

**BULIMIA: THE BULIMIC DAUGHTER'S PERCEPTION
OF THE MOTHER-DAUGHTER RELATIONSHIP**

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I hereby declare that this dissertation is my own work and that I have not submitted it, nor any part of it, for a degree at any other university.

Louise Frenkel.

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TABLE OF CONTENTS

Declaration i

Acknowledgements ii

Table of Contents iii

List of Tables xi

Abstract xii

CHAPTER 1 - INTRODUCTION 1

1.1 Bulimia: Clarification of Terminology 4

1.2 Description of Syndrome and Criteria
for Diagnosis 7

1.3 Epidemiology 13

1.4 The Mother-Daughter Relationship 20

CHAPTER 2 - LITERATURE REVIEW	25
2.1 Introduction	23
2.2 Behaviourist/Cognitive Theories	25
2.3 Classical Freudian Theories.	28
2.3.1 The Oral Stage and the relationship between Bulimic Daughter and Mother	31
2.3.1.1 The developing relationship between the Mother and Bulimic daughter expressed through the activity of feeding	31
2.3.1.2 The Sexual nature of the Feeding experience	34
2.3.2 Gorging and Binging	36
2.3.3 Vomiting and Purging	38
2.4 Feminist Theories	40

2.4.1	The Role of the Mother in the Bulimic daughter's socialisation	47
2.4.2	Close identification between the Mother and Bulimic daughter	47
2.4.3	The Mother of the Bulimic daughter and Maternal care	49
2.4.4	The Mother's ambivalent feelings towards her Bulimic daughter	50
2.4.5	Psychological Splitting as a Defence Mechanism	51
2.4.6	The Adult Bulimic	54
2.5	Research on the Personality Characteristics of Bulimics	59
2.6	Family Theories	63
2.7	Research on the Mother-Daughter Relationship	68

CHAPTER 3 - METHODOLOGY	72
3.1 Test instruments	73
3.1.1 The Bulimia Test (BULIT,	73
3.1.2 Demographic Questionnaire	74
3.1.3 The Thematic Apperception Test (TAT)....	75
3.1.3.1 Description of the TAT	78
3.1.3.2 Interpretation of the TAT Stories	78
3.1.3.3 Reliability and Validity of the TAT	79
3.1.3.4 Norms for the TAT	80
3.1.4 The Subjects' Description of the Mother	84
 3.2 Description of the Sample: Bulimic and non-Bulimic (Experimental and Control) Groups	85

3.2.1	Differences between the two groups on Binging behaviour	86
3.2.2	Differences between the two groups on perception of Eating Patterns	86
3.2.3	Differences between the two groups on feelings about themselves	86
3.2.4	Differences between the two groups on Purging behaviour	87
3.2.5	Differences between the two groups on Dieting and Fasting	87
3.2.6	Differences between the two groups on use of Laxatives	88
3.3	Procedure	88
3.3.1	Constitution of the Bulimic and non-Bulimic Groups	89
3.3.2	Analysis of Data	91
3.3.2.1	Interpretation of Data	91

3.3.2.2	Statistical Analyses	93
CHAPTER 4 - RESULTS AND DISCUSSION		94
4.1	Analysis of TAT stories and descriptions of the Mother	94
4.2	The Bulimic daughters as emotionally deprived	96
4.2.1	The Mother of the Bulimic as emotionally unavailable	100
4.2.2	The Mother of the Bulimic as impotent and ineffectual	105
4.2.3	The Mother of the Bulimic as immature, childlike and/or emotionally dependent ..	106
4.3	The Bulimic daughters'awareness of negative feelings towards her mother	108
4.3.1	A Comparison of TAT portrayal of mother and description of mother	108

4.3.2	The Bulimic daughters' anger and fear of its destructive power	117
4.4	The Bulimic daughters' rejection and punishment of their Mothers	118
4.4.1	The Bulimic daughters as passive and withdrawn	122
4.4.2	The Bulimic daughters as passive- aggressive	123
CHAPTER 5 - CONCLUSIONS		127
5.1	Limitations of the present study	132
5.2	Future research	133
REFERENCES		136

APPENDICES

1. DSM III and DSM IIIR criteria for diagnosis
of Bulimia 157

2. The BULIT test 162

3. Demographic questionnaire 168

4. TAT cards used in this study 170

5. Original Bellak form 174

6. Adapted Bellak form used in this study, and categories
for analysing the description of mother..... 177

7. Bulimic Group: Answers to selected questions on the
BULIT Test..... 180

LIST OF TABLES

**TABLE 1 - Theme: The Bulimic daughters as emotionally
deprived..... 96**

**TABLE 2 - Theme: The Discrepancy between the TAT portrayal
of the Mother and the Description of the
Mother..... 109**

**TABLE 3 - Theme: The Bulimic daughters'
extreme anger 118**

**TABLE 4 - Theme: The Mothers of Bulimics as rejected and
punished 119**

ABSTRACT

Bulimia, the syndrome characterised by a pattern of episodic binge eating followed by attempts to purge the food by vomiting or laxative abuse, was only identified as a distinct syndrome in the late 1970s. The first studies to record these symptoms focused on bulimia as an associated feature or subtype of anorexia nervosa. In subsequent research however, it became evident that binge-eating and purging behaviour also occurs in normal weight people. It is this group of 'normal weight bulimics' who are the focus of this study.

The present study focuses on the mother-daughter relationship, hypothesizing that this relationship will be of some significance in the etiology and maintenance of the syndrome (this has been shown to be the case in anorexia nervosa). There has been very little research in this area and available information is based on clinical material from individual case studies.

Two groups of women were selected, a bulimic and a non-bulimic group, and their perceptions of their mothers compared. The subjects were given a short demographic questionnaire, a projective test (the Thematic Apperception Test) which is sensitive to issues pertaining to the mother-daughter relationship, and an open ended question eliciting a

description of their mothers. The data was analysed by two independent clinicians, using Bellak's (1986) method, and significant trends in the mother-daughter relationship were identified.

The findings confirmed the significance of the mother-daughter relationship. The results were divided into two categories: the daughter's perceptions of her mother, and the daughter's feelings and responses. The major findings were, firstly, that the bulimic daughters feel emotionally deprived, and secondly, that the bulimic daughters feel extremely angry with their mothers but are afraid of expressing this anger directly. Instead they tend to become passive, and to withdraw into revengeful fantasies or to resort to passive aggressive behaviour.

The present research brings to light a number of issues related to the mother-daughter relationship and the relationships in the 'bulimic family' as a whole, which require further investigation.

"The woman is consoling the girl. But the girl feels the need to be alone. She can't accept love from others readily because she is scared. Scared that one day it will be removed, taken away or that it will turn to hate. She feels alone. Deep inside there is a need for consolation but she hides this insecurity with an invisible shield." (Bulimic subject's response to one of the TAT cards).

"She knew what she had to do before it was too late, and she rose up with difficulty and walked across the thick carpet to the bathroom, and flicked on the light. The tiled floor was cold under her bare feet. She shivered slightly and turned to face the mirror above the sink as she pulled back her long hair and fastened it with a rubber band. Then she turned on the faucet, full force, and filled a glass of water. She left the water running out of habit, though this time it wasn't necessary since no one was around to hear the sounds from the bathroom. When she had finished the glass of water she lifted the lid of the toilet and knelt down before it, her face within the bowl. She pushed her finger down on the back of her tongue in the exact right spot and the brownish liquid gushed out of her."

(Chernin, 1986, p.30)

CHAPTER 1 - INTRODUCTION

Normal eating for women in Western society is 'disturbed'. It is disturbed in the sense that the current societal preference for a thin physique has resulted in a corresponding societal preoccupation with dieting and weight loss (Polivy & Herman, 1987). The extent of this preoccupation is such that it is now "normal" for individuals in our society (specifically women) to express concern about their weight and to attempt on a frequent but sporadic basis, to change it. A study by Jacobovits, Halstead, Kelly, Roe & Young (1977), (cited in Polivy et al., 1987) found that, among young women and adolescent girls, dieting was more prevalent than not dieting and was thus normative. The awareness of body weight and food intake, however, goes beyond periodic dieting. Lawrence (1987) claims that between 80% - 90% of women in Western middle class society are "restrictive eaters". This means that they deliberately try to keep their daily calorie intake to a minimum and do not allow themselves to eat sufficient food to satisfy their hunger.

There is an interesting context to this increased pursuit of thinness. Garner, Garfinkel, Schwartz & Thompson (1980) surveyed the Playboy Centrefolds and Miss America Pageant contestants over the period 1959 - 1978. The data indicate

that there had been a gradual but definite evolution in the ideal body shape for women towards a thinner size. In addition, the ideal body shape (based on bust, waist and hip measurements) had evolved towards a more "tubular" body form. This trend towards thinness was however in direct opposition to actual changes in young women's bodies over the same period. The Metropolitan Life Assurance weight tables indicated that the expected weight for women under 30 years of age had actually increased at about the same rate as the average weight of the Centrefolds had decreased (Garner et al., 1980). Thus, in the late 70s very few women actually possessed bodies as slim as those of the models presented to them continually in the media; the prevailing ideal body was not synonymous with the actual body shape of the average woman. At the same time, Garner et al., (1980) measured a parallel increase in the society's interest in and attention to dieting (one indicator being the increased number of articles on dieting in popular women's magazines).

This is an interesting trend, but unfortunately there are no recent studies which examine the 'ideal body' in the 80s. Judging from the emphasis on slimming to sell a variety of products (e.g. Kellogs Special 'K' Cereal, or Diet Cooldrinks), and the popularity of dieting regimes (such as Weigh-less) it seems that thinness is still a highly sought after quality amongst women.

"We know that every woman wants to be thin. Our images of womanhood are almost synonymous with thinness" (Orbach, cited in Chernin, 1981, p. 20).

Most women in Western middle class society share with bulimics and anorexics an overriding concern about their body weight, and food intake. This suggests some sort of eating disorder continuum, with normal eating (i.e. restrictive eating coupled with a concern over body weight and food intake) on the 'normal' extreme, and severe disorders of eating such as bulimia and anorexia on the other. Any serious explanation of bulimia would then have to account for why, within a group of women living in a particular social environment, only some of them will develop an eating 'disorder'. A thorough explanation would have to take account of social processes and pressures as well as the individual's particular personality, psychological make-up, and family experience.

The view taken in this thesis is that bulimia is the result of a number of different factors, some social and some individual. It would be simplistic to say that cultural influences cause serious eating disorders. Culture is mediated by the psychology of the individual as well as the more immediate social context of the family. It would be equally simplistic to say that eating disorders are caused by individual psychological pathology. It is the very fact that

it is multi-determined that makes bulimia such a complex and tenacious symptom.

1.1 BULIMIA: CLARIFICATION OF TERMINOLOGY

Since the first recording of bulimic symptoms in the mid 1970s (Boskind-Lodahl & Sirlin, 1977) there has been much confusion and disagreement concerning the overlap between Anorexia and Bulimia. This has resulted in a lack of definitional clarity, reflected in the number of terms used to describe the syndrome e.g. 'The Gorging-Purging Syndrome' (Boskind-Lodahl et al., 1977), 'Bulimia Nervosa' (Russell, 1979), 'Bulimia' (Pyle, Mitchell & Eckert, 1981), 'Bulimarexia' (Boskind-White, 1985), 'Normal Weight Bulimia' (Kaye & Gwirtsman, 1985), and 'Under Weight Bulimia' (Lorenz, 1986). To add to the confusion, subjects have been described as 'restricting anorexics' (who fast, and sometimes use laxatives), 'anorexics' (who fast, but break their fasts with occasional binges), 'bulimarexics' (who regularly binge and purge, and usually fast in between the bingeing and purging), anorexics who have become bulimic, and 'normal weight bulimics' (who binge, and sometimes vomit, but who have no anorexic symptoms, or history of them).

The first studies to record Bulimic symptoms (compulsive binging and purging) understood Bulimia as an associated feature or subtype of Anorexia Nervosa (e.g. Boskind-Lodahl 1976; Boskind-Lodahl et al., 1977; Russell, 1979). Despite the obvious connection to anorexia (i.e. concern about body weight and food intake, fasting and binging), Boskind-Lodahl et al., (1977, p.50) explain that whereas anorexics usually break off their harsh fasting with an eating binge, the "distinguishing feature of bulimarexia is the regular binges, its orgies of eating followed by ritual purifications, over and over again."

Bulimia's connection to anorexia was reinforced by the fact that nearly half the anorexic patient population (who had sought treatment, and therefore were available for research), had at some stage exhibited symptoms of bulimia (Casper, Eckert, Halmi, Goldberg & Quinlan, 1980; Hsu, 1979; Pyle et al., 1981). Russell (1979) found that many anorexics developed bulimia as a result of undergoing treatment which entailed increasing food intake in order to regain a normal body weight.

Within the psychoanalytic framework, anorexia and bulimia are seen as reflecting the same core pathology, the only difference being the defenses that are utilized. "Both historically and currently, anorexia nervosa is a generic term

that includes the bulimic as well as the abstaining syndromes" (Wilson, 1983, p.8). Research conducted by Scott & Baroffio (1986) supports the idea of a common core pathology. Comparing anorexics, bulimics, and obese women with 'normals', they found no differences in the overall profiles of the 3 experimental groups, but a difference between these groups and the control group.

In subsequent research however, it became apparent that binge-eating and vomiting behaviour also occur in normal weight and even overweight people (Boskind-Lodahl & White, 1978; Stangler & Printz, 1980; White & Boskind-White, 1981). The recognition of a group of 'normal weight bulimics', who have no anorexic symptoms, and no history of anorexia, led to the classification of bulimia as a syndrome distinct from anorexia nervosa in the 3rd edition of DSM III (1980). The DSM III-R (1987) classifies Bulimia (by this meaning 'normal weight' bulimia) as a separate syndrome while at the same time acknowledging some connection between anorexia nervosa and bulimia by their choice of the term 'Bulimia Nervosa'.

Very little research has been conducted on the group of women with Bulimia Nervosa (i.e. normal weight bulimics). Given the complexity of distinguishing these disorders in reality, it seems important that research be conducted on this group, so that its relation to anorexia, or its unique characteristics may become clearer.

1.2 DESCRIPTION OF SYNDROME AND CRITERIA FOR DIAGNOSIS

For the purposes of clarification, it is necessary to look at the criteria for the diagnosis of bulimia in both DSM III (1980) and DSM IIIR (1987).

DSM III (1980, p. 69) requires the following criteria to be met for a diagnosis of Bulimia:

- A. Recurrent episodes of binge eating, rapid consumption of a large amount of food in a short period of time, usually less than 2 hours.

- B. At least 3 of the following:
 - (1) consumption of high caloric, easily ingested food during a binge
 - (2) inconspicuous eating during a binge
 - (3) termination of such eating episodes by abdominal pain, sleep, social interruption, or self-induced vomiting

- (4) repeated attempts to lose weight by severely restrictive diets, self-induced vomiting, or use of cathartics or diuretics
- (5) frequent weight fluctuations greater than 10 pounds due to alternating binges and fasts.

- C. Awareness that the eating pattern is abnormal and fear of not being able to stop eating voluntarily.
- D. Depressed mood and self-deprecating thoughts following eating binges.
- E. The Bulimic episodes are not due to Anorexia Nervosa or any known physical disorder.

DSM III describes bulimia as a syndrome characterized by a pattern of episodic binge eating, followed by feelings of depression and self-deprecation. Women with this disorder are aware that their eating behaviour is not normal, but feel unable to control it voluntarily. The binges are inevitably done in secret, and are sometimes planned beforehand. The food chosen is often high in calories, and has a texture that facilitates rapid eating (and also easy expulsion from the body i.e. vomiting). It is often gobbled down quite rapidly, with little chewing. Once eating has begun, additional food may be sought to continue the binge, and often there is a

feeling of loss of control, or inability to stop eating. A binge is usually terminated by abdominal pain, sleep, social interruption or induced vomiting. Vomiting decreases the physical pain of abdominal distention, allowing either continued eating, or termination of the binge. It also often reduces post binge anguish. Some theorists (e.g. Dana & Lawrence, 1988) prefer to see the bingeing and vomiting as inextricably linked and as having significance only as a single symptom (This is not the case however, in DSM III, where regular bingeing is seen as a prime diagnostic feature). Bulimics are preoccupied with thoughts of eating. They often possess an unrealistic fear of gaining weight and repeatedly attempt to prevent this by fasting, dieting, vomiting, or using laxatives or diuretics. Frequent weight fluctuations due to alternating binges and fasts are common. Often these individuals feel that their life is dominated by conflicts about eating. (See Appendix 1 for the DSM III description of Bulimia).

In DSM III-R, (1989, p. 67) the name of the syndrome is changed from Bulimia to Bulimia Nervosa, emphasizing the connection to Anorexia Nervosa.

The criteria for a diagnosis of Bulimia Nervosa in DSM IIIR are:

- A. Recurrent episodes of binge eating (rapid consumption of a large amount of food in a discrete period of time).
- B. A feeling of lack of control over eating behaviour during the eating binges.
- C. The person regularly engages in either self-induced vomiting, use of laxatives or diuretics, strict dieting or fasting, or vigorous exercise in order to prevent weight gain.
- D. A minimum average of two binge eating episodes a week for at least three months.
- E. Persistent overconcern with body shape and weight.

The important differences in the revised criteria of DSM IIIR are: i) the specification of a minimum frequency of binge eating episodes, of twice a week for at least three months, and

ii) the elimination of the requirement of depressed mood and self-deprecating thoughts following eating binges, which in DSM III-R is regarded as a common associated feature, as opposed to a diagnostic criterion. The results of the

present research however, are not in full agreement with the DSM IIIR de-emphasis on depression: 75% of the bulimic sample disliked themselves after eating too much (See Chapter 3).

What the DSM III-R classification does do, is to make the categorisation of anorexia and bulimia fairly clear. In both anorexia and bulimia, there is an overconcern with body weight and food intake, and a disturbed relationship to food. Anorexia however, involves a severe weight loss (15% below that expected for normal age and height). Bulimic symptoms of bingeing and purging may be present, but if there is a weight loss of 15%, the diagnosis will be Anorexia Nervosa, with associated Bulimia Nervosa. For a diagnosis of Bulimia Nervosa to be made, the person must, inter alia, binge eat twice a week for at least 3 months), and although weight fluctuations may be substantial, the weight does not fall below a minimal normal weight.

In addition to the psychological and behavioural manifestations of the Bulimia Nervosa described above, there are potentially severe physical consequences of the disorder.

The most common and most dangerous complication of vomiting and purgative abuse is the depletion of the electrolytes potassium, chloride, and sodium, which are essential for

normal functioning of nerve and muscle cells. Mitchell (1983), (cited in Garner & Garfinkel, 1985) found electrolyte disturbances in almost 49% of her bulimic patients. The symptoms of electrolyte imbalance are weakness, tiredness, constipation and depression (Webb & Gehi, 1981, cited in Garner et al., 1985). They may also result in cardiac arrhythmias and sudden death. Starvation seriously compromises cardiac functioning. This, compounded by electrolyte disturbances, may result in serious irregularities in the heart beat.

Frequently, bulimic patients complain of abdominal pain due to the physical trauma of vomiting. There have been numerous case reports of extreme expansion of the stomach (gastric dilation) due to binge eating (e.g. Mitchell, Pule & Milen, 1982; Russell, 1966; cited in Garner et al., 1985); such expansion has led to stomach rupture and death in some instances. Russell (1979) has commented on the possibility of permanent loss of bowel reactivity with chronic abuse of laxatives.

Dieting, vomiting, and laxative or diuretic abuse often lead to alternating periods of dehydration and 'rebound' excessive water retention (Fairburn, 1982, cited in Garner et al., 1985). Many patients notice swelling or 'puffiness' in their fingers, ankles and faces as a result of edema. Edema is

usually at its worst immediately after vomiting and laxative abuse have ceased. Some bulimic patients may gain between 5 and 10 pounds of water. They then feel so alarmed at the sudden weight gain or swelling that they return to vomiting or laxatives before their bodies have had a chance to achieve a balance, thus beginning the whole cycle again.

Many chronic bulimic patients begin to notice deterioration of their teeth; the gastric acid from self-induced vomiting causes serious dental erosion, loss of enamel, and discolouration.

Numerous other medical complications occur, but the above are the most common and therefore significant.

1.3 EPIDEMIOLOGY

Mitchell & Pyle (1982, p.63), in their review of bulimia in normal weight individuals, observe that "the frequency of this disorder (bulimia) in the general population has not been reported". They do note however, that the number of published reports dealing with bulimia has increased considerably in the last few years. Whether this increase parallels an increase in the frequency of bulimia, or whether it simply reflects the

recent recognition of bulimia as a syndrome separate from anorexia, is not clear.

The early epidemiological studies (in the late 70s and early 80s) are problematic for a number of reasons. The complex relationship between anorexia and bulimia, and the delay in recognizing bulimia as a distinct syndrome, may be responsible for the confusing variety of definitions of the syndrome used in the research. Often the diagnoses are based on the frequency of the binge-purge episodes and the presence or absence of self-induced vomiting. Only some of the studies (e.g. Zuk, 1986) made use of the DSM III criteria, whereas many of the earlier studies (e.g. Grace, 1983), used differing criteria. This lack of uniformity makes comparisons between the studies difficult. The present research uses the BULIT test (based on DSM III) to diagnose a group of subjects with Bulimia. Although the test does not incorporate the recent changes made in DSM III-R, the change is sufficiently minor so as to not invalidate the test's ability to distinguish between bulimic and non-bulimic subjects.

Another problem with much of the research is that the data reflect limited sample sizes and various recruitment biases.

Most studies have been conducted on White middle class student populations. The available literature indicates that this group (young women in late adolescence or young

adulthood) have the highest risk of developing bulimia (Pyle et al., 1981, cited in Mitchell et al., 1982). A few male cases have been reported, (Boskind-Lodahl, 1976; Russell, 1979), but these patients represent less than 5% of the total cases reported in the literature. Information about the incidence of bulimia across different age groups, classes and cultures is very sparse. Exceptions are two recent articles: one by Bulik (1987) on eating disorders of 2 Jewish women after emigrating from the Soviet Union to the United States, and the other by Clarke, Salmons & Harrison (1988) on psychogenic vomiting among female Asian migrants to the United Kingdom.

Finally, the research is hampered by the reluctance of many people to admit to binge-eating and purging behaviour. It is not uncommon for women to have been bulimic for a number of years, without the awareness of their families, partners or close friends. It is a deeply hidden secret. This can limit the research to those who have requested assistance, or to those whose confidentiality can be guaranteed (e.g. in anonymous questionnaires).

Keeping these problems in mind, the epidemiological research can be reviewed.

As mentioned above, the occurrence of bulimia is particularly common during late adolescence and young adulthood (Halmi, Falk & Schwartz, 1981; Herzog, 1982). Studies that have been done (Pyle et al., 1981; Fairburn & Cooper, 1982) reveal that the onset of bulimic behaviour appears to be related to dieting and is frequently associated with feelings of depression, loneliness, boredom and anger. The mean duration of the disorder is approximately 5 years (as reported at the time of the study). Because of its occurrence in the late teens or early twenties, much of the research has focused on this age group, drawing samples from university student populations. Stangler et al., (1980) reviewed the psychiatric diagnoses of 500 college students at a college psychiatric clinic and found that 3.8% (of those who had sought treatment at the clinic) fulfilled the criteria for bulimia. Pyle, Mitchell, Eckert, Halvorson, Neuman & Goff, 1983) using DSM III criteria, surveyed 1 355 college freshmen and found a similar prevalence of 4.1%. In a survey by Halmi et al., (1981) 13% of 355 summer liberal arts students experienced all the major bulimic symptoms as outlined in DSM III. Pyle (1983), (cited in Kaye & Gwirtsman, 1985) found that 19% of the sampled university population could be classified as bulimic (it is not clear what definition was utilized). In a study at an Australian university a 7% incidence was recorded (Touz & Ivoson, 1985). In South Africa, a study by Grace (1983), not using DSM III criteria, found 20% of a sample of

White university women exhibited vomiting and bingeing behaviour. Zuk (1986), using DSM III criteria, found a 7.5% incidence, in the same university population. The discrepancy in occurrence is most likely to be due to the varying criteria used to define the syndrome.

While research has established that bulimia is prevalent among young adult women, researchers have only recently begun to investigate the incidence of bulimia in high school populations. Johnson, Lewis & Love, (cited in Kaye et al., 1984) surveyed 268 schoolgirls aged 13 - 19 and found that 13% of them had bulimia. When they modified their criteria to include weekly binge eating (closer to the DSM III-R criteria), this figure decreased to 4.9%. Crowther, Post & Zaynor (in press, cited in Post et al., 1985) in a survey of 363 adolescent girls in the 9th - 12th grades found that 46% reported episodes of binge eating, but only 7.7% met the DSM III criteria for diagnosis of bulimia. Moss, Jennings, McFarland & Carter (1984) found a total of 17% of a female high school population reported frequent binges, while 7% reported frequent vomiting episodes after eating.

Only one study has been undertaken on a more general sample. Pope, Hudson & Yurgelun-Todd (1984) distributed questionnaires to 300 female shoppers in a shopping mall in suburban Boston, serving working, middle and upper class shoppers. He found

that 10,3% (33) of the respondents met the DSM III criteria for the diagnosis of bulimia at some time in their lives. Of those 45,2% (nearly half of this number i.e. 14 people) were actively bulimic at the time of the study.

In summary, the epidemiological data on bulimia is very limited due to the varying criteria used to define the syndrome, the almost exclusive focus on White university students, and the secretive nature of the disorder. Despite these problems however, it is apparent that (when using stricter criteria in line with the DSM III), between 5% and 7% of girls in the female school population are bulimic, and that the incidence amongst university women is probably a little higher (up to 10%).

In survey data from the United States and Britain, the typical bulimic patient is a Caucasian female in her early twenties. Little is known about the incidence of bulimia in other cultures. There have however been a handful of studies, e.g. the two on female Jewish and Asian immigrants mentioned above, as well as one by Johnson, Stuckey, Lewis & Schwartz (1982) reporting that a small percentage of 316 women identified as bulimic were Asian, Hispanic, American Indian and Black. They also reported that a high percentage of bulimics came from upper-class and middle-class families. Because of sampling biases in surveys conducted to date, however, the actual

prevalence of bulimia in different ethnic socio-economic groups is largely unknown (Kaye et al., 1985).

It is interesting to note that there has been a trend in recent research on bulimia away from epidemiology studies, to attempts to understand the context and meaning of the syndrome, and to formulate different methods of treatment.

There also seems to be no current literature on the occurrence of bulimia in the general population (as mentioned above, earlier studies concentrated on White middle class university populations). The present incidence of bulimia in the general population, as well as the question of whether or not it is on the increase, are therefore unknown. There does however, seem to be an increasing public awareness of the syndrome; there are now numerous 'popular' psychology books available on how to cope with bulimia (for example, The Hungry Self by Kim Chernin), as well as some recognition of it in the general media (for example one of the main characters in the American TV soap opera "Hotel" suffers from bulimia). This suggests that the 'secret disorder', is on the increase.

1.4 THE MOTHER-DAUGHTER RELATIONSHIP

Within the psychoanalytic literature, the mother-daughter relationship is acknowledged as an important factor in the development of anorexia (used here as a generic term which includes bulimia).

"It is recognised that constitutional factors of infancy, variations in drive endowment and gender differences affect each child's development, but it is the domineering and controlling personality of the mother which is stressed as the major factor in the profound warping and inhibition of normal development in the anorexia-prone child." (Wilson, 1983, p.8).

The recent trend towards understanding the context and meaning of the syndrome, has meant that there are more studies on (amongst other related topics) the so called 'bulimic family'.

This research on the families of bulimics indicates that the familial milieu and dynamics are not the same as in anorexic families (e.g. Strober and Humphrey, 1987; Zuk, 1986); the bulimic families are far more hostile and confrontational.

The significance of the mother-daughter relationship in anorexia is widely recognised. Although there have been very few studies on the relationship between the mother and the bulimic daughter, those that exist (e.g. Hicks, 1982; Kramer, 1983) seem to confirm the anecdotal evidence and clinical material pointing to a consistently more hostile and depriving

relationship between the bulimic daughter and the mother, than is the case in anorexia.

The paucity of research on the mother-daughter relationship in bulimia, and its likely significance in the development of eating problems, are the motivation for the present research. However, there is an additional reason for focusing on the mother-daughter relationship. Much of the psychological theory and research is limited, not because its explanations are incorrect or unhelpful, but because it is only a partial explanation of a complex and multi-determined syndrome. As mentioned earlier, a syndrome as complex as bulimia could only be understood by recognising both the individual's psychological make-up and family situation, as well as the social and historical context in which the individual develops the disorder. The mother in some sense, spans these areas; as the 'primary object' she is internalized by the daughter, and shapes the daughter's psychological development.

But the mother is also a socialized person, her perceptions of herself, as a woman and a mother are very much shaped by the social context in which she lives. She is therefore one of the most central mediators of the bulimic daughter's psychological and social development. The bulimic daughter's relationship with her mother will therefore have a profound effect on how she deals with ambivalent or conflicting

emotions, as well as the way she feels about herself, her body and her position in the world.

An investigation of the mother-daughter relationship, it is hoped, will reveal important information about the development and maintenance of bulimia. As explained above, however, it can only represent one level of explanation of a multi-determined syndrome requiring many levels of explanation.

CHAPTER 2 - LITERATURE REVIEW

2.1 INTRODUCTION

Epidemiological studies indicate that one in ten white middle class women suffer from bulimia. As noted in the previous chapter, however, the frequency of the disorder in the general population has not been reported. In addition, there have been no recent surveys which could indicate whether the disorder is on the increase, although the heightened public awareness of bulimia suggests that it is.

One factor which supports the notion that bulimia is on the increase, is the large number of theses which have been produced on this subject in recent years. This research, which is mostly unpublished, is being produced at American universities, and is reflected in the Dissertation Abstracts International for 1986, 1987, 1988 and 1989. This more recent research focuses on the context and meaning of the syndrome, rather than its prevalence in different population groups.

The current research and theoretical debates are reviewed in this section, with particular reference to the mother-daughter relationship. In addition, research in the area of the Bulimic's personality, the 'bulimic family', and the

relationship between the bulimic daughter and her mother, are also reviewed in this section.

Existing theoretical explanations of bulimia attempt to explain the syndrome by focusing on a number of seemingly separate areas. Sociological explanations look for the causes of bulimia in the stereotypical roles of women in our society; Behaviourist theories focus on bulimia as a learned behaviour; psychoanalytic theories explain the disorder in terms of unconscious forces within the individual, influenced by the early relationships with significant 'objects'; family theorists locate the causes in particular patterns of family interaction. This diversity of explanation mirrors an important feature of bulimia, namely that it is multidetermined. Many of the existing theories are limited precisely because they tend to focus on just one area of explanation, thereby not recognizing the complexity of the factors which precipitate and perpetuate the syndrome. A theoretical explanation which acknowledges the complexity of the syndrome would recognise a number of different interacting areas of explanation, for example the social/ideological influences, the family, the interpersonal, the personality of the bulimic daughter and the largely unconscious psychodynamic factors in her internal world.

Only one group of theorists in the following review attempt a holistic understanding of the bulimic syndrome, and are thus used extensively to explain the results of this study. The most significant representatives of this comprehensive approach are Dana et al., (1988) whose work is discussed under the section on Feminist Explanations of Bulimia.

2.2 BEHAVIOURIST/COGNITIVE THEORIES

The behavioural/cognitive understanding of bulimia is rooted in the attempt to formulate types of treatment which will alter what is perceived as the 'bulimic behaviour' (i.e. bingeing and vomiting).

Within this framework, bulimia is understood to be due to particular kinds of beliefs about oneself and the world, beliefs which are rigid and perfectionistic (especially beliefs related to eating, weight and appearance) (Scanlon, 1986). Johnson, Connors & Tobin (1987) talk of the bulimic's belief that if she were thin, she would feel in control. The explanation for these rigid beliefs is as follows: Bulimics experience affective instability which may be due to a number of factors, e.g. biological predisposition to major affective disorder, patterns of early parent-child difficulties or a disturbed family environment. This affective instability means that their moods are very variable, and that they are

unable to identify, articulate or control them. The feelings of ineffectiveness and low self-esteem are then a predictable side effect of being out of control. The culturally prescribed body shape then provides the focus for the bulimic's search for self-control; being thin means being in control. Research has shown however, that prolonged dieting results in physiological and psychological effects which destabilise thoughts and moods (Garner, et al., cited in Garner et al., 1985). It then becomes a self-defeating cycle.

As is evident from the above explanation, the possible root causes of the syndrome (biological predisposition to affective disorder, patterns of early parent-child relationships, or disturbed family environment) are only alluded to in a perfunctory way. The major emphasis is rather on the 'rigid and perfectionist' beliefs which are characteristic of the syndrome, and how they are reinforced by the environment.

Laurenza (1985) uses a 'behavioural analysis procedure' to treat bulimic behaviour. Binging and vomiting are understood as mechanisms for avoidance of a variety of stressful events. Therapy must therefore focus on a problem-identification and resolution format designed to elicit these conditions as well as to teach the skills needed to resolve them. The 'behavioural deficits' are the result of an inability to obtain (and maintain) reinforcement for the correct behaviours.

The Behaviourist/Cognitive approach to bulimia does not see the mother-daughter relationship as specifically important. In so far as the relationship is part of the child's general environment, it is included as one of the possible predisposing factors, but it is accorded no more significance than any other environmental or biological factor. The individual's environment is important in that it provides positive or negative conditioning, which will encourage or discourage the learning of particular behaviours (e.g. the maladaptive behaviours in bulimia).

Behaviourist approaches have been used fairly successfully in the treatment of bulimia. A study by Agras, Schneider, Arnow, Raeburn & Telch (1989) found that cognitive-behavioural treatment was successful in reducing purging and in promoting positive psychological changes in a group of 77 bulimic patients, over a period of 4 months. Fifty-six percent of the participants ceased binge eating and purging by the end of the four month treatment period, and the frequency of purging declined by 77.2% during the same period. At a six month follow-up, 59% of the cognitive-behavioural group were abstinent, and purging had declined by 80%.

The value of the behaviourist-cognitive model would seem to be in the area of treatment, rather than at the level of providing a comprehensive explanation of the etiology of the

syndrome. It does not, for example, adequately address the question of why women rather than men suffer from bulimia, or why it is, at this stage, a distinctly middle class syndrome. This however, is a criticism which also applies to other theoretical paradigms, for example the psychoanalytic one.

2.3 CLASSICAL FREUDIAN THEORIES

In this section psychoanalytic theories which have concerned themselves directly with the problem of anorexia will be discussed. The attempts by Feminist theorists to apply psychoanalytic concepts to an understanding of bulimia will be covered in the section on 'Feminist theories of Bulimia' (Section 2.4). The following analytic theories have focused primarily on the 'anorexic' syndrome.

In the psychoanalytic literature, "anorexia nervosa" is a generic term which encompasses bulimia, reflecting the belief that anorexia and bulimia share a common pathology. As mentioned in the Introduction, the major cause of anorexia is seen to be the domineering and controlling personality of the mother (Wilson, 1983).

Psychoanalysts understand anorexia as indicating a failure to reach true genitality. The person has remained fixated at earlier levels of development and is therefore seen as being

unable to establish proper sexual identification and heterosexuality. The role of the mother in this process is seen as central.

The channelling and refining of the libido (life force) through the different developmental stages: the oral, anal, phallic, latent and genital stages, was seen by Freud as the essential process in personality formation. At each stage the libido 'attaches' itself to or focuses on the relevant area of the body (mouth, anus, genitals etc). In normal development the libido attaches itself to each successive part of the body. This process of development however, is highly complex and precarious; the infant has to undergo many intense and contradictory feelings while negotiating the development from the oral to the latency stage. The individual's success partly depends upon the strength of the inborn instincts (Eros and Thanatos) and the quality and consistency of maternal care.

If some factor interferes with the normal channelling of the libido through the stages, part of the libido is said to become 'fixated' at that stage. Although the personality continues to develop, this fixation represents a fundamental weakness in the developing personality. When the adult, at a later stage is under stress (being of internal or environmental origin), the ego (which has been weakened

because of the holding back of a certain amount of libido) will automatically regress to the level at which the fixation occurred. If the libido has become fixated at the oral stage, as is believed to be the case in anorexia, then the psychic mechanisms appropriate to that stage will again be employed by the adult ego. Anna Freud (cited in Kaplan et al., 1988) identified denial, projection, introjection, regression and 'turning against the self' as important defence mechanisms employed by the ego during the oral stage.

The classical Freudians' explanation of the etiology of bulimia is not fully expounded. The first step seems to involve a fixation of the libido at the oral stage (which would account for the conflict taking an oral form). The reason for the fixation is said to be "a specific pathological relationship with mother in early childhood" (Merlitta, cited in Wilson, 1983, p.72). This oral fixation then interferes with the Oedipal development resulting in an intense Oedipal conflict. Then, during adolescence (the genital stage) the issues unresolved at the oral and oedipal stages are revived. This distorted development characteristic of anorexia is nowhere fully explained, compelling the reader to scrutinize general psychoanalytic texts for a more thorough knowledge.

2.3.1 The Oral Stage and the problematic relationship with the Mother: The 'specific pathological relationship with mother in early childhood' is said to occur during the oral stage. If we try to piece together the contributions from different theorists, it appears that two important processes are occurring during this stage.

2.3.1.1 The developing Relationship between mother and child expressed through the activity of Feeding: Anna Freud (1946, p.124), in her work on early feeding disturbances, explains that the child makes an unconscious connection between the mother and food. At first, the baby 'loves' the experience of feeding (he/she is hungry, is fed, and is satisfied). This is narcissistic love. The libido cathexis then moves to the food as the source of pleasure. So the infant 'loves' the milk, breast or bottle. This is a transitional stage between narcissism and object love. Finally 'love' is transferred to the provider of the food, i.e. the mother, representing the development of object love (Freud, 1946, p.124). (The 'object' refers to the person to whom the instincts are directed, in this case, the mother). Although the food and the mother are seen as separate after the second year, unconsciously the identity between the two remains.

Abraham's demarcation of two stages within the oral stage (Laplanche & Pontalis, 1985, p.288) links the development of

teeth to ambivalent feelings towards the loved object. Abraham's two substages within the oral stage seem particularly pertinent to bulimia.

The two stages are:

- * Preambivalent sucking
- * Oral-sadistic stage. This is concurrent with teething in which the activity of biting and devouring implies destruction of the object. The phantasies are of being eaten or destroyed by the mother. Incorporation has the meaning of a destruction of the object, implying that ambivalence has come into play in the object relationship. The bulimic's ambivalence towards food (the symbol of nurturance, and of her mother) suggests that she may have become fixated at this second oral-sadistic stage.

Anna Freud (1946, p.126) concludes:

"Much of the child's conflicting behaviour towards food does not originate from loss of appetite or lessened need to eat, but from conflicting emotions towards the mother which are transferred on to the food which is the symbol of her ... Ambivalence towards the mother may express itself as fluctuations between over-eating and refusal of food."

The origin of this early fixation on the mother is not clear. Lehman (1953) explains that feeding is the medium through which the mother expresses love for her child. When the mother feels ambivalent about the child, or does not want the child, she may feel very guilty and respond by becoming anxious about the child's nutrition, and become obsessive about it. "To be loved is to be fed... Consequently, a

child's rejection of food may be a reaction to rejection of the mother" (Lehman, 1953, p.461).

The connection between the mother and food may be strengthened, but in a pathological way, by a mother who, acting under the influence of her own unconscious fantasies, treats food which she offers as if it were a part of herself. Thus she will be pleased and affectionate when the child accepts her food, and offended when her food is rejected, as if her love for the child had suffered a rebuff; she may beg the child to eat 'for my sake'.

Sperling (cited in Wilson, 1983) adds that the anorexic equates food with the life-controlling, omnipotent mother, and uses food to reverse the early childhood situation when the mother was in control of food, and by extension, the patient's life. To be able to go without food is also to prove that life is possible without mother.

The activity of feeding is thus seen as the source of the particular meanings through which the object relationship is expressed and organised (Laplanche et al., 1985).

In anorexia, the relationship between mother and daughter, expressed via the activity of nutrition, is distorted. The exact nature of this distortion is not clear, but suggestions

point to the mother's unconscious linking of the child's eating with acceptance or rejection of herself, her possible ambivalence towards the child, and her controlling and domineering manner.

2.3.1.2 The sexual nature of the feeding experience:

The sexual nature of the feeding experience apparently explains the occurrence of the syndrome during adolescence. Adolescence is a time of developing awareness of sexuality. In order to be able to deal with this emerging sexuality the person needs to have successfully negotiated libidinal forces in earlier stages of development. In the oral stage, sexual pleasure is bound predominantly to the excitation of the oral cavity and lips which accompanies feeding.

The suckling of the mother's breast by the infant has been likened to coitus. This original infantile oral eroticism may later find expression in various pathologic psychic syndromes involving the ingestion of food (Lehman, 1953, p.469).

According to Lehman, the psychosexual significance of eating is clearly expressed in anorexia in which there is a marked repression of the sex drives and an inhibition of eating because eating is unconsciously linked to the sexual act. "They have a disgust for food, because eating is equated with intercourse, gratification and impregnation" (Lehman, 1953, p.410). Anorexia is therefore a regression from the genital level (in adolescence) to the oral level, and involves a de-emphasis of manifest sexuality and instinctual pleasure in

general. Sexual and masturbation conflicts are displaced from the genitals to the mouth, and food and eating are equated with forbidden sexual objects and sexual activities (Spurling, cited in Wilson, 1983). The anorexic's strongest fear is of losing control, i.e. gratifying impulses without restraint (both sexual and aggressive), (Merlitta, cited in Wilson, 1983, p.72). Klein (cited in Palazzoli, 1978) suggests that the anorexic girl tries by not eating, to deny her impulse to destroy the primary object. By not eating, she tries to repress her cannibalistic impulses.

The anorexic/bulimic's guilt over these unconscious sexual (and aggressive) impulses is assuaged by a strict superego which dictates starvation, illness and even the possibility of death. In addition, one of the primary tasks of adolescence (the genital stage) is the ultimate separation from, dependence on and attachment to the parents, and the formation of mature object relations with people outside of the family.

The bulimic struggles with this task because of her strong but ambivalent fixation on mother during the oral stage. This struggle is reawakened during adolescence. At the same time, a strict superego attempts to control her unconscious sexual and aggressive impulses.

The regression causes the infantile ties to mother, which have never been severed, to re-emerge with a primitive, omnipotent superego that strives for control over food and body and through them, the external world (Mintz, cited in Wilson, 1983, p.94).

The above theories are obviously most pertinent to anorexia in its classical or primary form. However, within the psychoanalytic framework, anorexia is used as a generic term, and bulimic symptoms are seen as part of the anorexic syndrome.

The psychoanalytic emphasis on the mother-daughter relationship in the etiology of eating disorders is based on the understanding of the mother as the first love object which the child internalizes. The child's conflicting feelings towards this internalized mother are seen as directly linked to the 'choice' of symptom (i.e. bingeing, vomiting or fasting) in adolescence.

Explanations for bulimic symptoms specifically (gorging or bingeing and purging) are given below.

2.3.2 Gorging and bingeing: Psychoanalysts see gorging as a symbolic expression of sexually related fears and aggression in relation to the mother. It is understood as indicative of deficient ego control and a strict but ineffective superego.

Mintz (cited in Wilson, 1983, p.94) explains that "to shove food down the throat is to be violated, which constitutes unconscious sexual fantasies of rape and bodily damage displaced upward from the vagina." Whereas anorexics are

thought to have unconscious pregnancy fears, bulimics are thought to have an unconscious wish to be pregnant.

Gorging is also a way of expressing aggression. To gorge is to "use the mouth and teeth to destroy" (Mintz, cited in Wilson, 1983, p.94), with the feared weight increase symbolising an explosive loss of control (Hogan, cited in Wilson, 1983, p.121). The impulse to gorge and to abuse laxatives also reflects a loss of impulse control and is related to unsatisfied infantile yearnings for closeness and security as well as aggressive discharge (Spurling, cited in Wilson, 1983).

According to Hogan (cited in Wilson, 1983), bingeing involves fusion with the maternal figure and the breast and also orgasmic masturbatory activity. At the same time bingeing represents sadistic devouring of the frustrating 'Lad' object and clearly replaces angry confrontations with the mother (Hogan, cited in Wilson, 1983).

The gorging patient has deficient ego control and a strict but ineffective superego. The fact that the superego is ineffective makes it difficult to adhere consistently to the demands for starvation and the denial of infantile cravings (Wilson, 1983).

2.3.3 Vomiting and Purging: The psychoanalytic explanation of vomiting alludes to the same areas of sexuality, aggression and conflicting feelings toward the mother.

Vomiting is the acting out of a fantasy of undoing and losing control of what is inside. It is actively attempting to relive and undo rape, ejection of semen, the baby, the passive yearning for perpetual infancy without responsibility, and symbiotic attachment to mother. Vomiting is the symbolic outpouring of rage (Mintz, cited in Wilson, 1983, p.94).

Vomiting is a compromise between a symptom and a defence. It is overdetermined, but at the most primitive level represents a rejection and ejection of the maternal figure, food and the breast. It seems to aid in the suppression from conscious awareness of upsetting conflict with the internalized mother. Insofar as vomiting is a conscious attempt to maintain a prepubertal figure, it is also a less conscious defence against sexuality and pregnancy wishes. Vomiting is about the bulimic's primitive envy and aggression against the maternal figure, who she wishes to devour, destroy, and eject. It is also the expulsion of the bad object, riddance of contamination and rejection of a wish for pregnancy. (Hogan, cited in Wilson, 1983, p.121).

The bulimic uses these defences to deny guilt and depression which, according to Hogan (cited in Wilson, 1983) are intimately related to intense sadistic and aggressive impulses directed toward the loved object.

Anorexics' superficial conformity as children is a reaction formation to repressed and denied hostility. The superego is identified with the maternal object who consciously is seen as a powerful controlling figure. The aggression towards her is displaced and appears in psychosomatic symptoms of anorexia and bulimia (Hogan, cited in Wilson, 1983). Unfortunately there appears to be no literature on what bulimic women (as opposed to anorexic women with bulimic symptoms) were like as children; one would imagine that conformity is not as evident as in anorexia, given the accounts of open conflict characteristic of bulimic families (e.g. Strober et al., 1987).

A major criticism of the psychoanalytic explanation of anorexia/bulimia is that it is not comprehensive. References are made to 'pre-Oedipal fixation on Mother', but the exact form this takes is not fully explained. The case material which is used to illustrate the theories, illustrate mainly that there is great individual variation in the psychodynamics that each particular woman displays. Finally, this paradigm does not distinguish between anorexia and bulimia, except to say that the superego is more strict and punishing in the anorexic, although in both cases the ego is protecting itself from a fear of letting go of impulses. As pointed out earlier, the assumption that anorexia and bulimia arise from a core pathology is a contentious one. It also forestalls

research aimed at clarifying the relationship between the two syndromes.

In summary, psychoanalysts understand anorexia to be a regression from the genital stage in adolescence, to the earlier oral stage, caused by a pathological relationship to the mother during the oral stage. The result is an inability to reach true genitality, the various conflicts being played out in a disturbed relationship to food (the oral compulsion and the symbol of mother and nurturance). Despite the fact that the mother is seen as central however, she is seen primarily as an 'internalized object', rather than a person in the real world. Further, the focus is on the early child-mother relationship and the present relationship with the mother is neglected, as well as the social context within which this relationship takes place.

2.4 FEMINIST THEORIES

The Feminist literature varies in the level of sophistication of its arguments and its attempts to explain the bulimic syndrome. It also varies in the significance it gives to the mother-daughter relationship.

Boskind-White's (1985) explanation of bulimia is similar to a limited behaviourist model in that environmental factors are given priority over all other factors.

She claims that:

Bulimarexia is not a disease; it is a learned habit fostered by an insidious socialization process which prepares women to accept weakness, sickness and victimization. Since these attitudes and behaviours are learned, they can be unlearned... We have found the prognosis for bulimarexic women to be good in general, primarily because they are bright, talented and capable (1985, p.115).

The mother is seen as an important agent of this "insidious socialization process" and she is blamed for the daughter's distress. According to Boskind-Lodahl (1976) bulimics are consciously aware of despising their mothers. They describe them as weak, unhappy women who have abandoned careers in order to raise children. Though the mothers are described as ineffectual, they are seen as exercising great power over their children. It is acknowledged that the mothers are oppressed by the social context in which they live, but they cause bulimia in the daughter by verting their misery on their children, by becoming suffocating, dominating and manipulative. Within this type of explanation then, the daughter is seen as an innocent victim of socialization, both by her mother and by the environment more generally. The daughter's role in the syndrome is totally denied.

In another account, Boskind-Lodahl (1976) distinguishes between explanations of bulimia which look at the inner psychological dimensions of women (and are wrong because they are perceived as criticising women for being weak), and those which acknowledge outer cultural pressures and historical themes (and are consequently seen as correct). Acknowledging psychological factors is perceived as placing blame on the woman, and is therefore rejected as ideological. This approach, like the previous one denies the importance of individual vulnerability and personality, and how these interact with, and are influenced by, the broader socio/historical context.

What the above theories do recognize however, is that in the mother-daughter relationship, a process of socialization into particular ways of perceiving the world and one's role in it, are at work. However, despite recognizing the mother as a socializing agent for the daughter, they ignore the mediating role of the individual mother's personality, as well as the important role of the 'internalized' mother in the daughter's perception of herself. They also deny the daughter's role in the development of the syndrome.

The more recent feminist writers (Dana et al., 1988; Orbach, 1986) approach these issues in a far more sophisticated way, moving from a description of the social context (patriarchy)

to the resultant emotional constraints on women, to the acceptance of these constraints through the process of socialization, most powerfully in the mother-daughter relationship. They also acknowledge the significance of the daughter's 'internal world', as influenced by the mother as an 'internalized object'. They however, extend the psychoanalytic view by not only viewing the mother as an internalized object, but also as a socialized person herself, so that what the daughter internalizes is a socially prescribed perception of what it is to be a woman in a particular cultural and historical moment.

These theories take as their starting point the belief that a woman's social role creates her particular psychology, and her psychology is understood as a reflection of her preparation for her allotted role (Orbach, 1986, p.29). Within this framework, anorexia and bulimia are to be understood as expressions of women's psychological conflict about their socially prescribed roles. The actual symptoms of drastically restricting one's food intake, or bingeing and purging, are metaphors for the underlying conflicts, and therefore clues to understanding them. Orbach claims that what women with eating disorders have in common, is not age or class, but "a shared conception of the kind of emotional life deemed permissible", that is, one which involves the suppression and denial of needs (Orbach, 1986, p.13).

In our society a woman gains her sense of identity and purpose by being connected to others, in particular, to a man. She learns that she must shape her life according to her relationship with him (and his children). The requirement of being connected to others means that the woman must make herself into a person that others will find pleasing. She does this by taking on the role of caretaker; she becomes very astute at anticipating others' needs, and helping them to fulfill them. To be successful, she has to work at keeping others happy.

This role of nurturer is the single most commonly perceived expectation of women. She has to constantly defer to others, to "follow their lead, articulate her needs only in relation to theirs" (Eichenbaum et al., 1982, p.29). To be successful, she has to work at keeping others happy. She comes to believe that she is not important in herself, and can end up feeling unworthy, undeserving and unentitled. In her attempt to be the perfect caretaker, she also loses touch with who she is, with her own buried needs. Because the nurturer seldom receives as much nurturing as she gives, she is often left carrying deep feelings of neediness (Eichenbaum et al., 1982).

Nurturers are taught to put their own needs second and not to demand too much for themselves. How then are women to express

their emotional dissatisfaction in a socially 'acceptable' form? For people who feel powerless and unheard, the body is the last vestige of power, it is the last object over which they have control. Orbach (1986) however explains that women's control over their bodies has become diminished by the commoditization of the female form in the media. This she says, encourages women to regard their bodies as somehow separate from them, something they can change and reform, as the fashions require.

The attitude towards women's bodies in Western middle class culture is also highly ambivalent; a woman's body is a potentially powerful attribute, which will win her acclaim and favour. It is also a source of shame and humiliation (particularly when associated with menstruation). Woman is temptation, defilement, man's downfall. But in her role as mother, her body is the source of life and nurturance (Greer, 1972). These conflicting qualities make the body an ideal arena for women to play out their conflicts about themselves. Dana et al., (1988, p.31) conclude:

Bulimia is a metaphor or symbolic representation of the conflicts and difficulties which beset many women and which cannot find a more overt expression.

What then is the nature of these conflicts? The social and political position of women has changed radically in the last eighty years. Yet women's position in society still involves

a particular contradiction. Despite advances in the job market, and increased career opportunities for women, the basic relationship between men and women has not changed. There is a new set of expectations for women who want to break out of their stereotyped roles. Women are expected to compete with their male counterparts in their careers, but at the same time are expected to retain responsibility for the domestic work, as well as to be competent wives and mothers. We are speaking here specifically of middle class women, who at this stage seem to be more susceptible to eating disorders, although there has not been sufficient research to confirm this. Working class women have always had to carry a double load. The result of the double burden is that women are culturally and psychologically prepared for a life in which they are required to continue to service the needs of others while at the same time they are told that they are more liberated than ever before (Orbach, 1986).

In order to accept these very real constraints on their lives, women have to come to perceive them as not only appropriate, but as reflecting their own capabilities and emotional as well as physical needs. In other words they need to see these needs as 'natural', rather than socially ascribed. This process of discovering and internalizing what is "deemed permissible" is complex and continuous throughout life. It is also not a one-way process. Women do reject and change the

definitions of what is acceptable. But to do so necessitates demystifying the ideology of the 'natural'.

2.4.1 The Role of the Mother in the Bulimic Daughter's Socialisation: Although the process of internalizing these notions of womanhood is ongoing, the family and in particular the mother plays a central role in establishing the daughter's perception of herself. Because the mother is not only an 'internalized object', but also a socialized person, her feelings about herself as a woman and a mother are directly affected by the social context in which she lives. The daughter thus internalizes not only her perception of her mother as an individual person, but also a whole set of dictums about what it is to be a woman.

Ego development starts at birth and occurs within the context of the relationship that the infant has with its caretaker. Women's ego development is thus shaped in the mother-daughter relationship which is the critical relationship in the formation of the woman's psychology (Eichenbaum et al., 1982, p.30).

2.4.2 Close identification between the Mother and Bulimic Daughter: Dana et al., (1988) propose that a mother has a closer identification with a baby girl, than with a son. "Mothers and daughters share a gender identity, a social role, and social expectations" (Eichenbaum et al., 1982 p.30). This close identification stirs up in the mother all her unresolved conflicts about her own needs. The mother with her needy

baby girl, will see before her someone who reminds her painfully of herself and of all the needs she still has which were never met for her by her mother. While consciously she will want to do the best for her daughter, unconsciously she will feel bitter and envious and unable to give her daughter what she had never had herself (Dana et al., 1988, p.84). In this process the mother may teach the daughter not to expect too much for herself, and to obtain some of what she needs vicariously by nurturing others.

In this perspective women bring to their role as mothers feelings of unworthiness, dependence on others for a sense of self, and a sense of emotional dissatisfaction. These feelings, because of the close identification between mother and daughter and the importance of the mother in the process of socialisation, are likely to become part of the daughters emotional vocabulary.

Dana et al., (1988, p.85) point out that the mothers they are referring to are not "psychologically or emotionally ill", but simply women who have grown up in a patriarchal culture and thus learned to put their own needs second, and to find satisfaction in meeting the needs of others.

They are suggesting therefore that:

What we have come to regard as the 'normal' mother/daughter relationship may contain within it certain elements which are destructive enough to lead to serious difficulties in the area of self-nurturance and meeting of needs (Dana et al., 1988, p.85).

There is however a problem with this explanation. If the mother/daughter relationship in a patriarchal culture is sufficient to bring on bulimia in the daughter, then there would be many more bulimic daughters! The explanation so far is not sufficient; it has also to take into account the psychological health of the mother and of the daughter.

2.4.3 The Mother of the Bulimic Daughter and Maternal Care; Spierling (1978, p.110), a psychoanalyst, says the following about the mothers of bulimics/bulimics:

The mother's feelings towards her daughter frequently stem from unresolved ambivalent conflicts from her own childhood which she has transferred to her child, or from her unconscious identification of the child with repressed and rejected aspects of her own personality.

Alice Miller (1985) explains that some parents who have never been loved fully for themselves, offer their children love in a conditional or partial way. Certain aspects of the baby are found to be lovable, whilst other parts of her are rejected. In order to keep the love of the parents, the child has to disown, or split off the part of her own experience which is not accepted by the parents. The feelings which are forbidden to the child usually represent a split-off and unintegrated

part of one of the parents, which they themselves have always been terrified to acknowledge.

The daughter who grows up with a part of herself which she has to split off and deny is very vulnerable to a symptom such as bulimia, the bulimic symptoms representing the split-off part (Miller, 1985, p.87). Extending Dana & Lawrence's theory, the mother of the bulimic daughter may have had to deny her own neediness as a child and consequently will not be able to allow her daughter to express any of these feelings.

2.4.4 The Mother's ambivalent feelings towards her Bulimic daughter: Research has shown (e.g. Kramer, 1983) that the mother's repetition of her own deprivation may become manifest in her ambivalent behaviour towards her daughter. Mothers of bulimics tend to alternate between being over-protective towards their daughters and at other times extremely neglectful. Using Guntrip's work, Dana & Lawrence note that ambivalence about needs and neediness can be understood in terms of the earliest relationships which the baby forms with its mother. Guntrip (cited in Dana et al., 1988, p.80) says:

The situation which calls out the reaction (of uncertainty about needs) is that of being faced with a desired but deserting object.

What he is suggesting is that the mother is not consistent in her role. Dana et al., (1988), using Guntrip, characterise the mother-daughter relationship (in bulimia) as a depriving

one. The baby is being deprived, but not totally deprived, not abandoned or abused or neglected in ways which would be obviously noticeable. In fact, this kind of relative deprivation mostly goes unnoticed.

The mother's reason for depriving her daughter of consistent caring is not clear. Weissberger (1986) however, found that both the bulimic daughters and their mothers feel emotionally deprived within the family. If we hypothesize that the mother's sense of deprivation arose from her own childhood experience, it seems possible that because of her close identification with her daughter, the mother will tend to project her own feelings onto the baby, thereby unconsciously repeating her own deprivation in her relationship to her daughter.

The 'relative deprivation' is not experienced as a distancing by the mother but rather as a kind of withholding from within a very close relationship (Dana et al., 1988, p.5).

2.4.5 Psychological Splitting as a Defence Mechanism: The observation made by Alice Miller (1985, p.86) throws additional light on the possible meaning of the symptom. Parents who were not allowed as children to express certain feelings will in turn disallow their expression in their own children. As mentioned earlier, a daughter who grows up with a part of herself which she has to split off and deny is very vulnerable to a symptom like bulimia. She may have to deny

her feelings of neediness, anger, dependence - all of which she has been taught are 'bad', and are therefore to be rejected. One way of dealing with 'bad' feelings is to split them off from the good ones and put them in a well-defined corner of our lives. The bulimic tends to split-off the bad from the good in her life and food is often seen in moralistic categories of 'good' and 'bad'. Many bulimic women say; "I have no problems apart from this horrible eating and vomiting", which encapsulates 'the problems' in her life (Dana et al., 1988, p.113). All the uneasy and painful feelings are blamed on the symptom. All the bad, needy, angry, dependent aspects become attached to the bulimia, so that they are not directly experienced. This encapsulated 'bubble' allows her to lead quite a 'normal' life where she can present herself as 'good' and coping. In fact many bulimic women hold down highly demanding jobs and present as functioning, coping adults during the day, limiting their bingeing and purging to when they are at home alone.

Klein explains the process of 'splitting' in psychoanalytic terms, as a defence against painful and unwanted feelings (Klein, cited in Mitchell, 1986). Klein did not write specifically about eating disorders, but Dana et al., (1988) use her theories to further understand the psychodynamic processes involved in bulimia.

According to Klein (cited in Mitchell, 1986) the baby is dominated by overpowering feelings and phantasies about the mother. It is the mother's breast, the source of nurturance, as experienced by the baby which is the recipient of all the baby's loving and hating feelings. When feeding goes well, then the baby can direct her loving feelings towards the breast. If she does not get enough milk, or she chokes, or the mother does not respond to her cries, then all her hateful, angry and destructive feelings are turned towards the breast. In her phantasy, the baby "attacks the breast, trying to suck it dry, bite it up and scoop out all its contents" (Klein, cited in Dana et al., 1988, p.118). The difficulty the baby has with aggressive phantasies, and her bad feelings, is that she is afraid that she will destroy the breast (her source of satisfaction and nurturance), and that the breast will retaliate and destroy her. In order to protect herself from the possible consequences of her bad feelings, the baby uses projection. She disowns her feelings and projects them onto the breast. She can then believe that it is not she who wishes to destroy the breast, but the bad breast which wants to destroy her. She then has a phantasy of a bad, destructive force, which is external to herself, and she is consequently not troubled by all the bad feelings within her. In the same way, by keeping the breast separated into two aspects, good and bad, the baby can retain the good breast, the aspect of mother, which she experiences as loving

and satisfying, without it having to come into contact with or be in any way spoiled by the bad breast. This is the primitive defence of splitting.

As well as projecting feelings onto the breast, the baby also introjects what she perceives or experiences of the mother. Thus she will take in as part of herself, both the good object, the loving and satisfying breast, and the bad object, the persecuting and vengeful breast. The defence of splitting also operates in an internal way, so that the ego itself is split into a good part which is kept entirely separate from the bad part. In normal development the baby will be able to take in both the good and bad aspects of mother, and of herself, and integrate them. She will have a sense of other people and of herself, as not perfect, but also not totally bad. Bulimic women seem to need to keep the 'good' and the 'bad' separate, both internally and externally.

2.4.6 The Adult Bulimic: In adulthood, Guntrip suggests, "...this entire problem is frequently worked out over food." (Dana et al., 1988, p.80). Dana et al., (1988) explain that symptoms which have to do with food, eating and the capacity for self-nurturance are always reminiscent of our early lives. This is because eating, or taking in nourishment is the first activity in which we have to engage in order to survive. At first we are not able to nourish ourselves - our ability to

survive depends upon the relationship we have with our caregiver.

The experience of feeding, and more importantly of being fed, is our earliest and perhaps our most profound experience of nurturance, of having our needs met or not met (Dana et al., 1988, p.80).

The adult bulimic is 'hungry' for nurturance, and for intimate relationships. Faced with something which she longs for, but which she feels is unreliable (just as her early feeding was unreliable), she denies her 'hunger'. "Symbolically it is as though she wants to possess, consume and control the person she desires (ultimately representing the mother)" (Dana et al., 1988, p.80). Not being able to do so, she consumes the food instead (the unconscious symbol of mother). She then becomes so terrified of having admitted to her needs that she has to deny them immediately and throw up what she has just taken in. Her desire to eat is endless - she needs to get as much as she can inside her before it is taken away.

Her attitude is incorporative in that her aim is to get something inside herself where she cannot be robbed of it; she has no confidence about being given enough (Dana et al., 1988, p.81).

Guntrip goes on to explain the origins of this incorporative attitude in infancy, and the resultant anxiety: If the baby knows that the breast will be available when she needs it again she will be able to suck contentedly and let go when she feels satisfied. If she is not secure about being fed again when she is hungry, then she will not be satisfied, even

when she is fed, for fear that she will lose her source of food before she is satiated. This gives rise to a desperate hungry urge to make sure of the breast, not merely by sucking at it, but by swallowing it, thus getting it inside where it cannot be taken away. The impulse changes from taking in from the breast into an urge to consume the whole breast itself.

Guntrip sums it up by saying:

The contented baby sucks, the angry baby bites, the hungry baby wants to swallow (Guntrip, cited in Dana et al., 1988, p.81).

This anxiety about never having enough, is what is later re-enacted in the symptom of binge-eating.

Dana et al., (1988) say we can understand the bulimic's frantic devouring of the huge amounts of food as an attempt to take in the good and nourishing breast, just as she had attempted and partially succeeded in introjecting it in infancy. But this good sense of mother, as soon as it comes into contact with the depriving sense of mother, turns bad. What she is dealing with are her own feelings of destructiveness, her sense of having destroyed, torn and bitten up the breast, which she now experiences as evil and poisonous inside her, turning bad everything which she takes in. Her response is to get rid of the bad food, to project it out, just as the original bad feelings were projected onto the mother.

Bulimic women then, according to this use of Klein's theory, have not been able to progress beyond the stage of keeping the good and bad separate i.e. of splitting. Winnicott (1985) suggests that it is a continuing, unchanging holding of the baby throughout all her many changes of mood and regardless of whatever bad feelings she projects onto the mother which will allow her eventually to see the mother as a whole person. This implies that the mother is able to contain and make safe all the baby's feelings. As long as the mother is able to provide constant care in the face of the baby's changing mood states, it remains possible for the infant to take back some of the projected feelings, to acknowledge that she, not the mother is sometimes full of anger and rage and that the mother, although not perfect can be experienced as one being, distinct from the baby.

The ability of the baby to integrate the good and bad in herself and in her mother is therefore dependent upon the early relationship between them. It has been suggested that the early relationship between the mother and bulimic daughter is characterised by 'relative deprivation', which is experienced by the daughter as a "kind of withholding from within a very close relationship" (Dana et al., 1988, p.85). The baby who struggles with this process will be more vulnerable to bulimia in later life, than a child who has had consistent mothering.

The feminist theories of bulimia thus place a strong emphasis on the role of the mother. She is seen both as an agent of socialisation bringing to this role socially and historically determined feelings about being a woman, as well as an individual person whose relationship with her daughter is mediated by her own psychological make-up and conflicts. The emphasis however is on the effect of patriarchy, making it normal for women to accept a level of emotional deprivation, and to unconsciously pass this on to their daughters.

The above theories (behaviourist, psychoanalytic and feminist) have attempted to provide an explanatory model for bulimia. Although they are all based on some clinical experience of bulimic women, there does not seem to be much empirical research to test these explanations.

Research in the field of bulimia has concentrated mostly on treatment (especially Cognitive/behavioural treatment), as well as on two other areas which are important, and far easier to research than heuristic models. These are: the personality of the bulimic, and the dynamics of the 'bulimic family'. Out of the latter has come some information about the mother-daughter relationship, which may have served as the motivation for the handful of studies focusing specifically on the mother-daughter relationship.

The research in these two areas: the bulimic personality and the bulimic family, are reviewed below. It appears that bulimic women exhibit certain common personality traits, and that their families are characterized by particular communication styles. The research in these areas addresses the question of why, given that most middle class, Western women live in a similar limiting, patriarchal context, only some women develop bulimia.

2.5 RESEARCH ON PERSONALITY CHARACTERISTICS OF BULIMICS

Research on bulimia has attempted to identify a "bulimic personality" profile. The potential danger in this focus is the implication that only people who have these character traits will develop bulimia and that somehow these traits are the causal factor. Clearly this is not true, although the role of personality traits in the syndrome may be more significant for some than for others.

There is fairly consistent agreement about the importance of the following traits:

Bulimic women experience an intense fear of being 'fat' (Casper et al., 1980; Pyle et al., 1981; Russell, 1979) which is seen as suggesting an overvaluation of appearance, and a

need for external approval. Bulimics also commonly suffer from a low self-esteem (Bruch, 1973; Dunn & Onderscin, 1981; Huon, 1986; Kaye et al., 1985; Pyle et al., 1981) and a severe sense of inadequacy (Boskind-Lodahl et al., 1978). As discussed earlier, however, many women struggle with these issues (low self-esteem, sense of inadequacy, fear of becoming fat and an overvaluation of appearance). Bulimic women however, seem to experience these feelings more acutely.

Bulimics suffer from a high level of anxiety (Casper et al., 1980; Dunn et al., 1981; Neckowitz, 1986; Pyle et al., 1981), especially in relation to social situations (Russell, 1979) and to possible weight gain (Pyle et al., 1981). The literature tends to relate both bingeing and purging to anxiety provoking situations (Grace, Jacobsor & Fullager, 1985).

There is also evidence for bulimics acting according to an external 'locus of control' (Bruch, 1973; Dunn et al., 1981). Bulimics commonly believe they have little personal control over the events of their lives and that what happens to them is due to luck, chance, or 'powerful others' (Dunn et al., 1981). They in fact often blame their symptoms on others (Bruch, cited in Garfinkel et al., 1985). Neckowitz (1986) found that bulimics perceived themselves to be less instrumental than non-bulimic women in their coping efforts. Bixler (1987) found that bulimic women had a higher need for

deference than autonomy, and abasement rather than aggression when compared to 'normal' women.

DSM III-R (1987) point to some overlap between bulimia and Borderline personality disorders; they note that binge eating is often a feature of the Borderline personality disorder in females. Another 'Borderline feature' which bulimics display, is a vulnerability to impulsive behaviour (Johnson & Larson, 1982; Kaye et al., 1985). The most common manifestations of this are stealing, alcohol and/or drug abuse, promiscuity, and suicide gestures (Casper et al., 1980; Garner et al., 1980; Pyle et al., 1981; Russell, 1979).

Many studies comment on the preponderance of depression amongst bulimic women (e.g. Herzog, 1982; Johnson et al., 1982; Kaye et al., 1985; Post & Crowther, 1985). As mentioned in the Introduction the recently published DSM III-R (1989) has withdrawn the requirement of depressed mood from the diagnostic criteria, although it is still recognised as a common associated feature of bulimia. Unfortunately no explanation is given for its exclusion from the diagnostic criteria in DSM III-R; it was an important feature amongst the bulimic women in the present study. The literature on the significance of depression in bulimia is equivocal. Some of the earlier studies (Johnson et al., 1982; Kaye et al., 1985) found that bulimics experience significantly more dysphoric

and fluctuating moods than normal controls. Interestingly, the nature of the depressive experience is not one of fatigue and lethargy, but rather one of activity and alertness, as well as a volatility in mood. Herzog (1982) believes bulimia to be an atypical variant of depressive illness. Johnson et al., (1982) propose that bulimics suffer from agitated depression marked by frequent mood fluctuations. Kaye et al., (1985) propose that bulimics frequently describe a history of chronic depression compatible with a DSM III diagnosis of dysthymia. Evidence for a connection between bulimia and major affective disorder is the high incidence of affective illness in first degree relatives of bulimics and, in some cases, improvement of bulimic symptoms with the administration of anti-depressants (Pope & Hudson, 1982; Pope, Hudson & Jonas, 1983; and Mitchell & Great, 1984; all cited in Kaye et al., 1985).

Some of the characteristics described above may overlap with those found in other eating disorders, or in other forms of psychopathology. However, characteristics which appear to be especially important in bulimia are extremely low self-esteem, an external locus of control (extreme feelings of passivity or helplessness), histrionic impulsive behaviour, and according to some, the presence of depression and mood fluctuations.

Grace et al., (1985) point out that the above personality features may have served initially to predispose the individual to develop bulimia, or they may be an integral part of its maintenance. Importantly, the personality profile of bulimics, (specifically low self-esteem, dependency on external approval, and sense of helplessness) would make the bulimic particularly vulnerable to the dictates or pressures placed on her by her family (particularly her mother) and society in general.

2.6 FAMILY THEORIES

Much research has been conducted on the structure and communication patterns of families with an anorexic daughter (eg. Kalucy, Crisp & Harding, 1977; Strober, Salkin, Burroughs & Morrell, 1982). By contrast, little attention has been given to the possible family correlates of bulimic patients, despite the fact that Garfinkel et al., as early as 1982, acknowledged the likelihood of familial differences in 'anorexic' and 'bulimic families'. The existing comparative research does strongly suggest that although anorexic and bulimic families share some common features, bulimic families are also different to both 'anorexic' and 'normal' families (families in which no member has an eating disorder), in important ways.

Humphrey (1989) explains that in classical anorexia, the family presents a facade of perfection, self-sacrifice and love, whereas in bulimia the presentation is quite different. Bulimic families are more openly hostile and withholding toward one another, and they are deficient in the same self-regulatory and self-caring capacities reflected in the behaviour of the bulimic daughter.

Johnson & Flach (1985) compared the family characteristics of 105 patients with bulimia to those of 'normal' families. Bulimic women perceived their families as being significantly less supportive and helpful and as not encouraging assertive, self-sufficient behaviour. Parents of bulimic daughters seem unable to allow their daughters to assert themselves and to differentiate from the family (Hicks, 1982; Sights & Richards, 1984).

Bulimic families experience a great deal of conflict, mutual hostility and anger (Humphrey, 1986a). Although there is conflict within the interpersonal relationships in the family, however, expression of the negative feelings that accompany or cause these interactions are not encouraged (Zuk, 1986). In a study by Johnson et al., (1985) bulimic daughters reported that open, direct expression of feelings is discouraged. Bruch (1974) found that parents of bulimic daughters seem unable or unwilling to express their feelings, especially

negative ones. They communicate in a rigid, intellectual manner in spite of the many conflicts and emotions. The result is a high level of unexpressed familial tension (Zuk, 1986), and no mechanism for resolving conflict.

Kramer (1983), Hicks (1982) and Lorenz (1986) noted that there was less flexibility in bulimic families as opposed to 'control' families. On a similar point, Zuk (1986) found that bulimic families were more likely to use set rules and procedures to run their family life, than 'control' families. Also the family pattern was predictable, rigid and often inappropriate to the family life stage, and the family was seen as unable to adjust to changing circumstances. Anecdotal evidence recorded by Boskind-Lodahl (1976) confirms that bulimic families are highly structured and hierarchical.

Strober et al., (1987) cite a number of studies which have compared perceptions of the family environment in the bulimic and restricting subtypes of eating disorders (Garner et al., 1985; Humphrey, 1986a, 1986b; Kog, Vertommen, & De Groote, 1986; Strober, 1981). With one exception, the findings converge in their portrayal of the intrafamilial environments of bulimics and bulimic anorexics as more hostile and conflictual, isolative and depriving, disorganized and as less nurturant, supportive and understanding than the family environments of restricting anorexics. Parents of the bulimic

subgroup were significantly more hostile, impulsive and excitable than the parents of the restricting groups. Humphrey (1986, cited in Strober et al., 1987) compared bulimic, bulimic anorexic, anorexic and normal control subjects. She found that whereas all 3 clinical groups perceived their relationships as more blaming, rejecting and neglectful than the control group, only the 2 bulimic subgroup also perceived a deficit in parental nurturance and empathy. Compared with the families of restricting anorexics, the families of bulimics were more hostilely enmeshed and deficient in affection and support, whereas the families of anorexics more frequently gave opposing messages of affection and caring with enmeshment and negation of the child's needs.

In bulimic families there is a high parental concern with appearances, social conformity and success, and expectations of the daughter's general compliance and adoption of the traditional female roles (Boskind-Lodahl et al., 1977; Moseley, 1986).

Humphrey (1989) investigated the father-daughter dyad in anorexics, anorexic-bulimics, bulimics and 'normals'. In all three disordered groups, the father's family interactions were characterised by more 'watching and managing' as well as 'belittling and blaming'. Interestingly, the father-daughter relationship in bulimia was no different from the other three

disordered groups. This suggests the importance of the mother-daughter relationship in the etiology of eating disorders.

Some studies (Garfinkel et al., 1985; Herzog, 1982; Zuk, 1986) have shown parental obesity, particularly of mother, to be moderately higher in bulimic families than in anorexic families. Strober, Salkin, Burroughs & Morrell (1982, cited in Strober et al., 1987) found a four-fold greater rate of alcoholism in the first degree relatives of bulimics than in the relatives of anorexics. This has been confirmed by a number of other investigations. Both alcoholism and obesity suggest a problem with impulse control - a characteristic also common to bulimic women.

Finally, Humphrey (cited in Strober et al., 1987, p.654) suggests, on the basis of a series of studies that the "binge-purge cycle" itself provides an apt metaphor for pervasive and chronically recurring family-wide deficits and excesses." Just as the bulimic periodically craves food during a binge, so do she and her family repeatedly crave and attempt to solicit nurturance, soothing and empathy from one another. Similarly, family members are thought to purge themselves by expelling their aggression and frustration toward one another without structure, focus or resolution. Humphrey & Stern (in press, cited in Strober et al., 1987) postulate that although

bulimic and anorexic families exhibit features in common, the bulimic more often assumes the projection of 'bad', inadequate and split-off parts of the parents' personalities.

The accumulating evidence suggests that there are distinctly different patterns of family interaction in bulimic, anorexic and 'normal' families. As we have seen, bulimic families are rigid and hierarchical. They are characterised by a lack of parental affection and overly negative, hostile and disengaged patterns of interaction with no mechanism for resolving conflict. In a conflict-ridden, emotionally depriving environment, in which open expression of feelings is discouraged, the daughter could become vulnerable to dealing with emotional conflict by 'splitting it off', (Klein, 1988) and symbolizing it in her relationship to food.

The family dynamic is also significant in that it is the context in which the mother-daughter relationship occurs, and will profoundly influence it.

2.7 RESEARCH ON THE MOTHER-DAUGHTER RELATIONSHIP

Very little research has been conducted in this area, although a number of unpublished theses written in the last few years (1986 -1989) have focused on the mother-daughter relationship in bulimic families.

The results of the studies on the mother-daughter relationship in bulimic families, as expected, concur with the broader 'family' and 'parent-child' research discussed in the previous section; many of the parental characteristics are identified as relating more specifically to the bulimic's mother. It is also interesting to note that not all daughters in the same family develop bulimia, implying that the relationship between the mother and the bulimic daughter (as opposed to the other daughters) is of particular significance.

Most of the studies focus on the daughter's perception of her mother. Moseley (1986) found that mothers were perceived as depressed, low in self-esteem, low in fulfillment of life goals, and less able to tolerate or express anger than mothers of controls, characteristics which could in fact be used to describe the bulimic herself.

Hicks (1982) noted strong conflict avoidance patterns between mother and daughter. Mothers of bulimic daughters have unrealistically high expectations of their daughters (Dietzen, 1986; Moseley, 1986) and are more critical than mothers of non-bulimic daughters, having little respect for their daughter's abilities. They give less encouragement and approval than mothers of controls (Moseley, 1986). They are very conscious of beauty and success, and place great emphasis on conformity, traditional femininity and appearance

(Boskind-Lodahl et al., 1977; Moseley, 1986). Moseley (1986) also found bulimic mothers to be more domineering than mothers of controls.

Lastly, the bulimic daughter's sense of emotional deprivation has been well established (Garfinkel et al., 1985; Strober et al., 1987). Weissberger (1986), however, found that bulimic daughters and their mothers both feel emotionally abandoned within the family.

An issue which has emerged from a number of studies is the mother's perceived ambivalence towards her bulimic daughter, manifest in a combination of being over-protective and at the same time, neglectful. Normal weight bulimics perceived more extreme patterns of mother overprotection and neglect compared to daughters of a control group (Kramer, 1983). Bulimic mothers were either extremely intrusive and controlling or, at other times, totally withdrawn from their daughters (Zuk, 1986), and unable to respond to their daughter's needs, to the point of being neglectful of them (Hicks, 1982; White & Boskind-White, 1984).

As can be seen by the above review, there is a dearth of research on the relationship between bulimic daughters and their mothers. The potential significance of this relationship in the etiology and maintenance of the syndrome

necessitates further research in this area, and is the motivation for the present study.

It was the aim of the present study to (1) establish the significance of the mother-daughter relationship in understanding the bulimic syndrome, and (2) to obtain some additional information about the content and form of the relationship, as perceived by the bulimic daughter.

Within the context of there being very little information on this topic, no exact hypotheses were formulated, the research being conceived of as essentially exploratory.

CHAPTER 3 - METHODOLOGY

This study investigates the bulimic daughter's perception of her mother. Given the notion that normal eating for women in Western society is 'disturbed', the exact nature of the bulimic women who constitute the sample in this study, needs to be clarified. The severity of bulimia can be identified along a continuum; on the one extreme so called 'normal eating', on the other more serious extreme, bulimia proper. The women in the present study are taken from the more serious extreme of the continuum; in other words, those women whose eating patterns have become serious enough for them to be diagnosed as bulimic, using the DSM III criteria. Also included are some who can be identified as having a serious potential for becoming bulimic (these latter would be classified according to the DSM III-R residual category used for eating disorders that do not meet the criteria for a specific eating disorder. The relevant category describes a person who has all the features of Bulimia Nervosa except the frequency of binge eating episodes). Although all of the women in the bulimic group could be diagnosed as having an eating disorder at the time of the study, none had been hospitalised for this condition. They therefore represent a non-clinical population.

The women in the sample are first year psychology students at the University of the Witwatersrand. The decision to use this sample was based on the literature which identifies women of this age (late adolescence or early adulthood) as particularly vulnerable to bulimia (Halmi et al., 1981; Pyle et al., 1981). Two studies have been conducted in South Africa: Grace (1983) using broader criteria than those stipulated in DSM III found a 20% incidence, and Zuk (1980) using DSM III criteria found a 7.7% incidence of bulimia amongst a student population.

In this study 700 first year psychology students constituted the population from which two samples were drawn: a bulimic group (20 women) and a non-bulimic group (20 women). These two groups were identified on the basis of a Bulimia questionnaire (the BULIT). The subjects were also given a short demographic questionnaire, a projective test (the Thematic Apperception Test), and were asked to give a description of their mothers.

3.1 TEST INSTRUMENTS

3.1.1 The Bulimia Test (BULIT)

The BULIT was developed specifically to meet the criteria of Bulimia as specified in DSM III (Appendix 1). Although the test does not incorporate the recent change made in DSM III-R, (de-emphasising depression and self-deprecating thoughts:

Appendix 1) the change is sufficiently minor as not to invalidate the test's ability to distinguish between bulimic and non-bulimic subjects.

The BULIT is a 32 item self-report multiple choice scale, developed by Smith and Thelen in 1984. It was constructed by comparing responses of clinically identified female bulimic subjects with normal female college students on a number of items or questions. The items cover issues such as eating patterns, bingeing and purging behaviour, perceptions of eating patterns, and feelings about oneself after bingeing or purging. When cross validation was performed on independent samples of bulimic and normal control subjects, the BULIT was found to be a good predictor for group membership of both initial and replicated samples. The test-retest reliability was found to be ,87 ($P < ,001$) Pearson correlation. The overall validity coefficient was significant at the ,05 level of confidence. Although the scale was developed on a college population it has been further validated on clinical, non-clinical and general populations (Zuk, 1986). In the present research, the BULIT was used to identify a Bulimic and non-Bulimic group.

3.1. Demographic Questionnaire: The subjects in the sample remained anonymous but certain demographic details were requested in order to make possible comparisons between the groups. The required information included: marital status of

parents; parents' age and occupation; number, age and sex of siblings; whether the bulimic daughter is still living at home; home language; and family religion. Finally, the subjects were asked if they had ever been treated for Anorexia Nervosa, in order to be able to exclude these people from the final bulimic sample.

The demographic information obtained indicated that the bulimic and non-bulimic groups were in fact equally heterogeneous across these variables. None of the variables significantly differentiated between the two groups.

3.1.3 The Thematic Apperception Test (TAT): For the present research, a test was needed which would tap into the daughter's unconscious perceptions of her mother. Projective tests are especially effective in revealing covert, latent or unconscious aspects of psychological functioning.

A major feature of projective tests is that they require the subject to respond to a relatively unstructured task (the test stimuli are usually vague or ambiguous), which allows almost an unlimited variety of possible responses. In addition, to encourage an unrestricted response, only brief and general instructions are given. The assumption is that the more unstructured the test, the more sensitive it will be to covert or unconscious material, because the stimuli will be less

likely to evoke defensive reactions on the part of the respondent.

Anastasi (1982, p.564) explains:

The underlying hypothesis is that the way in which the individual perceives and interprets the test material, or 'structures' the situation, will reflect fundamental aspects of her or his psychological functioning. In other words, it is expected that the test materials will serve as a sort of screen on which respondents 'project' their characteristic thought processes, needs, anxieties, and conflicts.

A projective test was also seen as appropriate given the exploratory nature of the present research. It was important not to predefine the issues in the mother-daughter relationship, but to allow them to emerge from the data. In addition, there were no available scales or research instruments for investigating the mother-daughter relationship. The existing Family Scales (e.g. the Family Environment Scale used by Zuk, 1986), were not sensitive enough to distinguish the mother-daughter relationship from other relationships in the family.

The T-T was selected as the most appropriate projective test for the present research because it provides information about the subject's perception of his/her relationships to significant others.

Bellak (1986, p.45) explains:

More than any other test in use (the TAT) shows the actual dynamics of interpersonal relationships. By the very nature of the pictures it gives basic data on the testee's relationship to male or female authority figures, to contemporaries of both sexes, and frequently it shows the genesis in terms of family relationship.

The reason for choosing the TAT as opposed to the Rorschach, was that whereas the TAT focuses on the subject's relationships, the Rorschach is more appropriate for an examination of the subject's personality as a whole (Anastasi, 1982). Also, the Rorschach is a much more lengthy test to administer and to interpret, and would have involved an additional procedure of identifying a bulimic and non-bulimic group in the large sample and then organising a second testing, at which the identified groups could be tested. The Kinetic Family Drawing Test, or the Draw a Person Test may have yielded interesting information about self-perception, and a drawing of Mother would have been most interesting. As a basis for projective interpretation however, these would have to be used in conjunction with the TAT. This procedure unfortunately, would have significantly extended the administration time, and made it impossible to conduct the data collection within the allotted time of 45 minutes (a lecture period).

3.1.3.1 Description of the Thematic Apperception Test:

The TAT consist of 20 cards containin, pictures in black and white and one blank card. The subject is asked to make up her own story to fit each picture, telling what led up to the event shown in the picture, describing what is happening at the moment and what the characters are feeling and thinking, and then giving the outcome (Anastasi, 1976). Four sets of twenty cards are available - for boys, girls, males over fourteen and females over fourteen. In most cases clinicians use a set of up to 10 cards, specially selected to reveal issues pertinent to a particular client.

3.1.3.2 Interpretation of the TAT Stories:

Interpretation of the TAT stories involves a qualitative content analysis and for this reason, requires the skills of a trained clinician. The analyses are usually based on Murray's (1938) system of 'needs' and 'presses' (Murray, 1938, cited in Holt, 1978). These refer to the subject's needs, and the environmental forces which may facilitate or interfere with the satisfaction of these needs. First, the 'hero' of the story has to be identified (i.e. the person in the picture with whom the subject identifies), and then the needs and presses of this person in the story are examined. The content of the stories is thus analyzed in terms of themes, for example, the need for achievement, and a punitive environment which prevents it. Special attention is given to the intensity, duration and

frequency of occurrence of these themes in the different stories.

The analysis has been systematized by using a form devised by Bellak (1986), of which there is a long detailed version, and a shorter version.

3.1.3.3 Reliability and Validity of the TAT: Anastasi (1982) argues that projective tests such as the TAT need to be regarded as 'clinical tools' rather than psychometric instruments, and that "attempts to evaluate them in terms of the usual psychometric procedures would thus be inappropriate." She asserts that:

The special value that projective techniques may have is more likely to emerge when they are interpreted by qualitative, clinical procedures than when they are quantitatively scored and interpreted as psychometric instruments (Anastasi, 1982, p. 590).

The question of scorer reliability is an important one, given the relatively unstandardized scoring procedures. Reliability is the extent to which different clinicians attribute the same personality characteristics to the subject on the basis of their interpretations of the identical record. In the present study, each protocol was interpreted independently by two clinicians. There were no major disagreements about the themes in the stories, although in some cases of slight

variation, the protocols were discussed, and an interpretation agreed upon.

Research on the validity of the TAT (Golden, 1964; Henry & Farley, 1959; Little & Shneidman, 1959; and Silverman, 1959, all cited in Anastasi, 1982, p.587) came to a common conclusion:

When experienced clinicians are given an opportunity to examine and interpret in their own way examinee's protocols from such projective tests as the Rorschach and TAT, their evaluations of the examinees' personalities tend to match independent case history evaluations significantly better than chance.

3.1.3.4 Norms for the TAT

Anastasi (1982, p.573) reports that

A fair amount of normative information has been published regarding the most frequent response characteristics for each card, including the way each card is perceived, the themes developed, the roles ascribed to the characters, emotional tones expressed, speed of responses, length of stories and the like (Atkinson, 1958; Henry, 1956; Murstein, 1972; all cited in Anastasi 1982).

Bellak (1986) says that to a certain extent, collecting statistical data on the TAT stories may provide a helpful frame of reference, e.g. finding out what percentage of a large sample of males see the figure in 3BM as male. Even so, however, the final interpretation must be an "ideographic" one; each response must be evaluated in relation to all the other responses in the test. In the present study, the type of statistical data that Bellak refers to (i.e. the most

common responses to particular cards) was used to select those cards which would potentially draw themes concerning the mother-daughter relationship, and the daughter's perception of her family. This data on norms was obtained from Holt (1978).

The following four TAT cards were used. The descriptions of the cards are taken from Murray, (1938, cited in Holt, 1978). (See Appendix 4 for illustrations of the four cards).

Card 2: "A country scene. In the foreground is a young woman with books in her hand. In the background a man is working in the fields and an older woman is looking on" (Murray, cited in Holt, 1978, p.83). (See Appendix 4).

This picture primarily draws themes of family relationships. Stein (1955, p.3) holds that from the stories about this picture we learn ... "what (the hero's) attitudes toward their parents might be". The stories usually refer to the hero's reactions to an uncongenial or unstimulating environment, or to problems arising as a result of difficult relations with members of the family. The card is also often used with adolescents as it relates to the conflict between autonomy and compliance (Holt, 1978). It may thus be an important indicator of the bulimic daughter's perception of her position in the family (e.g. the amount of independence or autonomy she is

allowed), and possibly the relative importance of the mother in the family, as perceived by the bulimic daughter.

Card 5: "A middle-aged woman is standing on the threshold of a half opened door, looking in" (Murray, cited in Holt, 1978, p.89).

In a study by Kiefer (cited in Holt, 1978, p.90) of females' responses to this card 29% of the sample gave the theme "investigates, disapproves, or scolds for behaviour or acts." A study by Eron (1953, in Holt, 1978, p.90) showed that 35% of women offer the theme of "parental pressure", plus another 7% of "disappointment to parent." According to Stein (1955) the middle-aged woman is frequently described as having surprised one or more individuals in an activity which they prefer to keep hidden from her. Given the secretive nature of bulimia, it was felt that this card may be useful in investigating the daughter's secrecy in relation to the mother, or a possible perception of the mother as intrusive.

Card 7GF: "An older woman is sitting on a sofa close beside a girl, speaking or reading to her. The girl who holds a doll in her lap is looking away" (Murray, cited in Holt, 1978, p.93).

Fleming's norms (cited in Holt, 1978) show that 78% of her female sample saw the relationship between the two figures as that between mother and daughter. The main alternative (given by 16% of her female sample) was a servant, governess, or nurse. Holt (1978) comments that this response is particularly characteristic of upper class women whose own childhood experience was often with surrogates rather than with their mothers. Over a third interpreted the mother's attitude as consoling, loving or concerned; 44% saw it as only reading, instructing, or amusing; and according to 14% she is 'not concerned, or reluctant to respond to the girl' (Fleming, cited in Holt, 1978, p.93). The typical story is of an older woman reading to the girl (58%) or telling her 'the facts of life' (20%) or teaching her something (14%). Fleming's sample usually portrayed her as unresponsive, probably because she is looking away; 20% saw the girl's reaction as enjoyment; 20% as reluctance to accept a lesson; 20% said that she is daydreaming; 18% felt that she is rebellious, wanting to leave, and 22% said that she is moody, lonely, sad, or unhappy. Holt (1978) comments that this is an excellent card for bringing out attitudes toward the mother, or maternal attitudes toward their own children in older women.

Card 12F: " A portrait of a young woman. A weird old woman with a shawl over her head is grimacing in the background" (Murray, cited in Holt, 1978, p.104).

Fleming's sample of 100 adult males and females, (cited in Holt, 1978, p.104) were divided into three approximately equal groups according to their basic interpretation. The 30% who saw the figures as related were equally split between mother-daughter, and grandmother-granddaughter. Another third offered symbolic interpretations; the most often was of a woman with her real self, or the same woman in youth and old age. The remainder saw the figures in a variety of miscellaneous ways. The mother-daughter interpretation, of course, was potentially most significant for this study. It was also thought that if the mother-daughter relationship is significant in bulimia, more subjects would refer to this relationship than in Fleming's study.

3.1.4 The Subjects' Description of the Mother: The subjects were asked to: "please describe your mother". The purpose of this question was to obtain the bulimic daughter's conscious perceptions of her mother, in order to compare it with her unconscious portrayal of her in the TAT stories.

3.2 DESCRIPTION OF SAMPLE: BULIMIC AND NON-BULIMIC
(EXPERIMENTAL AND CONTROL) GROUPS

Twenty bulimic women and twenty non-bulimic women constituted the two sample groups, these groups being differentiated on the basis of the BULIT test. Despite the fact that all the women in the bulimic group could be diagnosed as bulimic according to DSM III criteria, at the time of the study, none of them had been hospitalised for this condition. They therefore represent a non-clinical sample. It is not known however, if any of them had sought another form of professional help, for example psychotherapy. Lastly, they are all 'normal weight' bulimics and have never been treated for anorexia.

The bulimic and non-bulimic groups were matched for age, sex, and home language. There were no significant differences between the two groups on the variables of religion, occupation of parents, parents' marital status, number of siblings, and accommodation during the university term. The two groups were in fact equally heterogeneous across these variables.

Although the BULIT test was used primarily to identify 'bulimic' and non-bulimic subjects, the test consists of 36 multiple choice questions concerning aspects such as eating

patterns, feelings about oneself after bingeing or purging, and perception of eating patterns. An analysis of some of these answers gives a clearer profile of the two samples. The two groups (bulimic and non-bulimic) are compared on each aspect.

3.2.1 Differences between the two groups on bingeing behaviour: In the non-bulimic group, no-one eats uncontrollably 'to the point of stuffing themselves' i.e. goes on binges. On the other hand, nine women (45%) in the bulimic group binge two to three times a month; Five women (25%) binge once or twice a week and three (15%) binge three to six times a week.

3.2.2 Differences between the two groups on perception of Eating Patterns: None of the subjects in the non-bulimic group see themselves as binge eaters or compulsive eaters although not all of them were totally satisfied with their eating habits. In the bulimic group, however, thirteen people would presently call themselves binge eaters and all express concern about it, seven seeing it as 'a major concern' and four as 'probably the biggest concern in my life.'

3.2.3 Differences between the two groups on feelings about themselves: Women in the non-bulimic group did not generally struggle with self-recrimination or depressed feelings related to over-eating, whereas fifteen (75%) of the bulimic group

always dislike themselves after over-eating. All the bulimics felt 'sad or blue' after eating more than they planned to eat (answers ranged from 'always' to 'frequently'). All the bulimics admitted to feeling depressed immediately after over-eating (answers ranged from 'always' to 'sometimes'). From the present results it appears that the DSM III emphasis on feelings about oneself (self-deprecating thoughts with depressed mood) after bingeing is extremely important for a diagnosis. This is in conflict with the elimination of this requirement in DSM III-R (1987).

3.2.4 Differences between the two groups on Purging behaviour: None of the subjects in the non-bulimic group engages in vomiting behaviour. Only 3 people in the bulimic group intentionally vomit after eating (two people once a week, and the other does so two or more times a week). Interestingly these particular women did not obtain the highest scores overall on the bulimia test.

3.2.5 Differences between the two groups on Dieting and Fasting: Four people in the non-bulimic group (20%) had tried to lose weight by fasting or going on crash diets (once in the past year). Seventeen of the bulimics (85%) had tried to lose weight by fasting or going on crash diets: once in the past year (four people); two to three times in the past year (four

people); four to five times in the past year (six people); and more than five times in the past year (three people).

3.2.6 Differences between the two groups on use of Laxatives: None of the subjects in the non-bulimic group used laxatives or suppositories to help control their weight, and only three people in the bulimic group did (two to three times a month, once or twice a week, and once a day or more). Interestingly, only one of these overlaps with the people who vomit, and again, they are not the highest scorers on the BULIT Test.

The important features for a diagnosis of Bulimia according to the results of the present research are therefore, eating pattern (binging, and fasting/crash diets) and depressed feelings and self-deprecating thoughts after binging.

3.3 PROCEDURE

The research instruments were administered to first year psychology classes during a 45 minute lecture period. The students were told that the research was about eating patterns and family relationships, that participation was voluntary, and that they would remain anonymous. The tester also made herself available to discuss any concerns on an individual basis.

3.3.1 Constitution of the Bulimic and Non-Bulimic (Experimental and Control) Groups: There were 339 respondents, from which 45 male respondents were excluded leaving 294 respondents. Bulimic and non-bulimic women were identified on the basis of their scores on the Bulimia Test. On the test, a score of above 102 signifies a DSM III diagnosis of bulimia. Smith & Thelen (1984, p.869) add however, that a score of 88 or above would identify those people with "actual or incipient bulimia but whose behaviour patterns have not yet become chronic." As the present study was not focusing on a clinical sample, those women who scored between 68 and 102 were possible candidates for inclusion in the final sample.

Of the 294 women who had completed the BULIT test, 9 were bulimic, and another 17 could be said to have "actual or incipient bulimia" which has not yet become chronic. This represents an incidence of 3% bulimic, plus 5% with incipient bulimia. The total of 9% is slightly higher than the incidence noted by Zuk (1986), 7.5%, whose study was also conducted on a student sample, using the BULIT test.

In order to obtain a homogenous sample, a number of women had to be excluded from this group of 26. Those who were excluded, had incomplete protocols, were over 21 years of age, and spoke some language other than English at home. None of the 26 women had been treated for Anorexia Nervosa. Unfortunately

this left only 14 bulimic women in the sample. The next 6 subjects with the highest scores on the BULIT test, and the necessary other requisites, were therefore included in the Bulimic sample.

The final bulimic sample thus consisted of; 6 women with a score of 102 and above, 8 women who scored between 88 and 102, and an additional 6 women, whose scores on the BULIT test were: 87, 86, 85, 71, 67, and 66. The control group were then matched against the bulimic subjects, for age, home language and absence of treatment for Anorexia Nervosa.

The inclusion of the 6 subjects (who scored below 88 on the BULIT test) in the bulimic sample is justified on the basis that despite their inclusion, the two groups (bulimic and non-bulimic) remain clearly distinct from each other in terms of their eating behaviour and their perception of their eating patterns. The scores obtained in the bulimic group ranged from 66 to 131, making it a very heterogeneous group, in contrast to the non-bulimic group, whose scores ranged between 36 and 50, with 6 subjects scoring 47, making it a much more homogeneous group. Also, as mentioned above, the focus of the study is not a clinical sample, so that it is not strictly necessary to be able to distinguish between degree of bulimic behaviour.

3.3.2 Analysis of Data

3.3.2.1 Interpretation of data: The TAT stories, and the description of the mother were then analyzed by two clinicians independently (the categorization of the individual protocols, i.e. bulimic or non-bulimic, being withheld). For the analysis a modified version of the Bellak Long Form (1986) was used. This focused on the mother-daughter relationship but also allowed for comment on other themes which emerged. (See Appendices 5 and 6 for the Bellak Long Form, and the modified version used in this study).

The form used to analyze the stories had to be modified during the process of analysis as new categories began to emerge from the data, and other categories proved to be unhelpful.

The final form used to analyse the stories included the following categories:

- (1) the hero i.e. the person with whom the subject identifies (e.g. the young woman in Card 2: her age, sex, abilities, interests, traits, body/self image)
- (2) the main theme of the story (descriptive, e.g. a young woman who wants to leave her home and parents, in order to make her own way in life)

- (3) the subject's central dynamics and main defenses (e.g. fear of separation, and the use of denial as a defence),
- (4) behavioural needs of the hero (e.g. a need to escape implying that she feels restricted)
- (5) the nature of anxieties (e.g. fear of being denied something, or of being punished)
- (6) conception of the world (e.g. restricting, and unfair), and conception of the family (e.g. strict and hierarchical)
- (7) the perception of the mother (e.g. referred to directly or indirectly; seen as distant, emotionally cold, disapproving)
- (8) the daughter's response to the mother (e.g. withdrawal), and important conflicts with the mother (e.g. conflicts over autonomy/independence).

Within these categories the range of answers was not pre-determined. So, for example, themes such as: the daughter perceives herself as emotionally deprived, or the mother is perceived as emotionally withdrawn, emerged as important. (Importance was determined by the frequency of occurrence).

3.3.2.2 Statistical Analyses: The nature of the data was qualitative. However, it was possible to apply a Chi squared test of statistical significance to all of the themes representing ten or more subjects.

A qualitative and statistical analysis of the results of the present research are contained in the following chapter.

CHAPTER 4 - RESULTS AND DISCUSSION

4.1 ANALYSIS OF TAT STORIES AND DESCRIPTIONS OF THE MOTHER

In the analysis of the TAT stories and the descriptions of the mother, there were two basic categories of information:

- The daughter's perception of her mother
- The daughter's feelings and responses

One theme regarding the daughter's perceptions of her mother was significant across both groups:

The Mother as intrusive and domineering: This theme was found in both the bulimic and non-bulimic groups (nine protocols in each group). This would have to be explained without reference to the daughter's eating problems. It may be indicative of patterns of relating to parents during adolescence. (The women in the sample for the present study are late adolescent i.e. between eighteen and twenty one years). Adolescence is a time of negotiating one's own identity, a time in which both daughter and parents have to adapt to a different level of supervision and authority.

The other significant themes which emerged served to distinguish between the bulimic and non-bulimic groups. These themes were mostly characteristic of the bulimic group only, while the non-bulimic group displayed a level of heterogeneity in their answers which made it difficult to identify trends at all.

Three themes were found to be statistically significant (using a Chi square test) in distinguishing the bulimic from the non-bulimic group. They were:

- The bulimic daughters feelings of emotionally deprivation
- The bulimic daughters' conscious anger with their mothers
- The bulimic daughters wish to reject and punish their mothers

In what follows, these themes, plus related sub-themes which were not statistically significant but qualitatively important, are discussed. Examples of themes from individual protocols are given, and the implications of these themes discussed in the light of existing theory and current research in the area of bulimia.

4.2 THE BULIMIC DAUGHTERS AS EMOTIONALLY DEPRIVED

This theme strongly distinguished between the bulimic and non-bulimic groups. Twelve of the daughters in the bulimic group felt emotionally deprived or abandoned, and thirteen of them expressed anxiety about the lack of emotional support. (This relates to another theme described in Section 4.2.1 in which bulimic women perceive their mothers to be emotionally unavailable or 'dead'). Although a number of the non-bulimic daughters describe their mothers as being emotionally unavailable, none of them perceive themselves as emotionally deprived.

TABLE 1

BULIMIC DAUGHTERS AS EMOTIONALLY DEPRIVED

	Bulimic	Non-bulimic
Theme present	12	0
Theme absent	8	20

Chi square (1) = 17,14: $p < 0.01$
 $p < 0.05$

This theme is statistically significant at the 0,01 and 0,05 levels.

The theme of emotional deprivation was expressed in the TAT stories in a number of ways. In the following story, the metaphor of the dry veld is used to express feelings of loneliness and isolation.

Story 1, Card 2: "Janice is a white teenage girl on an African farm of British colonial origin. Her parents are rich but busy. Her time is spent alone mostly or with her tutor who is very strict. She is at present missing the green of England in comparison to the dry veld, and she misses her friends - at least then her mother's social life kept her happy as well. She will probably grow up alone until old enough to be sent to boarding school - perhaps once she has made some friends she'll come to love the dry beauty of this country and reconcile her loneliness caused by her parents' neglect."

The following story is about being trapped in a situation of loneliness and emotional dissatisfaction:

Story 1, Card 2: "A middle class family, live in the country on a farm at the turn of the century. The father works the land very hard and the mother plays the traditional role. They have a very beautiful but lonely daughter who helps on the farm. She enjoys reading but has little time to do so as she works hard at her chores. She has aspirations to be something better but is trapped in her situation. She has no friends and doesn't mix. She is thinking about leaving the farm but realizes that she has nowhere to go. She will stay on and stay trapped. She will run the farm when her parents die and will marry due to an arrangement."

Not only did many of the bulimic daughters feel emotionally deprived, but a related feeling of alienation or estrangement was evident amongst this group. Feeling oneself to be an 'outsider' implies a sense of not belonging, and perhaps not being understood. Nine bulimic daughters felt alienated from

the people around them. This was most often expressed in stories of being alone in a foreign country, or strange environment, or in one case, as a desire to be accepted by a group from which one is excluded. This theme may also be related to the hidden nature of the symptom of bulimia, which sets the bulimic apart from her peers and family.

Examples of this trend from the Bulimic group:

Story 1, Card 2: "Woman came to the town to teach from the city ...Feels an outsider. She's got to get through to them on their level. The people are going about their usual farming lives and she is pensively observing their ways. The farming people are indifferent to her need to teach them..."

Story 1, Card 2: "She came out as a tutor for the children. Louisa is quiet and only smiles when she teaches. Africa and this farm is totally foreign to her. Her nature is as exotic to the ways of this life as her " (story not completed).

Story 1, Card 2: "The young woman in the meadow walked past the working men. She longed to be part of the peasant society -to work with her hands, instead she walked quietly by, not daring to disturb the disapproving peasant wife. Her father owned these people - their land, their children and their hate. She would never be accepted by these people."

A deficit in emotional support and nurturance in bulimic families has been well established (Hicks, 1982; Johnson et al., 1985; Mosely, 1936; Strober et al., 1987). Also, mothers of bulimic daughters have been found to be neglectful (White & Boskind-White, 1984). It is not surprising then that bulimic daughters should point to emotional deprivation as one of their primary experiences.

Dana & Lawrence (1988) suggest that it is all too easy and too common to blame the mother for any difficulties which the daughter may suffer. It represents a very simplistic explanation, and they plead for a more holistic view which takes into account the fact that the mother and daughter, and the interaction between them are influenced by individual, familial and social factors. They would again point to the position of the woman in a patriarchal culture, her socialization into a nurturing role at the expense of having her own emotional needs met, and the inevitable transference of this sense of 'emotional deprivation' from mother to daughter. This position has already been criticized; it serves as a general explanation of why there may be problems of nurturance between mother and daughter, but it does not explain why, in some cases, this problem results in the daughter developing bulimia.

Weissberger (1986) found that both the mothers and their bulimic daughters feel emotionally deprived within the family. Perhaps this is a reflection of the general lack of warmth and support in the bulimic family (This raises an interesting question of whether, in 'bulimic' families, the fathers and sons also feel emotionally deprived?)

Alice Miller (1985) makes the point that parents cannot tolerate in their children feelings which they were denied in

their own childhood. If the mothers were not allowed as children to experience or express certain emotional needs, they will find the expression of these needs, particularly in their daughters, very threatening. They will on some level, replay their own deprivation in their treatment of their daughters. This raises a further interesting question; if the mothers were emotionally deprived, why did they not also develop bulimia (either as adolescents, or now? There has been no research on the history of the eating habits of mothers of bulimics, although DSM III-R (1987) points to the frequency of parental obesity in families of bulimics. These questions are however beyond the scope of the present research.

4.2.1 The Mother of the Bulimic as emotionally unavailable: A lack of emotional connection between mother and daughter occurred slightly more often in the bulimic group than the non-bulimic group (13 to 10). However, the bulimics felt the lack of connection to be much more extreme; five described their mother as dead, or denied their existence, whereas none of the non-bulimics perceived their mothers in this way. (In reality none of the bulimics' mothers are deceased).

Example of the most extreme category (mother as dead):

Story 4, Card 7GF: "The little girl looks out the window at the oncoming entourage of people. The cat asleep on her lap is oblivious of it all - she wishes she could be. Her nanny is reading her a story to take her mind off the fact that her mother has just died. She finds the more they try to distract her, the more preoccupied she becomes of the fact. She wants to cry but can't. She just feels like she is in a dream, suspended from her body and not real. It will be difficult for her to come to terms with it. Perhaps their ignoring the fact she is grieved makes it worse and she will never come to terms with death."

This is about a mother who is emotionally dead, and the daughter's grief/longing not being acknowledged. The theme of death is also about loss, loss of the chance of an emotionally nurturing relationship with the mother. Dana et al., (1988, p.92) point out that what is particular about 'bulimic' families, and what makes them such potentially difficult places to grow up in, is that they don't expect their children to be upset about what goes on (be it incest, loss of a parent etc). "Not only was there no encouragement for these children to talk about their feelings, but usually they were told they shouldn't have any!" They give an illustration of this, which is poignantly similar to the story depicted in the TAT above. The mother of a client of theirs died while she was still young. The death was not talked about, feelings were not expressed. Instead, the little girl was sent away to her grandmother for a few days. When she returned home, everything carried on as normal. There was no mention of the fact of her mother's death, no explanation, and no mourning.

It appears then that mothers in both the bulimic and non-bulimic groups are perceived as domineering and intrusive. They are also seen as emotionally unavailable. The bulimic group however perceive this emotional unavailability in an extreme form (mother as emotionally 'dead'). So, the dynamic of the mother as intrusive but also emotionally unavailable is present in both samples but in a much more extreme version in the bulimic group.

This finding is reflected in some of the research. Moseley (1986) found the mothers of bulimics to be more domineering than the mothers of controls, and also less likely to give encouragement or approval. They have also been described as more critical and hostile than 'normal' mothers (Hicks; 1982). Both Kramer (1983) and Zuk (1986) make reference to the mother's contradictory behaviour toward her daughter; she is alternately over-protective, and neglectful. Zuk describes the mothers of bulimics as either extremely controlling or totally withdrawn. Humphrey (1986) terms this pattern of relating 'hostile enmeshment'.

It is interesting here to look at what the most recent research has revealed about the interaction patterns in families with an anorexic and a bulimic daughter, as it brings into sharp relief the distinct pattern in bulimic families. Humphrey (1989) describes the anorexic family as presenting a

facade of perfection, self-sacrifice and love. Mothers are more nurturing and comforting than the mothers in her 'normal' group, but at the same time are more ignoring and neglectful than the 'normal' mothers or mothers of bulimics. This is a pattern of ambivalence, and perhaps one could hypothesize that the anorexic daughter is sensitive to her mother's ambivalence about her, and rejects food (nurturing) because she senses that it is not genuine, but part of a pattern of trying to prevent her from separating from mother.

The bulimic family members on the other hand, are openly hostile and withholding towards each other. Mothers are intrusive, and belittle and blame their daughters more than in the anorexic or normal groups. At the same time there is also greater ignoring and neglecting as well as sulking and appeasing than amongst the 'normal' mothers. This pattern then is also contradictory, but it is different to the anorexic mother-daughter relationship. There is hostile intrusion and undermining, with sulking and appeasing, alternating with ignoring and neglecting. This isn't ambivalence but rather different forms of negative interaction. As shown earlier this pattern was found to exist between bulimic daughters and their mothers in this study. Why is the pattern different, and how can we explain it?

Dana et al., (1988) as described in Chapter 2, explain why the mother-daughter relationship within patriarchy is likely to lead to serious difficulties for the daughter in the area of self-nurturance and the meeting of needs. However, because they emphasize patriarchy rather than on the individual mother and daughter, their explanation does not clearly account for why some women become bulimic and others do not (nor, in fact, why bulimic rather than anorexic, or some other symptom). In both the anorexic and bulimic mother-daughter relationship, there is a problem in the mother meeting the daughter's emotional needs (for nurturance, support, encouragement etc). The present research shows that the experience of mother as both intrusive and emotionally withdrawn is not unique to bulimia but rather, that it takes a qualitatively more extreme form in the bulimic mother-daughter relationship. The reason for the mother's inability to meet her daughter's needs, and for the hostile enmeshment that results is not clear.

Weissburger (1986) found that bulimic daughters and their mothers both feel emotionally abandoned within the family. Perhaps the mothers of bulimics feel more in touch with their own deprivation (in Dana et al's., explanation; are more conscious of their deprivation), and are therefore more likely to feel overtly bitter and envious of their daughters, and to act these feelings out in an openly hostile way? The answer is not clear.

Four of the 20 bulimic mothers in this study were described as emotionally or psychologically disturbed, which suggests that there may be a level of disturbance in the mother of the bulimic which is not present in the mothers of the normal group.

4.2.2 The Mother of the Bulimic as impotent and ineffectual: This theme occurred in both groups. However, there were both more counts in the bulimic group (10 compared to 6 in the non-bulimic group), as well as more extreme expressions of the theme in the bulimic group, e.g. the mother was depicted as frightened or desperate, weak and exhausted, dependent on her daughter, and needing her daughter's protection. None of these representations occurred in the non-bulimic group. It was thus an important theme in distinguishing between the bulimic and non-bulimic groups.

Example from the bulimic group:

This bulimic's story tells of a mother who cannot protect her child from danger:

Story 2, Card 5: "This woman is a mother and she has lost her little boy. It is the 19th century and her peaceful Victorian home is shattered with the sounds of her appeals for her baby. The homely atmosphere, flowers in a vase and warm light seem to mock her anxious calls. She feels anxious, worried and afraid. Her little boy was found dead that night."

In the following story, the mother is ineffectual in trying to discipline or control the daughter, and is left exhausted:

Story 4, Card 12F: "Sue is a very stubborn little girl. She stays alone with her mother and really gives her mother a hard time. Her mother tries everything possible to entertain her so that she does not throw a tantrum. But Sue knows this and demands more. Her mother becomes exhausted as she is running the home, working and looking after Sue."

There is no literature on bulimic mothers as impotent or ineffectual, although there is research to indicate that she is inadequate in performing her role as mother. As indicated in Chapter 2, she has been described as being critical and domineering and giving little encouragement and approval (Dietzen, 1986; Moseley, 1986). Importantly, she is perceived as intrusive and controlling while at the same time withdrawn and neglectful (Kramer, 1983; Zuk, 1986). There is conflict avoidance (Hicks, 1982) and belittling and sulking between the bulimic daughter and her mother (Humphrey, 1989).

4.2.3 The Mother of the Bulimic as immature, childlike and/or emotionally dependent: Seven people in the bulimic group perceived their mothers as being immature, childlike, and/or emotionally dependent, and felt some obligation or guilt in terms of satisfying their mother's emotional needs. There were no examples of this in the non-bulimic group.

Examples from the bulimic group:

Story 3, Card 12F: "These two are mother and daughter. They love each other very much. The mother dotes on the daughter and will do anything for her. The daughter is getting ready to go to a ball. She is sad because the mother has had such a bad life. There doesn't seem to be a father.." (My emphasis.)

Story 4, Card 12F: "I sat, as I had countless times before, trying to pay attention ... All I wanted was to get away but how could I, Daddy had left, how could I now. It was easier but not easy at all" (My emphasis).

Description of Mother: "Passive, lacks a little confidence, introvert ... she can be a little immature... she is stubborn, like a smoldering volcano that hides anger and then suddenly explodes..." (My emphasis).

Two bulimic daughters explicitly say that they sometimes have to take over the role of mother.

Description of Mother: "Warm, soft, plump ... domineering, and sometimes I do what she is supposed to..." (My emphasis).

Description of Mother: "My mother is a very soft person ... she suffers from nervous tension and often seems to take the child role while I take control of the household affairs" (My emphasis).

This is an important finding, pointing perhaps to a particular dynamic between the mother and bulimic daughter. Perhaps part of the reason for the daughter's feelings of emotional deprivation are due to the mother's own sense of emotionally deprivation (Weissberger, 1986). Orbach et al., (1984) talking in general terms about the relationship between mother

and daughter, propose that because the mother is to some extent needy herself, she may look to her daughter for the emotional contact that is missing elsewhere in her life. She feels the loss of her own mother's nurturance (or a satisfying relationship with her partner) and may hope that her daughter will make up for it somehow. This seems particularly pertinent to the relationship between the bulimic daughter and her mother.

4.3 THE BULIMIC DAUGHTER'S AWARENESS OF NEGATIVE FEELINGS TOWARDS HER MOTHER

4.3.1 A Comparison of the discrepancy between between the TAT portrait of Mother and the Description of the Mother: This theme was found only in the non-bulimic group, in 13 out of the 20 subjects. In these subjects there was a strong distinction between the unconscious portrayal of mother in the TAT stories (mostly negative, controlling, intrusive etc) and their conscious description of the mother (mostly positive i.e. immature, cliched and idealized). In the bulimic group, there was no such contradiction between the conscious and unconscious portrayal of the mother (both being generally negative).

TABLE 2

The discrepancy between the TAT portrayal of mother
and the description of mother

	Bulimic	Non-bulimic
Congruent	20	7
Non-congruent	0	13

Chi squared (1) = 19,26: $p < 0.01$
 $p < 0.05$

This theme is statistically significant at the 0.01 and 0.05 levels.

Examples: Examples of this theme are from the non-bulimic group only. Each TAT portrayal and description of mother quoted together are from the same protocol.

(a) In the following TAT stories, the subject's relationship with her mother is denied except for Story 4 in which the mother is seen as intrusive, emotionally detached, critical of her daughter and wanting to control her.

The description of the mother portrays the exact opposite and is a good example of a bland, positive portrayal, in which no negative feelings are permitted.

My mother is a warm, loving person. She is gentle and very giving and kind. She is very easy to talk to and is devoted to her family. She gives up a lot just to please her family and gives her all to being a wife and mother. She is a very sensitive person and is concerned with other peoples' needs. She is also very clever and has a good sense of humour. She is a fun person to be with and is easy to get on with. I really love her a lot.

(b) In a TAT story, the mother is depicted as extremely intrusive, authoritarian, inflexible, and unable to allow the daughter any freedom.

In contrast, this subject describes her mother as:

WONDERFUL (her emphasis), she is a best friend to me not a mother. She is caring, loving and will do anything for me.

(c) In a TAT story, the mother is seen as disapproving and intrusive (she is described as a 'nozy [sic] old bag'). In her description however, the subject expresses only positive feelings towards her mother:

I love my mother dearly. She is my best friend. I'm very afraid that something will happen to her. She is the stabilizing influence in my life.

Unconsciously she seems to acknowledge her negative feelings towards her mother in her fear of something happening to her (i.e. her negative feelings having some destructive power).

(d) In the TAT stories the mother is portrayed as attentive, caring, concerned, but also frail, burdened and needing protection.

In her description of her mother however, this subject perceives her to be a very self-sufficient person. "She is highly motivated and expects everybody around her to be exactly the same ... She is a considerate, caring person who loves her family lots ...".

As can be seen from the above examples from the non-bulimic group, the conscious portrayal of the mother is contradictory to the unconscious portrayal. It is a clear illustration of the use of reaction formation as a form of psychological defence. In reaction formation the attitude expressed is diametrically opposed to a repressed wish or feeling, and constitutes a reaction against it. (Laplanche et al., 1985, p.376).

In the bulimic group however, the conscious and unconscious perceptions of the mother were not in conflict, and were mostly negative, or simply more realistic. This finding may reflect the bulimic's continued over-involvement with their mothers (in the form of hostile enmeshment). The non-bulimics, on the other hand, are more likely to have been able

to individuate and therefore to present a more superficially bland description.

An additional factor distinguished the bulimic from the non-bulimic group: seven of the bulimic women, in their descriptions of their mothers, showed a degree of emotional insight and understanding of their mothers. They appeared to have enough distance from their mothers to analyze her good and bad features in a perceptive way. This may be linked to the bulimic daughters having to be sensitive to their mother's needs and to sometimes having to play the role of mother. Also they seemed to be able to openly express doubts or negative/hostile feelings about their mothers. This trend was reinforced by the fact that, on the whole, the bulimics' descriptions of their mothers and their TAT portrayals of her reflected similar feelings.

Examples of the bulimic daughters' descriptions of their mothers, illustrating some emotional insight and understanding on the part of the bulimic daughter are:

My mom is unconfident particularly with regard to her own intellectual ability but has a normal to above average intelligence. She is hugely protective, and extremely aggressive when threatened or when her family is threatened. She is quite nervous and paranoid about things like security and achievement, and is generally a hugely strong personality when angry she screams and becomes quite illogical and unreasonable. She is extremely loving and carries most of the emotional strain of the family.

My mom is a most wonderful, outgoing person. She cares a lot about the family, a lot about herself, and quite a lot about others. She sees herself as undergoing a change at the moment, and I must admit that after my returning from a year overseas, she seems a lot more directed, happy with herself, and confident in her abilities. I do think that she often tries to dominate my brother and I must admit that I sometimes resent that. In addition, after not being with her for so long, I realize that I'm very like her in many ways - sometimes that makes me quite angry. She loves us very much - dotes on us - but says that she's independent if questioned on the issue.

My mother has always been much kinder and more understanding than my dad. I suppose because she's much younger too, but I still often feel that she's never been like a true mother. I've stayed in residence for a year and a half now, but when I used to stay at home, I hardly ever saw her. She and my dad work too hard. It's difficult to speak about problems to them most times, but I do spend more time talking to my mom. Lately though I've been a bit overweight and she tends to complain about my mass. She moaned almost everyday about my eating, so much while I was at home for the June-July vacation. I was really depressed. Otherwise my mom's a reasonably nice person. Strangely enough I only started to eat so much when I began university last year. Sometimes its because I feel so over-stressed and nervous; tend to get depressed quickly too. My parents may be getting a divorce - think as things at home haven't been going so well - the past three years.

My mother? A sweet, kind person who will do anything for her children but who doesn't take any shit from them at all. An angel and a vixen, who can talk her way into or out of anything. Ambitious, but hasn't got the self-confidence to do something on her own.

I don't get on well with my mother. I feel that she doesn't trust me enough and is too domineering. I think that she is scared to be by herself when all of us have left home. I think that is why she interferes in our lives a lot. She loves us and is sometimes trying to prevent us from making drastic mistakes.

My mom is usually patient, she listens to me a lot and is interested in what I do. She gets on well with my boyfriend which is important to me. She does however try to impose her views and values on me. She has a different value system and sometimes there is a clash as I am more career orientated and children are not important to me to be happy. On the whole though I think we have a good relationship.

It seems then that bulimic daughters show a degree of emotional insight and understanding of their mothers, a factor which was not evident in the non-bulimic group. Also the bulimic daughters were conscious of and open about their negative feelings towards their mothers. In contrast the non-bulimic daughters were aware of their mothers' various failings (unconsciously portrayed in the 'fantasies'), but were not conscious of, or did not admit to negative feelings towards them.

There are no research findings on the bulimic daughter's insight into her mother, or on the difference between the bulimic daughter's awareness of her negative feelings towards her mother, and the non-bulimic daughter's lack of awareness of these feelings. There are also no theoretical explanations in the literature on bulimia. The results seem to suggest that bulimic daughters are more emotionally 'mature', more aware of their own and others' feelings, and more sophisticated in their understanding of their mothers, than 'normal' daughters. Perhaps bulimic daughters are forced into a 'pseudo-maturity', because they have to deal with an

ineffectual, non-coping, but most importantly, immature and dependent mother who engages in childlike behaviour: belittling and blaming, walking and appeasing (Humphrey, 1989), who can't deal with conflict or anger (Moseley, 1986) and who looks to them for mothering and emotional support (Humphrey (1989).

Is the bulimic daughter's emotional maturity developmentally appropriate? Winnicott (1985) in his writing on adolescent development (the women in the present sample are between 18 and 21 years), explains that "immaturity" is an essential element of health in adolescence. He warns of the danger of taking on responsibility too soon, the result being "...false maturities based on identifications rather than on the innate growth process" (1985, p. 174). An essential part of this adolescent growth process is one of confrontation with parental figures, and it is essential that the parents accept the challenge, and survive: "... the best they [the parents] can do is to survive, to survive intact, and without changing colour, without relinquishment of any important principle." What Winnicott requires of the 'good enough' parent, is that they deal with these confrontations "... with containment that is non-retaliatory, without vindictiveness, but having its own strength" (1985 p.176).

This is far from the reality the bulimic daughter faces in her family. She is forced into an untimely maturity because she is not given the opportunity to confront her parents and be assured in the knowledge that they will be able to deal with her feelings, and not withdraw or retaliate. The bulimic family is particularly characterised by open, hostile, unfocused aggression.

Perhaps this open aggression serves to explain why it is that bulimic daughters are aware of their negative feelings towards their mothers. One may ask, why do they not repress, deny or split off this anger? There can be little pretense or denial of aggression in a family which is ridden with open conflict and no mechanisms for resolving it. Perhaps, in a paradoxical way, because there is so much open anger expressed in the family, it is easier, less frightening or more acceptable for the bulimic daughter to be conscious of her negative feelings? Being conscious of negative feelings toward her mother does not necessarily imply however, that the bulimic would be able to express these feelings in a constructive way. In the bulimic family, anger, belittling and undermining are allowed, and there are no constructive mechanisms for dealing with these negative feelings. It is consequently very difficult for the bulimic daughter to express her anger towards her mother in a constructive way; her feelings become distorted i.e. translated into a symptom. Humphrey & Stern (1989),

for the bulimic daughter to express her anger towards her mother in a constructive way; her feelings become distorted i.e. translated into a symptom. Humphrey & Stern (1989), (cited in Humphrey, 1989, p. 213) make an interesting observation about the similarity between the bulimic's symptom, and the family dynamic:

Bulimics and their families are 'hungry' for nurturance, protection and empathy, but when they are unable to find them, turn instead to inanimate objects or altered states for comfort, such as food or alcohol. Bulimic families also project their mutual hostilities outwardly and seem unable to modulate them internally, so the bulimic may learn to relieve her own feelings by expelling them as well (through vomiting).

4.3.2 The Bulimic daughters' Anger and their fear of its Destructive power: In the bulimic group, six of the daughters felt very strong feelings of anger, and nine bulimic daughters (the aforementioned 6 plus another 3) indicated anxiety about the destructive power of their feelings. These feelings were not expressed by the non-bulimic daughters.

TABLE 3

The Bulimic daughters extreme anger

	Bulimic	Non-bulimic
Theme present	9	0
Theme absent	1	20

Chi square (1) = 11,8: $p < 0.01$

The theme is statistically significant at the 0.01 and 0.05 levels of significance.

In the following story (and in the context of the rest of the protocol), it becomes clear that the daughter fears that her feelings will explode and destroy the whole family.

Story 2, Card 5: "The mother of the family has been cooking, the family is watching TV. She calls them into the dining room for a relaxed evening meal. Everyone is satisfied and happy. Then the telephone rings. As the receiver is lifted, a bomb explodes."

4.4 THE BULIMIC DAUGHTERS' REJECTION AND PUNISHMENT OF THEIR MOTHERS

The fact that the bulimic daughters seem to be struggling with very strong negative feelings towards their mothers is also

evident in the following trend. Eight of the bulimic daughters rejected, mocked, degraded or punished their mothers, two of them in an overtly sadistic fashion. Extreme anger and revengeful fantasies was very evident amongst the bulimic daughters. Only one non-bulimic daughter was slightly mocking of her mother calling her "scatterbrained and forgetful". None of the extreme categories such as the daughter wanting to degrade and punish the mother, or of the mother as the object of the daughter's sadistic rage occurred in the non-bulimic group.

TABLE 4

The Mothers of Bulimics as rejected and punished

	Bulimic	Non-bulimic
Theme present	9	1
Theme absent	11	19

Chi square (1) = 6,53: $p < 0,02$

This theme is significant at the 0.05 level, but not at the 0.01 level.

The bulimic daughter in the following story rejects her mother's love and attention:

Story 4, Card 7GF: "These two are also mother and daughter. The mother loves the daughter very much but the daughter doesn't seem to be interested. The daughter is pining for her father ... the mother is sad because she can't get a response from her daughter ... [the daughter] will never get on with her mother and when her mother gets old she will forget about her ..."

In the following examples (from the bulimic group) the mother is the object of the daughter's sadistic rage. There were no examples of this category in the non-bulimic group:

Story 3, Card 12F: "The woman (young) is a murderess, she killed her family with a chain saw. She feels guilty and afraid, not of the crime - but of being discovered. It seems to her that death (the old woman) is continually looking over her shoulder. Every ring of the doorbell gets the young woman more nervy. Upstairs the mutilated corpses of her mother, husband and children lie where they fell. Death haunts her."

It is interesting that in this story the daughter refers to her adult family (husband and children) and then also to her mother, illustrating the mother's continued significance to the adult daughter. The story illustrates the daughter's raging, murderous anger and her fear of what would happen if she expressed it (if someone were to find out). She also seems to feel intense guilt about her feelings and fantasies.

Story 4, Card 7GF: "She has just seen her mother's guts being pulled out by their pet rotweiler, she hated her mother so she gives a short laugh, tells the dog to sit and continues to eat her spaghetti bolonaise."

The daughter here seems to be expressing a wish to destroy her mother and her need for her, and to be able to feed (nurture) herself.

There appears to be no literature or research specifically on anger as experienced by bulimic women. It is recognised in the psychoanalytic literature that binge eating is an aggressive act of using the teeth to destroy, and references are made to the need to discharge aggression in the form of the symptom (Mintz cited in Wilson, 1983). Vomiting is seen as a symbolic outpouring of rage - disguised as a symptom and therefore not vulnerable to retaliation (Mintz cited in Wilson, 1983). There seems to be no investigation however, of the extent of the anger that bulimic women experience, the form it takes, how aware of it they are, what their fantasies are about it, and the consequences for the individual woman. A fear of the destructive power of ones' anger however, is something that bulimics seem to have in common with children who have been abused.

Zenz (cited in Miller, 1985, p.89) referring to work done with abused children, says:

The children were almost never able to express their anxieties verbally, yet they harboured intense feelings of rage and a strong desire for revenge, which, however,

were accompanied by a great fear of what might happen if these impulses should erupt ... With the development of the transference during therapy, these feelings were directed against the therapist, but almost always in an indirect passive-aggressive form (My emphasis).

The implication seems to be that bulimic daughters do suffer some form of emotional abuse - that they have been traumatized in a similar way to emotionally abused children. It would seem that people who have suffered some form of abuse and therefore extreme anger, in a situation in which the expression of their anger is denied or likely to be met with retaliation or withdrawal of love, will perceive their anger as extremely powerful, destructive, and frightening. The hostility in bulimic families is well recorded, as well as the communication patterns characterised by retaliation and withdrawal. Alice Miller describes the seriousness of this form of abuse:

The greatest cruelty that can be inflicted on children is to refuse to let them express their anger and suffering, except at the risk of losing their parents' love and affection (Miller, 1985, p.106).

4.4.1 The Bulimic Daughters as passive and withdrawn

Many of the bulimic daughters appear to deal with their anger by becoming passive and withdrawn. (They withdraw into revengeful fantasies, as mentioned above, or into fantasies of escape). Fourteen of the twenty bulimic daughters reacted in this way (as compared to eight of the non-bulimic daughters).

The quality of the fantasies was also totally different - only the bulimic daughters had aggressive, revengeful fantasies.

Withdrawal into fantasy, or passivity was sometimes evident in the response of the identified person in the TAT story, but in other cases passivity and sometimes hopelessness and depression were evident in the protocol as a whole.

The following two stories (from the bulimic group) illustrate the use of fantasy as a means of escape, in both cases, from extremely punitive mother figures:

Story 2, Card 5: "... Theresa, in her own form of defence, creates a magical world of castles and princes, and roses and escape ..."

Story 4, Card 7GF: "The little girl wasn't too sure where the door had come from. It hadn't been there yesterday but here it was now with a tinkling bell, squeezed between the barber's and the candy store. She went in, just to see. and oh, what magic! corners to explore, and such a warmth. Then she saw an old, old man who spoke to her gently. A man she could love and trust with no fear. And he told her tales of wonder and light which transported her away from hunger and into fantasy."

4.4.2 The Bulimic Daughters as passive-aggressive

Although many of the bulimic daughters deal with their feelings, as has been described, by becoming passive, and withdrawn (fourteen of the twenty), another six of them (only one overlap with the fourteen), deal with their feelings by

becoming passive-aggressive. This form of behaviour did not occur amongst the non-bulimics.

Passive-aggressive people express their anger indirectly through forgetfulness, stubbornness, dawdling and unconsciously intentional inefficiency. Importantly, in terms of retaliation and withdrawal as being characteristic of bulimic families, passive-aggressive behaviour is "...the mode of discharging anger of one who feels like an underdog and who fears retaliation or rejection from the object of his aggression" (Wallace, 1983, 225).

The following are two examples of bulimic daughters behaving in a passive-aggressive way:

Story 2, Card 12F: "Mary's mother was very protective and denied her daughter's independence. Even after Mary turned 18, Mrs Jones continued to check up on Mary. Mary hates this intrusion on her privacy and when her mother began searching her room for incriminating evidence of sex, drugs and debauchery, Mary decided to give her reasons for these spot checks. She bought cigarettes and harmless medication and hid them (where they could be easily found).

Story 4, Card 7GF: "The young girl is from a wealthy family. She has been pampered and spoilt. The maid's task is to teach the girl to read and write. But the child is uninterested and remains distracted. The maid has defected from Russia and was taken up by this wealthy American family. She knows her life in America depends on her ability to succeed in this teaching. The girl tries her hardest to fail the maid. She is insolent and mischievous. The maid is kind and firm. At the moment the girl is watching her new puppy playing and the maid is teaching. The maid did not succeed."

Zenz (cited in Miller, 1985, p.89) referring to work done with abused children and their parents, explained that:

The children were almost completely unable to express anger and aggression toward adults. Their stories and games, on the other hand, were full of aggression and brutality ... Many children repeated their own abuse in their play (My emphasis).

The situation seems to be similar for bulimic daughters. They are unable to express anger and aggression towards their parents/mothers openly and directly. Instead, they repeat their abuse in their symptoms and their treatment of themselves.

In summary, the findings of the present study are as follows:

Regarding the perception of mother: in both groups, the mothers are perceived as intrusive and domineering. Bulimic daughters, however, portray their mothers as impotent and ineffectual, in some cases immature and emotionally dependent, and generally emotionally unavailable. In the non-bulimic group there is a distinction between the daughter's conscious portrayal of her mother (which is idealized) and her unconscious portrayal of her mother (which is critical). The opposite is true for the bulimic daughters; both portrayals of mother were generally critical. This suggested either that the bulimic daughters could be more open about their negative feelings, or that they were perhaps more emotionally enmeshed (in a hostile way) with their mothers than the non-bulimic

women. In addition, the bulimic women displayed a degree of emotional insight into, and understanding of, their mothers, which was not evident amongst the non-bulimic daughters.

The results therefore show that the bulimic daughter feels emotionally deprived, extremely angry, and anxious about the destructive power of this anger. She responds by rejecting, mocking and degrading her mother, or becoming passive and withdrawn and then escaping into sadistic or escape fantasies, or expressing her anger in a passive-aggressive way.

CHAPTER 5 - CONCLUSIONS

The aim of the present research was to explore the relationship between the bulimic daughter and her mother. This aim was based on two assumptions: firstly, that the relationship would be important in understanding some of the factors that precipitate and maintain the syndrome, and secondly, that an understanding of this relationship may reveal some information useful in terms of therapeutic approaches/interventions.

As hypothesized the mother-daughter relationship was found to be significant. The bulimic daughter's perception of her mother, and her responses to her, were significantly different from the responses of 'normal' or non-bulimic daughters.

The present research has established that: bulimic daughters feel emotionally deprived; they are fully conscious of their anger towards their mothers, but are afraid of its destructive power; their most common response to these feelings is to withdraw into fantasies of rejection, punishment and taking revenge on their mothers.

- * That bulimic daughters experience emotional deprivation is not surprising given the accounts in the literature of the hostile family milieu (e.g. Johnson et al., 1985; Zuk, 1986) and lack of parental nurturing (e.g. Strober et al., 1987). The bulimic daughters in this study perceived their mothers as impotent, ineffectual, and withdrawn (emotionally unavailable). At the same time, they were also perceived as being domineering and intrusive. This characteristic is described in the literature as the mother's ambivalence towards her bulimic daughter (Kramer, 1983; Zuk, 1986; Hicks, 1982). Perhaps a more accurate way of understanding this 'ambivalence' is to see it as alternating forms of negative interaction. Being at times emotionally unavailable and at times domineering and intrusive reflects not so much the polarity of negative and positive feelings, but an inability to relate to the daughter in a positive or healthy way.

- * It is recognised in the psychoanalytic literature that bulimic symptoms are to do with anger, and the need to discharge aggression (Mintz, cited in Wilson, 1983). The nature and extent of this anger as well as the bulimic's phantasies about it, have however not been explored in the literature.

Both bulimic and non-bulimic daughters appear to be angry with their mothers; the bulimic daughters are conscious of this anger, the non-bulimic daughters deny it (and seem to idealize their mothers). This raises the question of whether the denial of the anger, or awareness of it, is developmentally appropriate. Another issue would be the possible reasons for the distinction between the bulimic's and non-bulimic's response to anger, and the implications of this both for their relationship with their mothers, and the development of the syndrome.

Anger is included in the range of normal human emotions. Anger towards one's mother, particularly during adolescence (a time of needing to separate from parents) would seem to be normal or expected. The essential difference however, between the bulimic and non-bulimic daughters seems to be in the QUALITY of their anger. The bulimic daughter's anger is revengeful, sadistic and omnipotent, coupled with a fear of its destructive power. This fear of one's own anger is something that bulimics seem to have in common with children who have been abused. The quality of the non-bulimic daughters' anger was, on the other hand, much less extreme.

* The Bulimic daughter's response to her Mother:

The most common response of the bulimic daughters was to withdraw into fantasies of revenge and punishment, while some of them expressed their anger by becoming passive-aggressive. Mostly, the non-bulimic daughters responded by simply withdrawing from their mothers but, importantly, this was not accompanied by fantasies of revenge or by passive-aggressive behaviour.

The present study illustrates that the bulimic daughter feels emotionally deprived and perceives her mother to be inadequate. The result is that she experiences extreme anger (as is true for children who have suffered some form of abuse). Because of the family milieu, however, the bulimic daughter cannot express her anger openly (she would become vulnerable to retaliation). Thus, instead of openly expressing this anger, she (like other abused children) has to resort to indirect means of expression, such as revenge fantasies, passive aggressive behaviour, and most importantly, the bulimia itself.

It could be hypothesized that in the symptoms of bulimia she re-enacts her emotional situation. Her experience of her mother as both intrusive as well as withdrawn, is re-enacted in the binge-purge cycle. Perhaps it could be said that she replays her relationship with her mother, in her relationship

to herself and her emotional needs. Recognising her emotional needs (hunger), she attempts to fill the emptiness she feels by eating a large amount of food (nurturing herself), but then deprives herself of it (as her mother deprives her) by purging it from her body (thus not allowing herself any real nourishment). She thus re-enacts her rage towards her mother, as well as her own deprivation in her symptom of bulimia.

The findings of this study point to certain issues which would need to be dealt with in psychodynamic psychotherapy. It would appear that in the transference, the daughter would be most likely to perceive the therapist as the "intrusive but emotionally unavailable" mother. She will regard her as ineffectual, and most importantly will harbour intense anger towards her, which she will be unable to express openly. She will fear that her anger will 'destroy' the therapist (force her to withdraw), or that the therapist will be vindictive and retaliate. She is likely to test the therapist by acting out, or resorting to passive-aggressive behaviour. She will need to recognise the omnipotent quality to her anger, and the need to express it openly. All of these issues will need to be understood and 'worked through' in the context of her understanding of her relationship with her own mother.

5.1 LIMITATIONS OF THE PRESENT STUDY

A major limitation of the present study is its focus on the bulimic daughter's perception or experience of her mother. It could consequently provide no information on the mother's actual behaviour in relation to her daughter, nor on the mother's personality features as measured by psychometric tests.

Another important problem with the research was the failure to check whether any of the women in the sample had been in psychotherapy as this may have affected their perceptions of themselves and of their mothers. The experience of therapy would however probably not have changed radically the daughter's perceptions, but rather made it more possible for her to articulate her perceptions and feelings.

An interesting addition to the research would have been to develop a personality profile for each of the subjects. This may have shed some light on the possible role of the bulimic's personality in her perception of her mother.

The present study would have been much enhanced if it had been possible to follow up the subjects with in-depth interviews about some of the issues which emerged from the TAT stories and the descriptions of the mother (e.g. the bulimic

daughter's sense of deprivation, her anger etc). This was however, beyond the scale of the present research. Alternatively, a much larger sample would have made the results more generalizable.

5.2 FUTURE RESEARCH

The present research has confirmed the importance of the mother-daughter relationship (or at least the bulimic daughter's perception of this relationship) in an understanding of bulimia.

Given the exploratory nature of the research, a number of issues which warrant further investigation emerged.

An important area for future research would involve further clarification of the bulimic daughter's anger towards her mother. Research needs to be conducted on the form and quality of the daughter's anger, as well as important questions such as, why (in contrast to non-bulimic women) she is so acutely aware of her anger, and afraid of its destructive power, and how it is similar to the anger and fear expressed by abused children.

A second area for research would be the bulimic daughter's 'pseudo-maturity' evident in the present study by her insight

into and understanding of her mother. The possible significance of this factor as well as its developmental implications need to be clarified.

Thirdly, research needs to be done on the quality of the mother-daughter relationship, as perceived by the mother, as well as the actual relationship observable in the interactions between the mother and bulimic daughter.

A fourth area of research would be the personalities of the mothers of bulimics. If it could be established that many mothers of bulimics have some form of personality disturbance (borderline features of dependant inadequate features) this would contribute considerably to an etiological understanding of the syndrome.

Finally, there is an issue which does not emerge directly from this study, but which needs to be researched. Weissberger (1986) noted the feelings of emotional deprivation in bulimic daughters and their mothers. If this finding is confirmed, it may have important implications for an understanding of the form and content of the mother-daughter relationship. It raises the question of why, if the mothers of bulimics feel emotionally deprived, they are also not bulimic. Research would need to be undertaken on how the mothers express their sense of deprivation, and if it is in any way related to the

daughter's 'choice' of symptom. Lastly, the emotional deprivation experienced by both bulimic daughters and their mothers raises the question of the role of the other family members.

It is likely that the mother-daughter relationship has still much to reveal about this complex and pernicious syndrome affecting 10% of Western middle class women.

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APPENDIX 1

DSM III (1980) DIAGNOSTIC CRITERIA FOR BULIMIA

(DSM III, 1980, p.69-71).

- A. Recurrent episodes of binge eating, rapid consumption of a large amount of food in a short period of time, usually less than 2 hours.
- B. At least three of the following:
 - (1) consumption of high caloric, easily ingested food during a binge
 - (2) inconspicuous eating during a binge
 - (3) termination of such eating episodes by abdominal pain, sleep, social interruption, or self-induced vomiting
 - (4) repeated attempts to lose weight by severely restrictive diets, self-induced vomiting, or use of cathartics or diuretics
 - (5) frequent weight fluctuations greater than ten pounds due to alternating binges and fasts.
- C. Awareness that the eating pattern is abnormal and fear of not being able to stop eating voluntarily.
- D. Depressed mood and self-deprecating thoughts following eating binges.
- E. The Bulimic episodes are not due to Anorexia Nervosa or any known physical disorder.

Bulimia

"The essential features are episodic binge eating accompanied by an awareness that the eating pattern is abnormal, fear of not being able to stop eating voluntarily, and depressed mood and self deprecating thoughts following the eating binges. The bulimic episodes are not due to Anorexia Nervosa or any known physical disorder.

Eating binges may be planned. The food consumption during a binge often has a high caloric content, a sweet taste, and a texture that facilitates rapid eating. The food is usually eaten as inconspicuously as possible, or secretly. The food is usually gobbled down quite rapidly with little chewing. Once eating has begun additional food may be sought to continue the binge and often there is a feeling of loss of control or inability to stop eating. A binge is usually

terminated by abdominal pain, sleep, social interruption, or induced vomiting. Vomiting decreases the physical pain of abdominal distention, allowing either continued eating or termination of the binge, and often reduces post binge anguish. Although eating binges may be pleasurable, disparaging self-criticism and depressed mood follows.

Individuals with Bulimia usually exhibit great concern about their weight and make repeated attempts to control it by dieting, vomiting, or the use of cathartics or diuretics. Frequent weight fluctuations due to alternating binges and fasts are common. Often these individuals feel that their life is dominated by conflicts about eating.

Associated features: Although most individuals with Bulimia are within a normal weight range, some may be slightly underweight and others may be overweight. Some individuals are subject to intermittent Substance Abuse, most frequently of barbiturates, amphetamines, or alcohol. Individuals may manifest undue concern with body image and appearance, often related to sexual attractiveness, with a focus on how others will see and react to them.

Age of onset: The disorder usually begins in adolescence or early adult life.

Sex ratio: The disorder occurs predominantly in females.

Course: The usual course is chronic and intermittent over a period of many years. Usually the binges alternate with periods of normal eating, or with periods of normal eating and fasts. In extreme cases, however, there may be alternate binges and fasts with no periods of normal eating.

Familial Pattern: No information, although frequently obesity is present in parents or siblings.

Impairment and Complications: Bulimia is seldom incapacitating except in a few individuals who spend their entire day in binge eating and self induced vomiting. Electrolyte imbalance and dehydration can occur in those below normal weight who vomit after binges.

Prevalence and Predisposing factors: No information.

Differential diagnosis: In Anorexia Nervosa there is severe weight loss, but in Bulimia the weight fluctuations are never so extreme as to be life threatening. In Schizophrenia there may be unusual eating behaviour, but the full syndrome of bulimia is rarely present, when it is, both diagnoses should be given. In certain neurological diseases, such as epileptic equivalent seizures, CNS tumours, Kliver-Bucy-like syndromes,

and Klein Levin syndrome, there are abnormal eating patterns but the diagnosis Bulimia is rarely warranted, when it is, both diagnoses should be given.

DSM III-R (1987) DIAGNOSTIC CRITERIA FOR BULIMIA NERVOSA

(DSM III-R, 1987, p.67)

- A. Recurrent episodes of binge eating (rapid consumption of a large amount of food in a discrete period of time).
- B. A feeling of lack of control over eating behaviour during the eating binges.
- C. The person regularly engages in either self-induced vomiting, use of laxatives or diuretics, strict dieting or fasting, or vigorous exercise in order to prevent weight gain.
- D. A minimum average of two binge eating episodes a week for at least three months.
- E. Persistent overconcern with body shape and weight.

Bulimia Nervosa

The essential features of this disorder are: recurrent episodes of binge eating (rapid consumption of a large amount of food in a discrete period of time); a feeling of lack of control over eating behaviour during the eating binges; self-induced vomiting, use of laxatives or diuretics, strict dieting or fasting, or vigorous exercise in order to prevent weight gain; and persistent overconcern with body shape and weight. In order to qualify for the diagnosis, the person must have had, on average, a minimum of two binge eating episodes a week for at least three months.

Eating binges may be planned. The food consumed during a binge often has a high caloric content, a sweet taste, and a texture that facilitates rapid eating. The food is usually eaten as inconspicuously as possible, or secretly. The food is usually gobbled down quite rapidly with little chewing. Once eating has begun, additional food may be sought to continue the binge. A binge is usually terminated by abdominal discomfort, sleep, social interruption, or induced vomiting. Vomiting decreases the physical pain of abdominal distention, allowing either continued eating or termination of

the binge, and often reduced post-binge anguish. In some cases vomiting may itself be desired, so that the person will binge in order to vomit, or will vomit after eating a small amount of food. Although eating binges may be pleasurable, disparaging self-criticism and a depressed mood often follow.

People with Bulimia Nervosa invariably exhibit great concern about their weight and make repeated attempts to control it by dieting, vomiting, or the use of cathartics or diuretics. Frequent weight fluctuations due to alternating binges and fasts are common. Often these people feel that their life is dominated by conflicts about eating.

Associated features: Although most people with Bulimia Nervosa are within a normal weight range, some may be slightly underweight, and others may be over-weight. A depressed mood that may be part of a Depressive Disorder is commonly observed. Some people with this disorder are subject to Psychoactive Substance Abuse or Dependence, most frequently involving sedatives, amphetamines, cocaine, or alcohol.

Age at onset: The disorder usually begins in adolescence or early adult life.

Course: The usual course, in clinic samples, is chronic and intermittent over a period of many years. Usually the binges alternate with periods of normal eating, or with periods of normal eating and fasts. In extreme cases, however, there may be alternate binges and fasts, with no periods of normal eating.

Familial pattern: Frequently the parents of people with this disorder are obese. Several studies have reported a higher than expected frequency of Major Depression in first-degree biologic relatives of people with Bulimia Nervosa.

Impairment and complications: Bulimia Nervosa is seldom incapacitating, except in a few people who spend their entire day in binge eating and vomiting. Dental erosion is a common complication of the vomiting. Electrolyte imbalance and dehydration can occur, and may cause serious physical complications, such as cardiac arrhythmias and, occasionally, sudden death. Rare complications include esophageal tears and gastric ruptures.

Prevalence and sex ratio: A recent study of college freshmen indicated that 4.5% of the females and 0.4% of the males had a history of bulimia.

Predisposing factors: There is some evidence that obesity in adolescence predisposes to the development of the disorder in adulthood.

Differential diagnosis: In Anorexia Nervosa there is severe weight loss, but in Bulimia Nervosa (without associated Anorexia Nervosa) the weight fluctuations are rarely so extreme as to be life-threatening. In some instances Anorexia Nervosa occurs in a person with Bulimia Nervosa, in which case both diagnoses are given. In Schizophrenia there may be unusual eating behaviour, but the full syndrome of Bulimia Nervosa is rarely present: when it is, both diagnoses should be given. In certain neurologic diseases, such as epileptic equivalent seizures, central nervous system tumours, Kluver-Bucy-like syndromes, and Kleine-Levin syndrome, there are abnormal eating patterns, but the diagnosis of Bulimia Nervosa is rarely warranted; when it is, both diagnoses should be given. Binge eating is often a feature of Borderline Personality Disorder in females. If the full criteria for Bulimia Nervosa are met, both diagnoses should be given.

APPENDIX 2

THE BULIT TEST

Answer each question by marking the appropriate letter on the computer card. Please be as honest as possible. Your answers will be completely anonymous.

1. Do you ever eat uncontrollably to the point of stuffing yourself (.e. going on eating binges)?
 - (a) Once a month or less (or never)
 - (b) 2 - 3 times a month
 - (c) Once or twice a week
 - (d) 3 - 6 times a week
 - (e) Once a day or more

2. I am satisfied with my eating patterns.
 - (a) Agree
 - (b) Neutral
 - (c) Disagree a little
 - (d) Disagree
 - (e) Disagree strongly

3. Have you ever kept eating until you thought you'd explode?
 - (a) Practically every time I eat
 - (b) Very frequently
 - (c) Often
 - (d) Sometimes
 - (e) Seldom or never

4. Would you presently call yourself a 'binge eater'?
 - (a) Yes, absolutely
 - (b) Yes
 - (c) Yes, probably
 - (d) Yes, possibly
 - (e) No, probably not

5. I prefer to eat:
 - (a) At home alone
 - (b) At home with other
 - (c) In a public restaurant
 - (d) At a friend's house
 - (e) Doesn't matter

6. Do you feel you have control over the amount of food you consume?
 - (a) Most or all of the time
 - (b) A lot of the time
 - (c) Occasionally
 - (d) Rarely
 - (e) Never

7. I use laxatives or suppositories to help control my weight.
 - (a) Once a day or more
 - (b) 3 - 6 times a week
 - (c) Once or twice a week
 - (d) 2 - 3 times a month
 - (e) Once a month or less (or never)

8. I eat until I feel too tired to continue.
 - (a) At least once a day
 - (b) 3 - 6 times a week
 - (c) Once or twice a week
 - (d) 2 - 3 times a month
 - (e) Once a month or less (or never)

9. How often do you prefer eating ice cream, milk shakes, or puddings during a binge?
 - (a) Always
 - (b) Frequently
 - (c) Sometimes
 - (d) Seldom or never
 - (e) I don't binge

10. How much are you concerned about your eating binges?
 - (a) I don't binge
 - (b) Bothers me a little
 - (c) Moderate concern
 - (d) Major concern
 - (e) Probably the biggest concern in my life

11. Most people I know would be amazed if they knew how much food I can consume at one sitting.
 - (a) Without a doubt
 - (b) Very probably
 - (c) Probably
 - (d) Possibly
 - (e) No

12. Do you ever eat to the point of feeling sick?
 - (a) Very frequently
 - (b) Frequently
 - (c) Fairly often
 - (d) Occasionally
 - (e) Rarely or never

13. I am afraid to eat anything for fear that I won't be able to stop.
- (a) Always
 - (b) Almost always
 - (c) Frequently
 - (d) Sometimes
 - (e) Seldom or never
14. I don't like myself after I eat too much.
- (a) Always
 - (b) Frequently
 - (c) Sometimes
 - (d) Seldom or never
 - (e) I don't eat too much
15. How often do you intentionally vomit after eating?
- (a) 2 or more times a week
 - (b) Once a week
 - (c) 2 - 3 times a month
 - (d) Once a month
 - (e) Less than once a month (or never)
16. Which of the following describes your feelings after binge eating?
- (a) I don't binge eat
 - (b) I feel O.K.
 - (c) I feel mildly upset with myself
 - (d) I feel quite upset with myself
 - (e) I hate myself
17. I eat a lot of food when I'm not even hungry.
- (a) Very frequently
 - (b) Frequently
 - (c) Occasionally
 - (d) Sometimes
 - (e) Seldom or never
18. My eating patterns are different from eating patterns of most people.
- (a) Always
 - (b) Almost always
 - (c) Frequently
 - (d) Sometimes
 - (e) Seldom or never
19. I have tried to lose weight by fasting or going on a 'crash' diet.
- (a) Not in the past year
 - (b) Once in the past year
 - (c) 2 - 3 times in the past year
 - (d) 4 - 5 times in the past year
 - (e) More than 5 times in the past year

20. I feel sad or blue after eating more than I'd planned to eat.
- (a) Always
 - (b) Almost always
 - (c) Frequently
 - (d) Sometimes
 - (e) Seldom, never, or not applicable
21. When engaged in an eating binge, I tend to eat foods that are high in carbohydrates (sweets and starches)
- (a) Always
 - (b) Almost always
 - (c) Frequently
 - (d) Sometimes
 - (e) Seldom, or I don't binge
22. Compared to most people, my ability to control my eating behaviour seems to be :
- (a) Greater than others' ability
 - (b) About the same
 - (c) Less
 - (d) Much less
 - (e) I have absolutely no control
23. One of your best friends suddenly suggests that you both eat at a new restaurant buffet that night. Although you'd planned on eating something light at home, you go ahead and eat out, eating quite a lot and feeling uncomfortably full. How would you feel about yourself on the ride home?
- (a) Fine, glad I'd tried that new restaurant
 - (b) A little regretful that I'd eaten so much
 - (c) Somewhat disappointed in myself
 - (d) Upset with myself
 - (e) Totally disgusted with myself
24. I would presently label myself a 'compulsive eater' (one who engages in episodes of uncontrolled eating).
- (a) Absolutely
 - (b) Yes
 - (c) Yes, probably
 - (d) Yes, possibly
 - (e) No, probably not
25. What is the most weight you've ever lost in 1 month?
- (a) Over 20 pounds
 - (b) 12 - 20 pounds
 - (c) 8 - 11 pounds
 - (d) 4 - 7 pounds
 - (e) Less than 4 pounds

26. If I eat too much at night I feel depressed the next morning.
- (a) Always
 - (b) Frequently
 - (c) Sometimes
 - (d) Seldom or never
 - (e) I don't eat too much at night
27. Do you believe that it is easier for you to vomit than it is for most people?
- (a) Yes, it's not problem at all for me
 - (b) Yes, it's easier
 - (c) Yes, it's a little easier
 - (d) About the same
 - (e) No, it's less easy
28. I feel that food controls my life.
- (a) Always
 - (b) Almost always
 - (c) Frequently
 - (d) Sometimes
 - (e) Seldom or never
29. I feel depressed immediately after I eat too much.
- (a) Always
 - (b) Frequently
 - (c) Sometimes
 - (d) Seldom or never
 - (e) I don't eat too much
30. How often do you vomit after eating in order to lose weight?
- (a) Less than once a month (or never)
 - (b) Once a month
 - (c) 2 - 3 times a month
 - (d) Once a week
 - (e) 2 or more times a week
31. When consuming a large quantity of food, at what rate of speed do you usually eat?
- (a) More rapidly than most people have ever eaten in their lives
 - (b) A lot more rapidly than most people
 - (c) A little more rapidly than most people
 - (d) About the same rate as most people
 - (e) More slowly than most people (or not applicable)

32. What is the most weight you've ever gained in 1 month?
(a) Over 20 pounds
(b) 12 - 20 pounds
(c) 8 - 11 pounds
(d) 4 - 7 pounds
(e) Less than 4 pounds
33. Females only. My last menstrual period was
(a) Within the past month
(b) Within the past 2 months
(c) Within the past 4 months
(d) Within the past 6 months
(e) Not within the past 6 months
34. I use diuretics (water pills) to help control my weight.
(a) Once a day or more
(b) 3 - 6 times a week
(c) Once or twice a week
(d) 2 - 3 times a month
(e) Once a month or less (or never)
35. How do you think your appetite compares with that of most people you know?
(a) Many times larger than most
(b) Much larger
(c) A little larger
(d) About the same
(e) Smaller than most
36. Females only. My menstrual cycles occur once a month:
(a) Always
(b) Usually
(c) Sometimes
(d) Seldom
(e) Never

APPENDIX 3

DEMOGRAPHIC QUESTIONNAIRE

Please answer the questions below. Remember your answers will be completely anonymous.

1. Age
2. Male Female
3. What language do your parents speak at home?
.....
4. During term time, do you live;
 - i) at home with parents/family Yes ... No ...
 - ii) in Wits residence Yes ... No ...
 - iii) alone Yes ... No ...
 - iv) with friend/friends Yes ... No ...
 - v) other; please specify
5. How many brothers do you have?
6. What are their ages?
7. How many sisters do you have?
8. What are their ages?
9. What is your father's occupation?.....
10. How old is your father?
11. What is your mother's occupation?
12. How old is your mother?
13. What religion is your family?

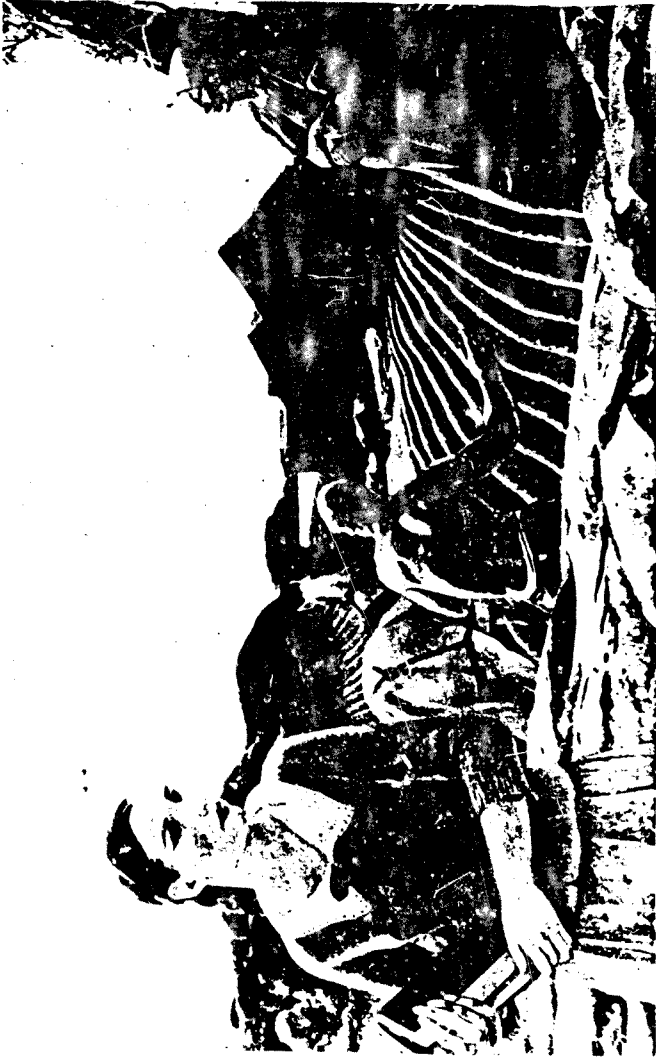
14. Are your parents married? Yes No
divorced? Yes No
separated? Yes No

15. Have you ever been treated for anorexia nervosa?
Yes No

APPENDIX 4

THEMATIC APPERCEPTION TEST; CARDS USED IN THIS STUDY

CARD 21



CARD 5:



CARD 7GF:



172

CARD 12F:



173

25x10

APPENDIX 5

THE ORIGINAL BELLAK FORM

The categories included in the original Bellak form are as follows;

1. Main Themes: (diagnostic level; if descriptive and interpretative levels are desired use a scratch sheet).
2. Main hero: age
 sex
 vocation
 abilities
 interest
 traits
 body image
 adequacy
 and/or self image
3. Main needs and drives of hero:
 - a) behavioural needs of hero (as in story);.....
 implying.....
 - b) figures, objects or circumstance introduced

 implying need for or to;

 - c) figures, objects or circumstances omitted;

 implying need for or to;

4. Conception of environment (world) as:

5. a) Parental figures (m f.....) are seen as

 and subjects reaction to a) is

 b) Contemporary figures (m.... f....) are seen as

 and subject's reaction to b) is

c) Junior figures (m f....) are seen as
and subject's reaction to c) is

6. Significant conflicts:

7. Nature of anxieties:
of physical harm and/or punishment
of disapproval
of lack or loss of love
of illness or injury
of being deserted
of deprivation
of being overpowered and helpless
of being devoured
other

8. Main defenses against conflicts and fears:
repression
reaction formation.....
regression.....
denial.....
introjection.....
isolation.....
undoing.....
rationalization.....
other.....

9. Adequacy of superego as manifested by 'punishment' for 'crime' being:
appropriate
inappropriate
too severe (also indicated by immediacy
of punishment).....
inconsistent.....
too lenient.....

also:
delayed initial response or pauses.....
stammer.....
other manifestations of superego interference.....

10. Integration of the ego, manifesting itself in:

He-o; adequate.....
inadequate.....

Outcome: happy.....
unhappy.....
realistic.....
unrealistic.....

Drive control.....
Thought processes as revealed by plot being;
stereotyped.....
original.....
appropriate.....
complete.....
incomplete.....
inappropriate.....
syncretic.....
concrete.....
contaminated.....

Intelligence.....

Maturational Level.....

Summary Categories:

Questions 1 - 3: Unconscious structure and drives of
subjects (based on variables 1 - 3).

Question 4: Conception of world.

Question 5: Relationship to others.

Question 6: Significant conflicts.

Question 7: Nature of anxieties.

Question 8: Main defences used.

Question 9: Superego structure.

Question 10: Integration and strength of ego.

APPENDIX 6

THE ADAPTED BELLAK FORM USED IN THIS STUDY

The categories included in the adapted Bellak form were as follows:

1. General:
 - Main theme (descriptive)
 - Central dynamic (story and approach to story).....
 - Main defences.....
2. Main hero:
 - age.....
 - sex.....
 - abilities.....
 - interests.....
 - traits.....
 - body/self-image.....
3. Behavioural needs of the hero.....
implying
4. Nature of anxieties.....
 - of physical harm and/or punishment.....
 - of disapproval.....
 - of lack or loss of love.....
 - of illness or injury.....
 - of being deserted.....
 - of deprivation.....
 - of being overpowered and helpless.....
 - of being devoured.....
 - other.....
5. Conception of the world.....
6. Conception of family (particularly Card 2).....
7. Mother-daughter relationship:
 - referred to:
 - directly.....
 - indirectly.....
 - Who does subject identify with in the picture

8. Mother seen as:

nurturant
demanding.....
warm.....
cold.....
critical.....
tolerant.....
other.....

9. Boundaries:

enmeshed.....
clear.....
alternate.....
withdrawn.....
other.....

10. Daughter's response to mother.....

11. Significant conflicts in the world.....

12. Significant conflicts with mother.....

Summary Categories:

Perception of mother.....

Daughter's response.....

Significant conflicts with mother, and in general.....

CATEGORIES FOR ANALYSING THE DESCRIPTION OF MOTHER

1. Mother perceived as:

nurturant.....
demanding.....
warm.....
cold.....
critical.....
tolerant.....
other.....

2. Boundaries
 - emphasized.....
 - clear.....
 - alternate.....
 - withdrawn.....
 - other.....
3. Daughter's response to mother.....
4. Significant conflicts experienced by the daughter
in relation to mother
5. Nature of daughter's anxieties (see list above)....
6. Precise of description and comment.....
7. Comparison of the TAT stories and description of mother
 - consistent.....
 - ambivalence in both.....
 - identical perceptions.....
 - different or contradictory portrayal.....

APPENDIX 7

BULIMIC GROUP; ANSWERS TO SELECTED QUESTIONS ON THE BULIT TEST

Question 1: Do you ever eat uncontrollably to the point of stuffing yourself?

- | | | | |
|----|---------------------------------|-----|-----|
| a) | Once a month or less (or never) | (3) | 15% |
| b) | Two to three times a month | (9) | 45% |
| c) | Once or twice a week | (5) | 25% |
| d) | Three to six times a week | (3) | 15% |
| e) | Once a day or more | (0) | |

Question 12: Do you ever eat to the point of feeling sick?

- | | | | |
|----|-----------------|-----|-----|
| a) | Very frequently | (1) | 5% |
| b) | Frequently | (3) | 15% |
| c) | Fairly often | (3) | 15% |
| d) | Occasionally | (9) | 45% |
| e) | Rarely or never | (4) | 20% |

Question 17: I eat a lot of food when I'm not even hungry.

- | | | | |
|----|-----------------|-----|-----|
| a) | Very frequently | (3) | 15% |
| b) | Frequently | (6) | 30% |
| c) | Occasionally | (4) | 20% |
| d) | Sometimes | (6) | 30% |
| e) | Seldom or never | (1) | 5% |

Question 2: I am satisfied with my eating patterns.

- | | | | |
|----|-------------------|-----|-----|
| a) | Agree | (0) | |
| b) | Neutral | (1) | 5% |
| c) | Disagree a little | (3) | 15% |
| d) | Disagree | (3) | 15% |
| e) | Disagree strongly | (8) | 40% |

Question 4: Would you presently call yourself a 'binge' eater?

- | | | | |
|----|------------------|-----|-----|
| a) | Yes, absolutely | (3) | 15% |
| b) | Yes | (3) | 15% |
| c) | Yes, probably | (1) | 5% |
| d) | Yes, possibly | (6) | 30% |
| e) | No, probably not | (7) | 35% |

Question 10: How much are you concerned about your eating binges?

- | | | | |
|----|--|-----|-----|
| a) | I don't binge | (0) | |
| b) | Bothers me a little | (4) | 20% |
| c) | Moderate concern | (5) | 25% |
| d) | Major concern | (7) | 35% |
| e) | Probably the biggest concern
in my life | (4) | |

Question 18: My eating patterns are different from the eating patterns of most people.

- | | | | |
|----|-----------------|-----|-----|
| a) | Always | (0) | |
| b) | Almost always | (3) | 15% |
| c) | Frequently | (7) | 35% |
| d) | Sometimes | (8) | 40% |
| e) | Seldom or never | (2) | 10% |

Question 24: I would presently label myself a compulsive eater (engaging in episodes of uncontrolled eating).

- | | | | |
|----|------------------|-----|-----|
| a) | Absolutely | (2) | 10% |
| b) | Yes | (2) | 10% |
| c) | Yes, probably | (3) | 15% |
| d) | Yes possibly | (9) | 45% |
| e) | No, probably not | (4) | 20% |

Question 14: I don't like myself after I eat too much.

- | | | | |
|----|----------------------|------|-----|
| a) | Always | (15) | 75% |
| b) | Frequently | (2) | 10% |
| c) | Sometimes | (2) | 10% |
| d) | Seldom or never | (1) | 5% |
| e) | I don't eat too much | (0) | |

Question 20: I feel sad or blue after eating more than I planned to eat.

- | | | | |
|----|---------------------------------|-----|-----|
| a) | Always | (7) | 35% |
| b) | Almost always | (6) | 30% |
| c) | Frequently | (5) | 25% |
| d) | Sometimes | (2) | 10% |
| e) | Seldom, never or not applicable | (0) | |

Question 29: I feel depressed immediately after I eat too much.

- | | | |
|-------------------------|-----|-----|
| a) Always | (9) | 45% |
| b) Frequently | (4) | 20% |
| c) Sometimes | (7) | 35% |
| d) Seldom or never | (0) | |
| e) I don't eat too much | (0) | |

Question 15: How often do you intentionally vomit after eating?

- | | | |
|------------------------------------|------|-----|
| a) 2 or more times a week | (1) | 5% |
| b) Once a week | (2) | 10% |
| c) 2 to 3 times a month | (0) | |
| d) Once a month | (0) | |
| e) Less than once a month or never | (17) | 85% |

Question 19: I have tried to lose weight by fasting or going on crash diets.

- | | | |
|---------------------------------------|-----|-----|
| a) Not in the past year | (3) | 15% |
| b) Once in the past year | (4) | 20% |
| c) 2 to 3 times in the past year | (4) | 20% |
| d) 4 to 5 times in the past year | (6) | 30% |
| e) More than 5 times in the past year | (3) | 15% |

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Author Frenkel Louise Charlene

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