave.

B. Goals and Expectations
   1. I want: to be a star
   2. I want: to be discovered
   3. I want: to be loved and taken care of
   4. I want: to be special
   5. I want: attention
   6. I expect: to get the short end of the stick
   7. I expect: to be taken advantage of
   8. I expect: to have no control
   9. I expect: closeness, but am often disappointed.

C. World View
   1. The world is a place where: men leave
   2. The world is a place where: people take advantage of the weak
   3. The world is a place where: I have little control
   4. The world is a place where: I must always make people notice me and take care of me
   5. Life is: wonderful when there is love
   6. Life is: waiting
7. Life is: A place where people cheat and connive.

D. Discussion
The judges all agreed that this subject was passive and had an external locus of control. Her worth, value, and self-esteem came from others. There was no conflict resolution in her family of origin, therefore, she had no models for problem solving. She was waiting to be discovered as a "beautiful swan" by "Prince Charming" with no effort on her part.

II. Demographics - Subject #2

Age - 25
Self-diagnosed
Age at onset of bulimia - 15
Birth order - first born
Counseling - Yes

Lifestyle Summary for Subject #2

A. Apperceptions
1. I am: often out of control, eager to please, at the mercy of others, hardworking, intelligent, loyal, supposed to be a "dream", perfect, worried about fitting in.
2. Others are: unavailable, more in control, more important and valued, have a harder life than I do.

3. Men are: to be pitied, passive, weak, sickly, emotionally unexpressive, don't stand up for themselves, very intelligent, leave when they are angry.

4. Women are: fixers, strong, vicious, verbally critical, vivacious, must be attractive and fit, frustrated and unhappy, don't know how to get along with men.

B. Goals and Expectations

1. I want: to be special and pretty
2. I want: to be able to take care of myself
3. I want: to feel free
4. I expect: not to fit in
5. I expect: to feel terrified when I have no control
6. I expect: to feel afraid when someone's not there for me.

C. World View

1. The world is a place where: I am scared and powerless without a place.
2. The world is a place where: It's not OK to show who you really are.
3. The world is a place where: You should be perfect, never a problem.
4. The world is a place where: People should be well educated.
5. The world is a place where: People don't trust each other.
7. Life is: A place where people can be cruel
8. Life is: A place where people keep secrets.

D. Discussion

Upon review, the judges agreed that this subject was passive and had an external locus of control. Again, there was no problem solving or conflict resolution within the family. She felt the need to be "Patty Perfect" and thought that if she acted on, or acknowledged her emotions, she would be out of control. This subject felt safest when she was hiding.

III. Demographics - Subject #3

Age - 26
Self-Diagnosed
Age at onset of bulimia - 19
Birth order - only
Counseling - yes
Lifestyle Summary for Subject #3
A. **Apperceptions**

1. I am: A good kid, eager to please, well-behaved, sensitive to others, need approval from others, passively aggressive, goal-oriented.

2. Others are: More in control, more intelligent, supposed to approve of me and dote on me.

3. Men are: Giving, supportive, pleasers, passive, pitiful, kind, when angry they leave.

4. Women are: Aggressive, domineering, strong willed, hard workers, goal-oriented, in control, stubborn, rarely satisfied.

B. **Goals and Expectations**

1. I want: to be recognized
2. I want: to be accepted
3. I want: to be openly acknowledged
4. I want: to be the center of attention
5. I want: to be special
6. I want: to be free
7. I want: to have control
8. I expect: not to get what I really want
9. I expect: to get positive information about myself from men
10. I expect: my support system to leave
11. I expect: to force people away like mom did

C. World View
1. The world is a place where: I am supposed to be the center of attention.
2. The world is a place where: I should be special.
3. The world is a place where: Others have control.
4. Life is: wonderful when I get attention.
5. Life is: happy when I'm in control.

D. Discussion
The judges all felt that this subject was passive and had an external locus of control. As with the others, there was no conflict resolution or healthy problem solving in the family of origin.

IV. Demographics - Subject #4
Age - 24
Clinically Diagnosed
Age at onset of bulimia - 11
Birth order - first born
Counseling - Yes
Lifestyle Summary for Subject #4
A. **Aperceptions**

1. **I am:** Trying to be perfect but give up when I can't be the best, hard-working, intelligent, idealistic, I have high expectations, I need to be the best.

2. **Others are:** Hard to get along with, jealous of my capabilities.

3. **Men are:** Untrustworthy, selfish, aggressive, violent "jerks", abusive, very powerful, when angry they leave.

4. **Women are:** Nice, forgiving, submissive, good, caring, hard-working, taken advantage of.

B. **Goals and Expectations**

1. **I want:** control

2. **I want:** to be accepted

3. **I want:** to worry less

4. **I expect:** to be taken advantage of

5. **I expect:** to sit and wait

6. **I expect:** to be afraid when I am victimized

7. **I expect:** to feel guilty even when things aren't my fault

8. **I expect:** to feel lonely, sad and disappointed when people break promises.
C. World View

1. The world is a place where: I have no control.
2. The world is a place where: People take advantage of you.
3. The world is a place where: I don't feel safe.
4. The world is a place where: I'm confused and I don't understand.
5. Life is: hard and often disappointing.
6. Life is: feeling guilty.

D. Discussion

The judges all agreed that this subject was passive and had an external locus of control. There was no problem solving or conflict resolution in the family. This subject was an observer and a passive victim. She viewed the world as black and white—women as good, men as bad. She felt the need to be "Patty Perfect" but felt powerless.

V. Demographics - Subject #5

Age - 21
Self-Diagnosed
Age at onset of bulimia - 17
Birth order - first born
Counseling - Yes

Lifestyle Summary for Subject #5

A. Apperceptions

1. I am: different, confused, more of a loner than others, intelligent, dedicated, an object, daddy's girl, critical of others, have high expectations, unable to speak for myself.

2. Others are: trying to take my space, more outgoing, more in control.

3. Men are: powerful, intelligent, liars, have no self-control.

4. Women are: helpless, vulnerable, nurturers, pleasers, responsible for everyone's actions, depressed, codependent, they try hard.

B. Goals and Expectations

1. I want: to have my own space.

2. I want: to be beautiful, perfect, and normal.

3. I want: to feel free and content.

4. I expect: to have to protect myself.

5. I expect: scary, weird things to happen when I'm alone with men.

6. I expect: to have to fight for what I want.
C. **World View**

1. The world is a place where: it's unsafe to show my body.
2. The world is a place where: things happen that I don't understand.
3. The world is a place where: people turn on you if you let your guard down.
4. Life is: safe when I'm hiding.
5. Life is: scary.

D. **Discussion**

This subject was the only one who exhibited some internal locus of control. The judges agreed that she was passive and that there was no conflict resolution within the family of origin. She was concerned with boundaries and felt the need to be perfect.

VI. **Demographics - Subject #6**

Age - 42

Clinically Diagnosed

Age at Onset of Bulimia - 17

Birth Order - Middle

Counseling - Yes
Lifestyle Summary for Subject #6

A. Apperceptions

1. I am: numb, not good enough, no one's favorite, neurotic, left out, not social, disorganized, a pleaser, addicted, a passive victim.

2. Others are: always advising me, more important, not there for me if they aren't abusing me.

3. Men are: silent, distant, kind, aloof, confusing, weak, unavailable.

4. Women are: Beautiful, neurotic, mean, competetitive with each other, self-centered, molesters, care-givers.

B. Goals and Expectations

1. I want: to be picked up, have my wound cleaned, and cry.

2. I want: to feel safe.

3. I want: to be accepted and loved.

4. I want: to like myself.

5. I want: someone to care for me.

6. I expect: to be abused and abandoned.

7. I expect: to be numb and confused.

8. I expect: to have to be hurt to be cared for.
9. I expect: to be unhappy when everyone else is happy.

C. World View
1. The world is a place where: I am a passive victim.
2. The world is a place where: you can't trust anyone to take care of you.
3. The world is a place where: I have to numb my feelings.
4. Life is: Dangerous and unpredictable.
5. Life is: Being abandoned or being used sexually.

D. Discussion
The judges perceived this subject as passive. She had an external locus of control. Again, there was no conflict resolution or problem solving within the family. This subject showed a great deal of masculine protest, which the judges felt may have created some sexual identity issues.

VII. Demographics - Subject #7
Age - 31
Self-Diagnosed
Age at onset of bulimia - 21
Birth order - only
Counseling - No
Lifestyle Summary for Subject #7

A.  *Apperceptions*

1.  I am:  Different, unfocused, willful, critical, alone, a victim of what others think, smart but no one else thinks so, odd, I don't fit in, I set high standards for myself but don't achieve what I want.

2.  Others are:  More social than I am.

3.  Men are:  Confusing, bright and principled, they seem kind but can be mean, when they are angry they leave.

4.  Women are:  Insecure, bright, strong, unsure of their worth, reserved, they don't trust their feelings.

B.  *Goals and Expectations*

1.  I want:  to be special.

2.  I want:  to make decisions and stick to them.

3.  I want:  to control my own life.

4.  I want:  to think it's OK to be different.

5.  I expect:  to be different.

6.  I expect:  to be lonely.

7.  I expect:  to make my own decisions.

C.  *World View*

1.  The world is a place where:  I'm spanked and I don't know why.
2. The world is a place where: it matters what other people think.

3. The world is a place where: people can turn on you quickly.

4. Life is: to be observed and endured.

D. Discussion

The judges all saw that this subject was passive and had an external locus of control. There was no conflict resolution in the family. She was a victim of what others think and saw herself as "The only little white kid on the merry go round"—different and alone.

VIII. Demographics - Subject #8

Age - 22
Self-Diagnosed
Age at onset of bulimia - 10
Birth order - first born
Counseling - yes

Lifestyle Summary for Subject #8

A. Apperceptions

1. I am: discouraged, eager to please, interested in learning, intelligent, not social, open-minded, scared.

2. Others are: more social and easy going, they laugh at me when I am afraid.
3. Men are: never satisfied, critical, use women as sexual objects, chauvinistic, domineering, distant.

4. Women are: always trying to please men, controlling, perfectionists, dogmatic, idealistic, ethical.

B. **Goals and Expectations**

1. I want: to feel good about myself.
2. I want: to outwit authority figures.
3. I want: to be active and to be a doer.
4. I expect: to get hurt if I'm angry.
5. I expect: to be abused and left out.
6. I expect: that others don't care how I feel.
7. I expect: to have to flirt indirectly to get what I want.

C. **World View**

1. The world is a place where: people don't consider me.
2. The world is a place where: women can gain control through sex.
3. The world is a place where: you can't rely on anyone else.
4. Life is: a place where you must look good.
5. Life is: something of a mystery.
6. Life is: a place where I won't stand and fight.

D. Discussion
The judges all agreed that this subject was passive and had an external locus of control. There was no problem solving or conflict resolution in the family. This subject was discouraged and was not really in tune with other people. She also exhibited and utilized passive power.

IX. Demographics - Subject #9

Age - 24
Clinically Diagnosed
Age at onset of bulimia - 15
Birth order - first born
Counseling - yes

Lifestyle Summary for Subject #9

A. Apperceptions

1. I am: sensitive, flexible, shy, a loner, hardworking, responsible, not social.
2. Others are: better than I am, others have my place, more social, loved.
3. Men are: strong, overbearing, ragers, impossible to please, unpredictable,
undependable, in control, self-centered, when angry they isolate.

4. Women are: at the mercy of men, confused, scared, affectionate, communicative, out of control.

B. **Goals and Expectations**

1. I want: to be normal.
2. I want: to feel supported.
3. I want: to drop my "baggage".
4. I want: to ride by myself.
5. I expect: to be terrified when someone focuses on my body.
6. I expect: to confuse terror, anger and embarrassment.
7. I expect: to be confused.

C. **World View**

1. The world is a place where: I can ride by myself if I have support.
2. The world is a place where: people keep secrets.
3. The world is a place where: everyone is in denial.
4. The world is a place where: things aren't as they appear.
5. The world is a place where: people don't know how to communicate.

6. Life is: a place where I run away from painful things.

7. Life is: unpredictable and dangerous.

8. Life is: confusing.

D. Discussion

The judges all viewed this subject as passive and as having an external locus of control. Again, there was no modeling for conflict resolution or problem solving within the family.

X. Demographics - Subject #10

Age - 39

Clinically Diagnosed

Age at onset of bulimia - 4

Birth order - last born

Counseling - yes

Lifestyle Summary for Subject #10

A. Apperceptions

1. I am: afraid, not involved, a pleaser, a victim, a survivor, sensitive, split, have high standards, hard-working, strong.

2. Others are: dangerous, torturers, more rebellious, not as hard-working.
3. Men are: abusive, strong, cruel, when angry they leave.
4. Women are: mean, crazy, emotionally unstable, gone, out of control, unpredictable, when upset they get busy.

B. Goals and Expectations
1. I want: to be free from dependance on food.
2. I want: to feel safe.
3. I want: to feel strong by myself.
4. I want: to ride my horse away and be free.
5. I expect: to be afraid.
6. I expect: to be mistreated.
7. I expect: to be confused.
8. I expect: to be alone.
9. I expect: to need food when I'm upset.

C. World View
1. The world is a place where: I'm not safe and I need to hide.
2. The world is a place where: people are abusive.
3. The world is a place where: you need to do it all by yourself.
4. The world is a place where: I am afraid and confused.
5. Life is: scary.
6. Life is: confusing and dangerous.
7. Life is: cruel.

D. Discussion
As with the others, the judges agreed that this subject was passive and had an external locus of control. There was once again, no conflict resolution or problem solving in the family of origin. This subject strived to be "Patti Perfect" by following the rules. She was a survivor.

Discussion
A review of the research findings accumulated in this study provides some commonly observed themes in the bulimic population. The judges perceived passivity in 100% of the subjects. Forty percent see themselves as passive victims, while 50% expect to be abused, mistreated, or taken advantage of. Ninety percent of the subjects operate from an external locus of control. Thirty percent want more control and 40% see others as having more control. There was no real or perceived conflict resolution within the family of origin in 100% of the subjects. In agreement with the research, this seems to be one of the highest determinants for bulimic behavior.

Specific commonalities appeared in the subject's apperceptions, goals and expectations, and world view.
These thematic similarities are summarized as follows:

**Apperceptions**

I am a pleaser - 50%
I am not social, a loner, not involved - 70%
I am worried, scared, afraid - 40%
I have high standards, expectations - 40%
I am hardworking - 40%
I aim for perfection - 40%
Others are more loved, valued, more important - 50%
Others are more social - 40%
Men are powerful, angry, abusive, scary - 70%
Men are passive, weak, pitiful - 30%
Men leave when angry - 70%
Men are intelligent - 30%
Women are weak, pleasers, submissive, victims - 60%
Women are strong, controlling, critical - 50%

**Goals and Expectations**

I want acceptance, approval, love - 60%
I want attention, to be special - 40%
I want freedom - 40%
I expect to feel afraid - 50%

**World View**

Life, the world is scary, dangerous, unsafe - 60%
Life, the world is confusing - 40%
Life, the world is where people keep
secrets, cheat, have no trust - 40%

Life, the world is where people can be cruel - 40%

Common Trends

Based upon the most significant percentages it is possible to make a hypothetical sketch of the family environment and the bulimic's outlook on life. It is likely that father was powerful and abusive while mother was weak and submissive. Because there was no conflict resolution in the family, dad would leave when he was angry. The bulimic subject learned to cope by becoming passive and unsocial, thus developing an external locus of control. She expects to feel afraid because the world is a scary and dangerous place. She strives for acceptance, approval, and love by becoming a pleaser, but she sees that others are more loved and valued so she becomes discouraged. This subsequent discouragement is supported by Adlerian theory based upon women's general sense of inferiority and inability to successfully meet life's requirements.

Other possible contributing factors that emerged as common trends in the lifestyle analysis were divorce and/or separation of parents (see Table 1) and verbal, sexual, and/or physical abuse (see Table 2). Sixty percent of the subjects experienced a divorce or separation of the parents. The mean age of the subject during this occurrence was 13.1
Table 1. Demographics.

<table>
<thead>
<tr>
<th>Subject Number</th>
<th>Age</th>
<th>Self-Diagnosed</th>
<th>Clinically Diagnosed</th>
<th>Birth Order</th>
<th>Age at Onset of Bulimia</th>
<th>Divorce/Separation of Parents</th>
<th>Subject Age at Divorce</th>
<th>Death of Parent</th>
<th>Subject Age at Death</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>24</td>
<td>X</td>
<td>youngest</td>
<td>20</td>
<td>X</td>
<td>11</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>2</td>
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<td>3</td>
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<td>X</td>
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<td>X</td>
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<tr>
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<td>1st born</td>
<td>15</td>
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<td>13</td>
<td></td>
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<tr>
<td>10</td>
<td>39</td>
<td>X</td>
<td>youngest</td>
<td>4</td>
<td></td>
<td></td>
<td>X</td>
<td>36</td>
<td></td>
</tr>
</tbody>
</table>

Summary of Table 1

- Model Age - 24
- Subject mean age - 27.8
- Number of self-diagnosed - 6
- Number of clinically diagnosed - 4
- Age at onset of bulimia - 16.2
- Number of subjects from divorced parents - 6
- Mean age at divorce - 13.1
- Number of subjects with parental death - 3
- Mean age at death - 26.3
- Number of subjects with parents together - 1
Table 2. Incidence of Abuse.

<table>
<thead>
<tr>
<th>Subject Number</th>
<th>Sexual Abuse</th>
<th>Type of Abuse</th>
<th>Physical Abuse</th>
<th>Verbal Abuse</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Yes</td>
<td>No</td>
<td>Overt</td>
<td>Covert</td>
</tr>
<tr>
<td>1</td>
<td>X</td>
<td></td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>X</td>
<td></td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>3</td>
<td></td>
<td></td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>4</td>
<td>X</td>
<td></td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>5</td>
<td>X</td>
<td></td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>6</td>
<td>X</td>
<td></td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>7</td>
<td></td>
<td></td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>8</td>
<td>X</td>
<td></td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>9</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>10</td>
<td>X</td>
<td></td>
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<td>X</td>
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</tbody>
</table>

Summary of Table 2

<table>
<thead>
<tr>
<th>Abuse Type</th>
<th>Count</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sexual Abuse</td>
<td>6</td>
<td>60%</td>
</tr>
<tr>
<td>Overt</td>
<td>2</td>
<td>33.3%</td>
</tr>
<tr>
<td>Covert</td>
<td>6</td>
<td>100%</td>
</tr>
<tr>
<td>Physical</td>
<td>7</td>
<td>70%</td>
</tr>
<tr>
<td>Verbal</td>
<td>10</td>
<td>100%</td>
</tr>
</tbody>
</table>
years of age. The mean age of the subjects at the onset of the bulimic behavior was 16.2 years of age. One possible hypothesis is that divorce or separation of the parents may act as a catalyst in some women, predisposing them to bulimic behavior.

A stronger argument can be made regarding the high correlation between abuse and bulimic behavior. Sixty percent of the subjects experienced sexual abuse, 33% was overt, 100% was covert. Seventy percent of the subjects experienced physical abuse and 100% reported verbal abuse. Fifty percent of the subjects experienced all three types of abuse, 30% reported at least two types of abuse, while only 20% reported one type. This is a fairly new area of correlational study, but the growing body of research collectively reports between 75-80% correlation specifying sexual abuse or trauma as the most prevalent indicator.

An analysis of the subjects' birth order characteristics and placement as related to their apperceptions shows support and agreement with Adlerian theory (see Tables 3, 4 and 5). First borns characteristically have high standards, and can be shy, withdrawn and discouraged (Christensen & Shramski, 1983). Of the five subjects who are first borns, two have apperceptions regarding high standards, one sees herself as shy, one sees herself as discouraged, and one is worried
Table 3. Birthorder.

<table>
<thead>
<tr>
<th>Birth Order</th>
<th>Number</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>First Born</td>
<td>5</td>
<td>50</td>
</tr>
<tr>
<td>Middle</td>
<td>1</td>
<td>10</td>
</tr>
<tr>
<td>Last Born</td>
<td>2</td>
<td>20</td>
</tr>
<tr>
<td>Only</td>
<td>2</td>
<td>20</td>
</tr>
</tbody>
</table>

Table 4. Counseling Background.

<table>
<thead>
<tr>
<th>Counseling Background</th>
<th>Number</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Attended counseling, therapy or treatment</td>
<td>9</td>
<td>90%</td>
</tr>
<tr>
<td>Not attended counseling, therapy or treatment</td>
<td>1</td>
<td>10</td>
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</table>
Table 5. Apperceptions.

<table>
<thead>
<tr>
<th></th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>I am a pleaser</td>
<td>50</td>
</tr>
<tr>
<td>I am not social, a loner, not involved</td>
<td>70</td>
</tr>
<tr>
<td>I am worried, scared, afraid</td>
<td>40</td>
</tr>
<tr>
<td>I have high standards, expectations</td>
<td>40</td>
</tr>
<tr>
<td>I am hardworking</td>
<td>40</td>
</tr>
<tr>
<td>I aim for perfection</td>
<td>40</td>
</tr>
<tr>
<td>Others are more loved, valued, more important</td>
<td>50</td>
</tr>
<tr>
<td>Others are more social</td>
<td>40</td>
</tr>
<tr>
<td>Men are powerful, angry, abusive, scary</td>
<td>70</td>
</tr>
<tr>
<td>Men are passive, weak, pitiful</td>
<td>30</td>
</tr>
<tr>
<td>Men leave when angry</td>
<td>70</td>
</tr>
<tr>
<td>Men are intelligent</td>
<td>30</td>
</tr>
<tr>
<td>Women are weak, pleasers, submissive, victims</td>
<td>60</td>
</tr>
<tr>
<td>Women are strong, controlling, critical</td>
<td>50</td>
</tr>
</tbody>
</table>
about fitting in. Middle children characteristically see themselves as inferior, small, cheated and abused (Christensen & Shramski, 1983) and the one subject who is a middle child perceives herself as not good enough, left out, and a passive victim. Youngest children tend to utilize helplessness as a form of manipulation (Christensen & Shramski, 1983). Of the two youngest child subjects, one sees herself as a victim, the other sees herself as lacking in self-confidence, wanting to be taken care of and loved, and views women as helpless. Only children are characteristically demanding, self-centered, controlling, and ambivalent (Christensen & Shramski, 1983). Two subjects are only children. One sees women as in control, strong-willed and rarely satisfied while the other sees herself as willful and critical and views life as something to be observed and endured.

The final two areas of commonality that were observed in the lifestyle analysis involve feelings and ambition. Ninety percent of the subjects reported mom as being the most ambitious for the children. One hundred percent of the subjects exhibited issues around expressing feelings. They either have difficulty in expressing them or it was unsafe to do so in their family of origin (see Tables 6 and 7).
### Table 6. Goals and Expectations.

<table>
<thead>
<tr>
<th>Expectation</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>I want acceptance, approval, love</td>
<td>60</td>
</tr>
<tr>
<td>I want attention, to be special</td>
<td>40</td>
</tr>
<tr>
<td>I want freedom</td>
<td>40</td>
</tr>
<tr>
<td>I expect to feel afraid</td>
<td>50</td>
</tr>
</tbody>
</table>

### Table 7. World View.

<table>
<thead>
<tr>
<th>Perception</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Life, the world is scary, dangerous, unsafe</td>
<td>60</td>
</tr>
<tr>
<td>Life, the world is confusing</td>
<td>40</td>
</tr>
<tr>
<td>Life, the world is where people keep secrets, cheat, have no trust</td>
<td>40</td>
</tr>
<tr>
<td>Life, the world is where people can be cruel</td>
<td>40</td>
</tr>
</tbody>
</table>
Additional Findings

For the purpose of providing a complete and inclusive picture of this bulimic population, it is of interest to note their physical appearances. From the researcher's perspective, three of the subjects appear to be 10-20 pounds overweight, six appear to fall under the average weight for their height and build, and one subject was noticeably on the underweight side. Five of the subjects reported being actively athletic or involved in some type of routine, daily exercise program. These five were among the average weight subjects.

Three of the subjects provided references to food in their early recollections. There was no expectation on the part of the researcher pertaining to this finding, but it appears to be a point of interest.

The results of the judges' life themes were reported back to the participants individually as a form of closure for this study (see Table 8). The pervading response from the subjects was one of agreement with the information presented by the researcher. These findings tend to support the use of the Lifestyle Questionnaire as an assessment technique.
Table 8. Overall Themes.

<table>
<thead>
<tr>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Passivity</strong></td>
</tr>
<tr>
<td>Sees selves as passive victims</td>
</tr>
<tr>
<td>Expect abuse, mistreatment</td>
</tr>
<tr>
<td><strong>External Locus of Control</strong></td>
</tr>
<tr>
<td>Wants more control</td>
</tr>
<tr>
<td>Sees others as having more control</td>
</tr>
<tr>
<td><strong>Internal Locus of Control</strong></td>
</tr>
<tr>
<td><strong>No conflict resolution in Family of Origin</strong></td>
</tr>
<tr>
<td><strong>Mom was most Ambitious for Children</strong></td>
</tr>
<tr>
<td><strong>Trouble Expressing Feelings</strong></td>
</tr>
</tbody>
</table>
Summary

This chapter initially presented case studies on each of the ten, female, bulimic participants and continued with a discussion of the results and implications for this population. Commonalities were observed in the subjects' apperceptions, goals and expectations, and world view as well as family of origin characteristics and demographics.

Chapter 5 will include conclusions and areas for further research as recommended by the researcher.
CHAPTER 5

CONCLUSIONS AND RECOMMENDATIONS

Introduction

The final chapter will summarize the findings of this study which examined the commonality of life themes held by bulimic women as measured by the Adlerian Lifestyle Questionnaire. Conclusions will be drawn about this population based upon the gathered information. Implications for therapists and recommendations will be made for future research in this area. The chapter will conclude with a summary.

Conclusions

The purpose of this study was to describe in terms of Adlerian Lifestyle information the personality characteristics, family environment, and common life themes of bulimic women. Although this study was limited to ten subjects, the panel of Adlerian Lifestyle interpreters were able to recognize shared life themes, apperceptions, and family characteristics.

In terms of common apperceptions, pleasing, perfectionism, high standards, hard work, fear, and loneliness were pervading themes for each subject's view of themselves. Others were seen as more loved and valued as well as more social. Men were commonly viewed as powerful,
abusive, and scary and were seen as leaving when they get angry. Women were viewed predominantly as weak, submissive victims.

In terms of goals and expectations, wanting acceptance, approval, and love but expecting fear, were common themes. The world was seen as scary, dangerous, and an unsafe place for most of the participants.

Fifty percent of the subjects were first born children in their family of origin. There was no conflict resolution or problem solving in any of the families. All of the subjects exhibited passivity, with 90% having an external locus of control.

The judges noted the passivity and victimization as directly related to the high percentage of experienced abuse. Sixty percent of the subjects were sexually abused, 70% were physically abused, and all of the participants were verbally abused.

In summary, the Adlerian judges concluded that several common life themes and characteristics could be identified in this bulimic population. In conjunction with present research, it can be inferred that bulimic behavior may be a dysfunctional attempt at conflict resolution, an expression of the feelings of inadequacy, a "stuffing" of feelings in general, and a learned coping strategy in a scary and confusing world.
Recommendations Including Future Research

Although the conclusions and implications in this study are based upon Adlerian life themes in a ten-subject sample, the concurrence with past and present research indicates the progressive nature of this disorder and invites certain recommendations. These recommendations are geared towards parents, educators, and helping professionals.

1. This study reinforces the need for more advanced and specialized sexual education in the school system. The high incidence of sexual abuse and molest indicates that it is still being treated as a shame-inducing family secret. Because bulimic behavior may develop as a result of unattended abuse issues, it is imperative to address this topic in sexual education classes early enough to provide healthy coping strategies. Education regarding appropriate touch versus inappropriate touch should be first addressed in pre-school.

2. Findings strongly suggest the need for providing teachers and students with information regarding eating disorders. Early identification and a clear understanding of the predisposing factors and effects may, in some cases, eliminate the development or progression of bulimia.
3. Findings regarding family atmosphere reinforce the need for parental education and appropriate support for families with eating disordered members.

4. Beginning at the junior high school level, assertiveness training and healthy conflict resolution education should be provided. These may help to interrupt the trend toward passivity.

5. Future research in this area may want to examine the critical incidents that moved the bulimic subjects into therapy or treatment. This study included percentages regarding attendance in counseling, but did not delve into the catalysts behind the decision to seek help.

6. As with many studies, a replication with a larger sample size would provide more conclusive data. The recommendation here is to select a more homogeneous sample to insure that the results are representative.

7. For future reference, questions regarding marital status, work history, and medical history including present physical condition may want to be included in the bio-data section of each interview. This information would provide a more
complete case file for each subject and could potentially uncover further similarities.

Implications

The results of this study present certain implications for the mental health professionals and counseling agencies that will encounter bulimic clients. They are as follow:

1. Because of the high correlation between sexual abuse and eating disordered behavior, counselors and treatment facilities may wish to dually track these clients with a sexual recovery program. The underlying issues of fear and anger are an integral component to the healing process.

2. Counseling approaches and therapeutic interventions should include familial sessions as well as counseling opportunities for all family members. This study supports the notion of bulimia as an inclusive and family-oriented disorder.

3. A third focus for the therapeutic community would emphasize self-esteem building. It is necessary to approach bulimic clients with a shame-reducing framework and build upon esteem and identity issues.
Summary

The helping professionals who choose to work with an eating disordered population must consider a global approach to treatment with their subjects. There is evidence supporting the need for individual and family therapy as well as formal and informal methods of education. Further research and hypotheses might be generated from this study's findings and information.
APPENDIX A

FLYER SEEKING VOLUNTEERS
SEEKING VOLUNTEERS FOR A RESEARCH STUDY!

Could you answer yes to any of the following?

- I consume large amounts of food (binge), sometimes in secret, with little or no control.
- I sometimes purge or vomit after a binge.
- I use laxatives and/or diuretics as a form of weight control.
- I excessively exercise.
- I use diet pills and restrictive eating to help control my weight.
- I consider myself bulimic.
- Others (friends, family members, doctors, etc.) think I am bulimic.

Are you interested in learning more about your life-style and how it might contribute to your eating disorder? If you are willing to give up an hour of your time for a personal interview, Please call Amy at 322-0521.

(U of A Counseling and Guidance Masters Student)
APPENDIX B

PARTICIPANT PERMISSION SLIP
I understand that my participation in this study is voluntary and that I can withdraw at any time. I also understand that my anonymity and confidentiality has been insured by the researcher, and that my personal data (recorded interview) will be destroyed upon completion of the transcription. I am aware that my transcribed interview will appear in the written study as research, but that no personal identification could be made from it. I give permission to have my interview tape recorded.

Subject's Name______________________________

Researcher's Name____________________________

Date________________________________________
APPENDIX C
LIFESTYLE BIO-DATA QUESTIONNAIRE
Lifestyle Bio-Data

1. How old are you?
2. How long have you been bulimic (or eating disordered)?
3. Are you a self-diagnosed bulimic or a clinically diagnosed bulimic?
4. Have you ever been in counseling, therapy, or to a support group?
5. If yes, when and for how long?

6. Please check off the behaviors that you engage in:
   - Binge
   - Purge
   - Restrictive Eating
   - Laxative Use/Diuretic Use
   - Excessive Exercising
   - Diet Pills
   - "Secret" Eating

7. Do you have any recollection of family violence, sexual abuse, or trauma?
   Please explain.

8. How would your life be different if you weren't bulimic?
APPENDIX D

LIFESTYLE QUESTIONNAIRE
I. Family Constellation
   A. Description of Siblings
      1. Who is most different from you? In what respect?
      2. Who is most like you? In what respect?
      3. What kind of kid were you?
      4. Describe the other siblings.
B. List the highest and the lowest siblings for each attribute, and if subject is at neither extreme, give his position as to similarity to either.

1. Intelligence
2. Hardest worker
3. Best grades in school
4. Helping around the house
5. Conforming
6. Rebellious
7. Trying to please
8. Critical of others
9. Considerateness
10. Selfishness
11. Having own way
12. Sensitive - easily hurt
13. Temper tantrum
14. Sense of humor
15. Idealistic
16. Materialistic
17. High standards (of achievement, behavior, morals, etc.
18. Who was most athletic?
19. Who was strongest?
20. Who was tallest?
21. Who was prettiest?
22. Who had most friends? Relationship?
23. Most spoiled?
24. Most punished?

How?

Why?
C. Sibling Interrelationship
1. Who took care of whom?
2. Who played with whom?
3. Who got along best with whom?
4. Which two fought and argued most?
5. Who was father's favorite?
6. Who was mother's favorite?

D. Description of Parents
1. How old is father? ____ mother? ____
2. What kind of person is father?

3. What kind of person is mother?

4. Which of the children is most like father?

__________________________
In what way?

5. Which of the children is most like mother?

__________________________
In what way?
6. What kind of relationship exists between father and mother?
   a. Who made the decisions, etc.?
   b. Did they agree or disagree on methods of raising children?
   c. Did they quarrel openly? ________
      About what? ________________________
      How did these quarrels end?
   d. How did you feel about these quarrels?
      Whose side did you take?

7. Who was more ambitious for the children?
   In what way?

8. Did any other person live with the family?
   Describe them and your relationship to them.

II. Early Recollections
Based on the information provided, please comment on the following:

**Apperceptions**

1. I am

2. Others are

3. Men are

4. Women are

5. The world is a place where

6. Life is

7. I expect

8. I want

*Note: Any further comments would be appreciated:*
APPENDIX F

HUMAN SUBJECTS EXEMPT LETTER
February 13, 1991

Amy Axtell, B.A.
c/o Betty J. Newlon, Ph.D.
Department of Counseling and Guidance
Division of Educational and Professional Studies
Education Building, Room 218
Main Campus

RE: AN ANALYSIS OF ADLERIAN LIFE THEMES OF BULIMIC WOMEN

Dear Ms. Axtell:

We have received documents concerning your above referenced project. Regulations published by the U.S. Department of Health and Human Services [45 CFR Part 46.101(b)(3)] exempt this type of research from review by our Committee.

Please be advised that approval of this project and the requirement of a subject's consent form is to be determined by your department.

Thank you for informing us of your work. If you have any questions concerning the above, please contact this office.

Sincerely yours,

William F. Denny, M.D.
Chairman
Human Subjects Committee

WFD:rs

cc: Departmental/College Review Committee
SELECTED BIBLIOGRAPHY


