AN ABSTRACT OF THE THESIS OF

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Title: Moral Dilemmas of Bulimics and Nonbulimics:
A Study of Voice and Self in Eating Disorders

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The central question of this study was to examine the moral orientation and the role of self in subject generated moral dilemmas for information on the developmental and cultural forces contributing to the etiology and maintenance of eating disorders in college women. The research was based on the theories of Carol Gilligan (1982,1988,1990).

Twelve women identified as bulimic by therapists and twelve women with no eating disorder were administered the BULIT-R and the moral conflict and choice interview. A Guide to Reading Narratives of Moral Conflict and Choice for Self and Moral Voice provided the framework for analyzing the the interviews.

Using Chi squares to analyze the data, no significant differences were found between the two groups on presence, predominance, and alignment of the moral voices of care and justice or on relationship framework, although a trend toward the bulimic sample aligning both with the justice and care orientations was noted. The bulimic sample expressed one or more of the vulnerabilities of care and both care and justice significantly more often than the comparison sample. No difference was found for expression of self care, though the quality of self care expressed was different. Subjects from the bulimic sample mentioned self care in conjunction with self-preservation, while subjects in the comparison group mentioned self-care as an ordinary consideration in conflicts. A significant difference was found between the two groups on mention of a problematic relationship with father, with bulimics describing an emotionally distant relationship with father more often. Finally, the quality of the conflicts described by bulimics tended to be more critical to self than those described by the comparison sample.

Results were related to what Gilligan (1990) calls the biggest challenge of the adolescent female: how to integrate inclusion of self with inclusion of others. Disturbances in relationships within the family resulted in the women from the bulimic sample having difficulty with this task. Two coping styles were identified: role reversal and hostile avoidant (Salzman, 1990). The relevance of these coping styles to bulimia was discussed.

Implications for therapy were reviewed and recommendations were made for future research.

MORAL DILEMMAS OF BULIMICS AND NON-BULIMICS: A STUDY OF VOICE AND SELF IN EATING DISORDERS

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I. INTRODUCTION

Although bulimia is commonly regarded as a recent phenomena, Janet (1903, as cited in Pope, Hudson, & Mialet, 1985) described 4 cases of patients with clear bulimic symptoms, and Linder (1955), in his book, The Fifty Minute Hour, described another. Bulimia did not begin to catch the eyes of researchers, however, until Bruch's (1973) classic book, Eating Disorders, began to focus attention on bulimia and its similarities to anorexia, and Boskind-Lodahl (1976) challenged the traditional psychoanalytic interpretation of anorexia and bulimia. Research has been slowed by problems in the definition, classification, and even the naming of the syndrome. It was not until 1980 that the Diagnostic and Statistical Manual of Mental Disorders (DSM-III; American Psychiatric Association, 1980) included bulimia nervosa as a diagnostic category and provided researchers with a standard definition of bulimia. Unfortunately this definition proved to be overinclusive (Strober and Yager, 1989), and the revised edition of the DSM-III, the DSM-IIIR (American Psychiatric Association, 1987), refined that definition to require both binging and a form of purging to meet the criteria for bulimia nervosa. Binge eating is characterized by the ingestion of large amounts of calories, usually through carbohydrates and fats, in a short period of time, and purging is the attempt to rid the body of those calories. The current DSM-IIIR criteria include:

A. Recurrent episodes of binge-eating.

B. A feeling of lack of control over eating behavior during the eating binge.

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. (DSM-IIIR, 1987, p. 68 & 69)

Prevalence studies of bulimia nervosa have yielded widely varying figures. Recent studies have reported the incidence of bulimia among high school women at 2.2%, 3.4%, and 3.98% (Gross & Rosen, 1988; Stein & Brinza, 1989; Howat & Saxton, 1988), and the incidence in college women at 3.2% and 5.4% (Stein & Brinza, 1989; Howat and Saxon, 1988). However, these studies utilized self-report inventories, and in follow-up interviews Stein and Brinza (1989) found that the inventory they used gave a 57% rate of false positives. Bilich (1989) and Bowen-Woodward & Levitz (1989) report that the college population is considered to have the highest prevalence rates, though they offer no data to support the hypothesis. Strober and Yager (1989), in reviewing studies of overall prevalence rates that included both binging and purging, found a consistent range of 1% to 2% of women who met the criteria. It is estimated that 10% of bulimics are male (Striegel-Moore, Silberstein & Rodin, 1986), though Gross & Rosen (1988) found only 0.1% males of their sample who met the criteria, which was less than 5% of the total number of men and women meeting criteria.

Researchers have consistently found that bulimia occurs most frequently in young adults (Bilich, 1989). Stein and Brinza (1989), however, found 4.4% of the junior high women tested met criterion for bulimia on the Bulimia Test. Ages in the studies reviewed ranged from 14 to 42. The mean age of subjects in

clinical studies clustered around 22, while the mean age in college studies was understandably less, usually around 20. Some researchers (Root, Fallon & Freidrich, 1986; Johnson & Connors, 1987) have suggested that bulimia surfaces at the "launching stage" of family and adolescent development. Whatever the impetus for its initial appearance, it is clearly a problem primarily of young women.

Theoretical Considerations

Several authors have proposed a multi-risk factor model for bulimia (Striegel-Moore, Silberstein & Rodin, 1986; Bilich, 1989). This model suggests that the development of bulimia is contingent on the interaction between many different factors, including genetic, intrapsychic, developmental, family, and socio/cultural variables. Research examining the effects of the different factors will be summarized in the review of the literature. Relevant developmental and sociocultural theory will be introduced below.

Although the contribution from developmental psychology is potentially very important since bulimia tends to appear during the developmental crossroad of adolescence, lack of a clear understanding of the developmental pathway for girls has clouded the picture. As recently as 1980 Adelson and Dohrman in the Handbook of Adolescent Psychology remarked on the lack of studies on girls and women. Gilligan, Brown and Rogers (1988) disputed the unitary developmental models of Freud, Piaget, Erickson, Kohlberg and Perry, all of whom have based their theories on boys and men and who saw the different responses of girls and women as aberrations. Gilligan and Rogers (1988) state:

> "If sex is a difference that makes little or no difference in personality, the Psyche is encapsulated, walled off from body, from

> relationships and from culture. Conversely, if Psyche is embodied and also in relationship and in culture, then, since human bodies are characterized by sexual dimorphism, since human cultures are largely male creations and disproportionately represent men's lives, since sex is a difference that makes a difference in terms of social and economic status and perspectives, and since human relationships typically follow different patterns for male and female children, we would expect to find sex differences writ large in personality theory and the differences in the lives of women and men illuminated in terms of psychological development. That this is not the case presents a problem." (p. 4)

Moral Orientation. One lens used to chart a developmental sequence has been moral orientation (Colby & Kohlberg, 1986). Kohlberg identified three levels of moral development, the pre-conventional, conventional, and principled morality, with each level containing two separate stages (Colby and Kohlberg, 1986). One of Kohlberg's research associates, however, began to notice a difference in the way most women responded to the posed moral dilemmas, a difference that resulted in women being scored lower on Kohlberg's developmental scale (Gilligan, 1982). Gilligan (1982) identified two different 'voices' or perspectives, the "justice" voice, which emphasized fairness, rights and general principles and was the central focus of Kohlberg's work, and the "care" voice, which emphasized interdependence, concern with the individual, and the avoidance of hurt.

While not gender dependent, subsequent studies have shown that these two moral orientations, the voice of care and the voice of justice, are gender related (Gilligan & Wiggins, 1987; Lyons, 1988; Johnston, 1988; Gilligan & Attanucci, 1988). The two perspectives are not mutually exclusive and people can shift from one to another in their transactions with others; however, people tend to prefer one orientation over the other (Johnston, 1988). Gilligan (1988) has compared the two orientations to the classic figure/ground problem of the

young woman and the old woman. If a person pays attention to one set of cues and stimuli, s/he sees the old woman. If the person reorients him/herself to attend to a different set of stimuli, s/he sees a young woman. Even after knowing that both figures are embedded in the drawing, the eye tends to orient to one or the other, not both.

While almost all the boys and men spontaneously took the perspective of the voice of justice in describing solutions to self-generated moral dilemmas (Gilligan, 1982; Lyons, 1988) and dilemmas in fables (Johnston, 1988), slightly over half the women spontaneously described solutions using the voice of care. A recent study confirms this pattern holds true for college students (Stiller & Forrest, 1990). These two perspectives are elaborated in Table 1, in which the relationship between the conceptions of self and orientations to morality is presented schematically (Lyons, 1988, p. 35).

Table 1

Conceptions of Self & Morality in Relation to Moral Choice

A MORALITY OF JUSTICE				
individuals defined as SEPARATE/ OBJECTIVE IN RELATION TO OTHERS: see others as one would like to be seen by them, in objectivity;	tend to use a morality of justice as fairness that rests on an understanding of RELATION-SHIP AS RECIPROCITY between separate individuals, grounded in the duty and obligation of their roles.	Moral problems are generally construed as issues, especially decisions, of conflicting claims between self and others (including society); resolved by invoking impartial rules, principles or standards,	considering: (1) one's role - related obligations, duty, or commitments or (2) standards, rules, or principles for self, others, or society including reciprocity, that is, fairness--how one should treat another considering how one would like to be treated if in their place	and evaluated considering: (1) how decisions are thought about and justified; or (2) whether values, principles, or standards were/are maintained, especially fairness.

Table 1 (cont.)

Conceptions of Self & Morality in Relation to Moral Choice

A MORALITY OF CARE				
Individuals defined as CONNECTED IN RELATION TO OTHERS: see others in their own situations and contexts;	tend to use a morality of care that rests on an understanding of RELATION-SHIPS AS RESPONSE TO ANOTHER in their own terms.	Moral problems are generally construed as issues of relationships or of response, that is, how to respond to others in their particular terms; resolved through the activity of care,	considering: (1) maintaining relationships and response, that is, the connections of Interdependent individuals to one another; or (2) promoting the welfare of others or preventing their harm; or relieving the burdens, hurt, or suffering (physical or psychological) of others;	and evaluated considering: (1) what happened/will happen, or how things worked out; or (2) whether relationships were/are maintained or restored.

But what creates these different perspectives and why are they gender related? Three major contributors can be identified: (a) the different developmental paths of young boys and young girls; (b) socio/cultural variables; and (c) family influences.

Developmental Factors. Chodorow (1978) hypothesized that young boys and girls follow two separate but equal developmental paths. Since sexual identity is established by age 3 for both sexes, and since the primary caretaker in this culture is almost universally a woman, Chodorow believed that male development entails a more emphatic separation from the mother. Young girls, on the other hand, have no need to develop such differentiated ego boundaries and emerge with a stronger basis for experiencing another's needs or feelings as her own.

From this Gilligan (1982) posited that masculinity and a masculine identity are based on separation, and that femininity and a feminine identification are based on attachment. For boys, a major developmental task entails seeing others as equal to self so that equality provides a way of making connections safe. For girls, the task entails expansion of a network of connection and interdependency so that separation can be protective and need not mean isolation.

According to Gilligan (1988), each perspective is based on experience in relationships with other people. The justice orientation is based on the experience of separation and the awareness of equality and inequality that results. The care orientation is based on connection and the awareness of attachment and detachment that results (Brown, 1988). While every person experiences relationships along both dimensions, a girl's developmental path emphasizes attachment and a boy's path emphasizes separation. Thus girls are more likely to have a care orientation and boys a justice orientation.

Lyons (1988) further defined the effects of these differing developmental paths. The separate, objective self, whose focus is autonomy in relation to others, experiences relationships in terms of reciprocity between separate individuals. Concern with others centers around treating others as s/he would be treated, with objectivity and in fairness. Rules and standards that maintain fairness and reciprocity are important and are defined by the roles which come from duties of obligation and commitment. On the other hand, the connected self, whose focus is interdependence in relation to others, experiences relationships as a response to others on their own terms. S/he is concerned for the good of others and the avoidance of hurt. Care, concern, and empathy

maintain the connection in relationships which is grounded in the interdependence and interconnectedness of people.

Socio/Cultural and Family Influences. Superimposed upon these developmental paths are the messages and pressures of the sociocultural context and of the family. Traditionally women have been socialized as children and adolescents to be nurturers, to support, please, and be subservient to others (Baker-Miller, 1976). This behavior was often modeled through the parental relationship. However, activities such as sensitivity, emotionality, and dependency, which support the traditional feminine sex-role, were seen as weak and mentally unhealthy by college students and mental health professionals (Broverman, Vogel, Broverman, Clarkson, & Rosenkrantz, 1972). Among psychologists and society as a whole a healthy adult is associated with autonomy and independence (Steiner-Adair, 1989; Gilligan, 1988).

In the last 20 years, however, society's message to women has been changing, and the role of women has undergone tremendous, fundamental change. Instead of increasing the value of those attributes which have traditionally been associated with femininity, society is now encouraging women to be more autonomous and independent, and emotionality, sensitivity and dependence are seen even more as weaknesses.

The family unit itself is a powerful purveyor of standards and values. Each has its own idiosyncratic set of relational rules, of how people should interact and of what makes people 'good' or 'bad'. These may reflect current mores as well as traditonal ones that have descended from their particular ethnic or socioeconomic group. Since these can be in conflict, the messages received from family may not always be consistent. Furthermore, Jack (1987) contends:

> "If the family standards and the cultural norms reflect and magnify each other, the woman may find it difficult to challenge these standards on the basis of her personal experience." (p. 5)

Rothenberg (1986) and Gordon (1989) have pointed out the similarities between the epidemic of eating disorders seen today and the epidemic of hysterical conversion reactions seen in the early part of the century, another time women's roles were undergoing significant change. Gordon (1989) believes:

> "Bulimic women in fact present an exaggerated picture of what has become a common dilemma among contemporary female college students, that of integrating values of achievement and mastery with an underlying self-concept that is defined in terms of nurturance, physical attractiveness, and an entwinement of one's own identity with relationships to others. Their own accomplishments as students frequently strike them as being hollow and false, and they feel that, despite the external trapping of independent achievement, that true fulfillment will only come through a relationship with a man." (p. 46)

Steiner-Adair (1985) investigated the relationship between eating disorders and the conflict between the relational aspects of female identity and the cultural image of the independent and autonomously achieving woman in a qualitative study of 32 girls aged 14-18. Twelve of the young women, dubbed "Super Women" by the researchers for their frequent use of the term, identified traditional feminine attributes as those which society valued today. Nonetheless, they described the cultural image of the successful, achieving superwoman who has it all as the ideal woman, and they identified that superwoman as their individual ideal. These young women scored significantly higher than the other women in the study on the Eating Attitude Test (EAT; Garner & Garfinkel, 1979), a self-report inventory that measures a wide range of eating disordered behavior. Eleven of the 12 Superwomen scored within the

symptomatic range of the EAT. The remaining teenagers, dubbed "Wise Women", perceived more accurately the new cultural expectations of independence and autonomy, linked these values to the cultural ideal of the Superwoman, yet challenged and rejected these values and claimed for themselves an ideal image of adulthood which included the relational component of female identity. None of these women scored within the symptomatic range of the EAT.

While Steiner-Adair's study identified young women who scored highly on the EAT, it did not identify whether these women actually engaged in the behaviors which define an eating disorder. Indeed, using the most generous estimate of incidence of bulimia, 5.5%, only two of a randomly selected sample of 32 young women would be expected to be actively bulimic. What is the determining factor that pushes one or two of the twelve women identified by Steiner-Adair into the actual behaviors of an eating disorder? And how, then, is this tension between traditional and developmental values of connectedness and interdependence and the current societal values of autonomy and separation played out as these women pass through their late teens and into the early twenties? These questions form the focus of the present study.

Focus of Study

The central question of this study is whether examining the moral orientation and the role of self in subject generated moral dilemmas can provide us with useful information on the developmental and cultural forces contributing to the etiology and maintenance of eating disorders in college-aged women.

Methodological Considerations

The Center for the Study of Gender, Education, and Development has developed a methodology for studying the perspectives of care and justice and their relationship to self through analyzing subject-generated moral dilemmas (Brown [ed], 1988). They believe:

> "As moral language marks experiences of vulnerability in a world of relationship and is itself the legacy of a culture, it provides a way of listening to Psyche embedded and thus a new way of exploring empirically the place of body, relationship and culture in personality psychology." (p. 10)

Their approach is qualitative and hermeneutic, and the specifics of the approach will be discussed more thoroughly in Chapter 3. By discarding the predetermined moral dilemmas of Kohlberg (1986) and even the sentence stems of Loevinger (1978), and having the subjects themselves generate their own dilemmas of a situation where they were unsure of the right thing to do, Brown (ed.) (1988) have accomplished two purposes. First, their format allows the interviewees to define morality from their own context and experience, and gives researchers a peek into their real world. Second, it brings the question of morality and moral language into focus, down from removed questions of great import like life and death, and into the daily lives of all people who must constantly make decisions as to what is right and what is wrong.

Kvale (1983) defines "hermeneutics" as a study of the interpretation of texts whose purpose is to obtain a valid and common understanding of the meaning of the text. He gives seven canons for understanding the interpretative process that occurs in hermeneutic research:

1. Interpretation involves a 'hermeneutic circle', a continuous back and forth process between parts and the whole of the text. Each new reading and interpretation of the text informs and deepens the previous understanding.

Kvale (1988) recommends that the interpreter begin by getting an overall understanding of the meaning of the text, return with a different focus or theme and develop the meaning through that particular lens, then return and apply that to the global meaning, and so on.

2. An interpretation of meaning ends when the meanings of the different themes in an interview make sensible patterns and go into consistent unity, when what seem like logical inconsistencies achieve a unity of meaning.

3. Part-interpretations should be tested against statements in the interview and against the global meaning of the text to see if they make sense.

4. The interpretation must reflect the actual content of the statements and attempt to deepen the understanding of the world of the interviewee. According to Gilligan (personal communication), interpretations should always be based on actual statements in the interview, not inferred meanings of statements.

5. Both the interviewer and the interpreter must be knowledgeable about the theme being investigated so that the subtle nuances and connections can be explicated.

6. Although the ideal situation in a qualitative research project is to have the researcher presuppositionless, in real life, since the interviewer and the interpreter have a value system and a perspective from which they interpret the world, this is impossible. It is important, therefore, to make those presuppositions of which the researcher is conscious as explicit as possible from the beginning. The fact that the researcher(s) operate from the bias of their own value system is not an entirely negative factor, however. Shared values may help in the interview to create an atmosphere of safety and understanding, and they may help to understand what the interviewee is saying and enrich the interpretation. Techniques for protecting the integrity of the text from being overwhelmed by researcher bias will be discussed in Chapter 3.

7. Finally, every interpretation involves innovation and creativity. The goal is to transcend the immediately given and enrich understanding by uncovering new connections, relationships, and nuances.

Kvale (1983) also identifies some limitations of applying hermeneutics to interview texts. While in literature the text is already a finished product, in psychological interviews the interviewer may influence the direction and resulting interpretation of the text. This is mitigated somewhat by having a standard interview, although interviewers are expected to deviate from the standard in order to clarify statements of the interviewee. Awareness of his/her own presuppositions, knowledge and understanding of all aspects of the themes investigated, and sensitivity to the perspective of the interviewee, are also critical.

Another limitation is that communication goes beyond just the words in an interview, and much of that communication can be lost by focusing only on the words (Packer, 1988). Dorney (personal communication) recommends that the interpreter listen to the tape of the interview to pick up some of the paraverbal communication that is lost in a typed transcript. In the present study, the interviewer and the interpreter will be the same person and thus the non-verbal components of the interview will not be lost.

Finally, while literary texts are finished products, an interview is a dynamic process, and the interviewee may change and evolve even as the interview progresses. While this may make interpretation more difficult, it will also add to the richness of the process and the picture presented.

The themes that will guide the interpretation of the individual texts will be discussed in Chapter 3. After interpreting the individual text according to these

parameters, a general interpretation which summarizes the major themes of care, justice and self that emerge will be written for each subject.

The next step in analyzing qualitative data is to move from the individual, idiographic case to the nomothetic, general case. Wertz (1983) identifies four components of that jump. These include:

1. Seeing general insights in individual structures. This is another level of interpretation involving identification of that which transcends the individual protocol and represents the entire group. What meanings and messages are consistent through the bulimic group and what ones are consistent through the non-bulimic group? What are common for both?

2. Comparison of individual descriptions. The researcher must establish convergence and divergence in individual protocols by comparing them directly and not by assuming a general theme. Wertz (1983) suggests that the researcher "continue to reflectively interrogate the original descriptions while striving for the most specific and precise insights."(p. 231)

3. Imaginative variation. The researcher must continually challenge his/her interpretation to see if it does indeed meet the requirements for the phenomena under study. In other words, might a statement or a general theme represent something other than the care or justice orientation? What are the limits of the general statements?

4. Explicit formulation of generality. This final step, which summarizes the results of the study, must be done with great caution. The researcher must reflect on his/her judgments, making certain that the interpretation of overall trends is both efficient and sensible.

In this study, the final results should answer the following questions:

1. Is there a relationship between the voice of care and/or justice and self that is unique to women with bulimic eating patterns?

2. How does that unique relationship inform us about the etiology and maintenance of bulimia?

3. Are there themes in the voices of both women with bulimic eating patterns and non-bulimics in this age group that are important to note?

Limitations of the Present Study

There are several limitations to this proposed study. First, the sample size is quite small. The entire sample is composed of college students in Oregon and Washington, which could imply a regional and socioeconomic bias. The subjects are all volunteer, and all bulimic subjects have sought counseling at a campus counseling or mental health center, which would further bias the sample. Because of these reasons, the results may not be generalizable to other settings or times.

In addition, the methodological limitations discussed above hold true for this study. Any conclusions drawn from this study are based on the researcher's interpretations of the interview texts, and others may come up with different meanings for any of the interpretative levels.

Definition of Terms

Moral Dilemma - a subject-defined situation where s/he was not certain of the right thing to do but had to make a decision. The subject has also defined the situation as a moral conflict. (See Interview, Appendix 3)

Care Orientation - An orientation toward relationships that reflects the importance of connection and interdependence. It is marked by attention to attachment/detachment issues and with a moral imperative of responsiveness and avoidance of hurt or pain to others. This orientation includes the

consideration of particular situations over general principle and can include responsiveness to self as well as to others.

Justice Orientation - An orientation toward relationships that reflects the importance of independence and autonomy. It is marked by attention to equality/inequality issues and has a moral imperative to treat others fairly and impartially and as one would wish to be treated. It is based in duty, obligation, and commitments, and principles or standards of self and society. This orientation includes a consideration of general principle over particular situations.

Self - The narrator's representation of him/herself in the story, most often indicated by 'I' or 'me'. There is an assumption that the self is known through relationship (see Baker-Miller, 1984), and that in these narratives is a choosing, organizing, moral agent.

II. REVIEW OF THE LITERATURE

The review of literature for this study will focus first on the different components of a multifactor theory of the causation and maintenance of bulimia. This research will then be linked to the tension observed in women with bulimic eating patterns by Steiner-Adair (1985) and Gordon (1989) between the traditional and developmental push toward connectedness and interdependence and the current sociocultural values of autonomy and separation.

Developmental Factors

Although bulimia does not manifest itself until adolescence, there is evidence that it is the culmination of a process that begins in infancy (Striegel-Moore, 1986). Hartup (1989), in his review of social relationships and their developmental significance, underscores the importance of strong vertical attachments in childhood. Vertical attachments are those formed with individuals who have greater knowledge and social power, and are first and foremost formed with parents. Object relations theorists such as Klein (Bacal, 1987) and Bowlby (1980) have postulated the critical importance of the maternal relationship with the infant and its effect on subsequent development.

There is some evidence that these early relationships are disrupted for women who become bulimic. Several studies have examined attachment and separation issues between women with bulimic eating patterns and their mothers. Armstrong and Roth (1989) found that eating disorder patients manifested significantly more anxious attachment and separation-based depression on the Separation Anxiety Test than both normal adolescents and adolescents experiencing problems in identity formation and intimacy.

Becker, Bell & Billington (1987), using the Bell Object Relations Inventory, uncovered significantly more object relations deficits in the area of Insecure Attachment in women with bulimic eating patterns than in normal eaters, while Becker (1986) found greater object relations impairments involving separation and autonomy in women with bulimic eating patterns than in binge eaters and controls, but did not find any greater psychopathology in the mothers of women with bulimic eating patterns than the mothers of non women with bulimic eating patterns. Flanagan (1983), in reviewing the results of her study on the psychological assessment of personality organization in eating disorders, concludes that early deprivation in the mother-child relationship is central to the etiology of bulimia. Finally, women with bulimic eating patterns themselves perceive an insufficiency of parental care, particularly from their mothers (Pole, Stewart, & Parkin-Feigenbaum, 1988).

But what of relationships with father? The security or insecurity of the mother-child relationship appears to be independent of the father-child relationship (Main & Weston, 1981) and the father-child relationship appears to be qualitatively different, encompassing more play and leisure activities and having a more task-oriented focus (Hartup, 1989). Here, too, there is evidence that the relationship is troubled. Boskind-White and White (1983) state:

> "Parental rejection and secret yearnings for intimacy with their fathers were evident in the history of many of the bulimarexics we treated. Lack of intimacy with dad was as much responsible...as were strife-ridden relationships" (p. 72).

Humphrey (1986) found that deficits in parental nurturance and empathy were significantly more severe in women with bulimic eating patterns than in

controls or women with anorexic eating patterns, and that this finding was most consistent in respect to the father than the mother. From his research Golomb (1985) concluded that significantly more women with bulimic eating patterns than anorexics or controls perceived their fathers as critical and controlling, although they respected and admired him. Strober's (1981) work uncovered that women with bulimic eating patterns were significantly more distant from mother and father than anorexic women, and that there was significantly greater alienation from the father than the mother. Calam, Slade, and Newton (1990) found that eating disordered patients recalled that both their parents were lower in perceived care and warmth, and that their fathers, but not their mothers, were more overprotective than controls. Finally, Johnson and Flach (1985) found that bulimic families had significantly less emphasis on intellectual, social, and recreational activities than controls.

The picture painted by these studies is one in which the young girl does not achieve a secure sense of attachment in her vertical relationships. If, as Gilligan (1982) hypothesized, a firm sense of connection and interdependence is necessary for girls before separation seems safe, the goals of autonomy and independence can be highly disruptive. This disruption can become particularly acute in adolescence which has traditionally been seen as a period of painfully intensified emotions, of identity confusion and disorganization, and is a time when unresolved material from earlier developmental phases typically reappears (Barth, 1989). However, adolescence is also the time when the dictates of society's values become particularly pressing, when a young person becomes quite aware of what the 'right way' to see, to feel, to think and to act (Gilligan, 1988). Gilligan relates:

> "The deep sense of outrage and despair over disconnection, tapped by Konopka, by Miller, by me, and by others--the strong feelings and the judgments often made by girls and women about being excluded, left out, and abandoned, as well as the desperate actions girls and women often take in the face of detachment, indifference, or lack of concern--may reflect an awareness on some level of the disjunction between women's lives and Western culture. Yet the equally strong judgments made by girls and women that such feelings are illegitimate and that their exclusion is justified or deserved serve to undercut this awareness."(p. xi)

Family Factors

While parent-child relational factors have already been discussed, how the family system itself operates may also increase the risk for bulimia (Striegel-Moore, Silberstein & Rodin, 1986). Bulimics' families have been described as being highly enmeshed and demanding family cohesion, loyalty, mutual protectiveness and obligation; having difficulty with intense feelings which manifests itself particularly in poor conflict resolution; showing lack of affection and empathy; and exhibiting emotional overinvolvement or detachment (Strober & Humphrey, 1987; Roberto, 1986; Root, Fallon & Friedrich, 1986). In addition, bulimics' families have problems with individuation and separation (Root et al., 1986) and value success and achievement, controlling body weight, and maintaining an attractive appearance (Strober & Humphrey, 1987; Roberto, 1986).

Research supports these views of the bulimic family system. Johnson and Flach (1985) found that bulimic families were less supportive than families of normal eaters. The bulimics' families did not encourage independent behavior; experienced more conflict and anger but discouraged open, direct expression; and paradoxically valued high achievement but did not support intellectual or social activites or participating in recreational

activities. In a study by Pole Waller, Stewart and Parkin-Feigenbaum (1988) bulimic families scored lower on care variables and higher on overprotection, while Humphrey (1986) reported severe deficits in parental nurturance and empathy. The reports of women with bulimic eating patterns of emotion, attention and interaction from their parents were significantly less positive than were those of the control group in a study by Dolan, Leiberman, Evans, and Lacey (1990).

Paradoxical messages from her family confront the young girl who develops bulimia. While apparently valuing closeness, cohesion, and obligation, there is less care and support than other families. Independence is not encouraged, yet family members are expected to achieve, an activity that promotes separation from the peer group and is often problematic for young women (Horner, 1972). At the same time, because open and direct expression of feelings is not encouraged, true intimacy and interdependence are stifled. A bewildering set of demands confront her, but the discouragement of direct communication gives her the message that the problems she faces are hers to deal with, and she questions their legitimacy (Brown, 1988).

Intrapsychic Factors

Depression: One of the striking features of bulimia is the elevated level of depression and anxiety which has been associated with it (Brouwers, 1988; Mizes, 1988; Weiss & Ebert, 1983; Ford, 1985). Whether depression is a precursor to (Pope & Hudson, 1988) or a result of (Laessle, Kittl, Fichter & Pirke, 1988) the eating disorder remains controversial. Several cognitive features have been identified which may cause and maintain the high levels of depression. The first of these is low self esteem which includes self dislike

(Brouwers, 1988; Katz and Wolchik, 1984; Mizes, 1988; Boskind-White & White, 1983) and self-blame (Brouwers, 1988). Dysphoric mood, particularly bulimics' lack of humor, fun, and self pleasure (Boskind-White & White, 1983), and anger and negativity (Weisberg, Norman & Herzog, 1987), has been noted. Women with bulimic eating patterns have been found to have a greater sense of helplessness than normal eaters (Mizes, 1988) and less efficacy in their choice of coping strategies when under stress (Cattanbach & Rodin, 1988). An external locus of control has been found by some researchers (Weiss & Ebert 1983; Rost & Florin, 1982) while others report women with bulimic eating patterns do not differ from normal eaters on externality (Holleran, Pascale & Fraley, 1988). Findings have likewise been mixed for assertiveness, with some researchers finding no assertive deficits (Sullivan, 1986; Mizes, 1988) and others finding low assertiveness skills (Holleran, Pascale & Fraley, 1988).

Two other factors contribute to the elevated levels of depression seen in women with bulimic eating patterns. Women with bulimic eating patterns experience considerable body image distortion (Mizes, 1988; Brouwers, 1988; Ford, 1985) and believe their bodies are bigger than they actually are. Hsu and Sobkiewicz (1991) found that eating disorder patients not only overestimate their body size, but that they are more disparaging toward their bodies as well, a finding that Brouwers (1990) confirms. Finally, women with bulimic eating patterns have been described as having a high degree of narcissism and perfectionism. This has variously been described as high self-expectation and demand for approval (Mizes, 1988; Katz & Wolchik, 1985), striving for perfection (Boskind-White & White, 1983), and narcissism and egocentricity (Weisberg, Norman & Herzog, 1987). Fremouw and

Heyneman (1983), however, found that women with bulimic eating patterns did not set more stringent goals for themselves but that they did evaluate themselves more negatively after failure than did non-bulimics. Similarly, Lehman and Rodin (1989) found that women with bulimic eating patterns engaged in less non-food related-nurturance than dieters or nonrestraining women, and engaged in significantly more negative self-criticism and reactivity to negative events than the nonrestrainers, and Etringer, Altmaier, and Bowers (1989) uncovered lower self-appraised problem-solving ability; lower sense of personal efficacy with regard to successful performance in a wide variety of life tasks; and a tendency to attribute positive events to external, global and unstable factors among women with bulimic eating patterns.

Childhood Abuse: Clinicians have suggested a relationship between bulimia and physical and sexual abuse. Root and Fallon (1988) found that 66% of their sample of bulimic women had been physically victimized: 23% raped, 29% sexually molested, 29% physically abused, and 23% battered. Likewise, in a sample of women with anorectic and bulimic eating patterns, Hall, Tice, Beresford, Wooley & Wooley (1989) found that 50% had experienced sexual abuse, compared to only 28% of other female patients. However, other studies present a mixed picture. Lacey (1990) uncovered only slightly higher prevalences of incest and indecencies than the general population, and Calam & Slade (1989) found bulimia to be associated with unwanted sexual experience using force, but not intrafamilial unwanted sexual experience. Finn, Hartman, Leon & Lawson (1986) and Bailey & Gibbons (1989) found no relationship between sexual abuse and bulimia, although Bailey and Gibbons (1989) did find a significant relationship

between child physical abuse and bulimia. From their research, Smolak, Levine & Sullins (1990) suggest that while abuse characteristics alone are only weakly related to Eating Disorder Inventory scores, there appears to be an interactive relationship between abuse states and family support variables. Finally, in their research, Beckman and Burns (1990) discovered that while bulimic subjects did not report a higher incidence of past intrafamilial sexual abuse than did the comparison group, they did report significantly more experiences of extrafamilial abuse after age 12, and that women with bulimic eating patterns were sexually assaulted more often than the comparison group of women, but that difference missed being significant by a narrow margin.

It appears that childhood physical abuse may put a young woman at risk for bulimia. However, the data suggest another intriguing possibility, i.e., that women who are bulimic already put themselves in situations where they risk sexual or physical assault. Further research separating the effects of early childhood abuse and extrafamilial victimization of young women with bulimia are warranted.

Relationships: With the lack of strong vertical attachments in their childhood, women with bulimic eating patterns seem to develop an approach avoidance conflict with their horizontal relationships, or relationships with peers. Weiss and Ebert (1983) found that while women with bulimic eating patterns have fewer close relatives, superficially the number of intimate relationships and the number of social contacts do not differ from normal eaters, and Sullivan (1986) found that women with bulimic eating patterns did not lack social skills. However, Boskind-White and White (1983) describe women with bulimic eating patterns as having no genuine intimacy in their relationships,

Segal and Figley (1985) found that women with bulimic eating patterns appeared outgoing and socially active but privately they were shy, and in a study by Ford (1985), women with bulimic eating patterns were found to have greater interpersonal sensitivity. In both intimate and non-intimate stress situations, bulimic women used more escape avoidance, experienced more anticipatory threat emotions and perceived themselves as being less instrumental than non-bulimics (Neckowitz, 1986). At the same time women with bulimic eating patterns feel uncomfortable being alone. Results from a study by Larson and Johnson (1985) indicate that women with bulimic eating patterns report the lowest mood states when alone at home, and, contrary to non-bulimics, experience being at work and being alone at work positively.

It would appear that women with bulimic eating patterns desire connections with others, develop relationships on a superficial level, but do not develop genuine intimacy which would require open expression of emotions and self revelation. Johnson (1985) and Gans (1983) speak of the "False Self" of women with bulimic eating patterns, a self which accommodates the expectations of others, avoids controversy, and protects the "True Self". The "True Self" is vulnerable and filled with fear that others will discover her fundamental imperfections (Schutz, 1986), so that even in her closest relationships the bulimic must maintain a protective wall.

Sex Roles: Since early theories about eating disorders had women with bulimia either rejecting the feminine role or over-identifying with the feminine role (Boskind-Lodahl, 1976), several researchers have examined sex-role identification with mixed results (Striegel-Moore, Silberstein & Rodin, 1986). Masculinity scores have generally been lower than non-bulimics; however, Pettinati, Franks, Wade & Kogan (1987) attribute those low scores to

depression, rather than to the bulimia itself. While Pettinati et al. (1987) did not find any difference in actual feminine ratings between women with bulimic eating patterns and non-bulimics, women with bulimic eating patterns described their ideal self as significantly more feminine than did the non-bulimics. Gans (1985) reports that bulimic women experience themselves as less feminine than did normal eaters and would ideally like to be more feminine. Likewise, Rost, Neuhaus and Florin (1982) found that bulimics' behaviors were rated as far more feminine than their general attitudes. There appears to be a significant discrepancy between ego ideal and perception of self.

Sense of Self. The research on the intrapsychic factors in bulimia further enriches our understanding of the forces and conflicts associated with the eating disorder. Rather than being the result of dependence on relationships per se, recent research indicates that depression in women can be attributed to what happens within relationships (Jack, 1991; Cole, 1989; Miller, 1984; Gilligan, 1988). Women most frequently become depressed over loss or conflict within a relationship, while men become depressed over achievement and performance issues or loss of an ideal (Beck, Shaw, Rush & Emery, 1979). In fact, positive relationships appear to protect women from depression, even when other vulnerability factors are present (Jack, 1991). Depression can be interpreted, then, as a response to a failure of attachment instead of a failure of separation, and resistance to psychological distress among adolescent girls and women is associated with their ability to have and maintain authentic relationships or responsive engagement with others (Gilligan, 1988).

Cole (1989) identifies a pattern common for women:

1. Relationships are fundamental to women's sense of self.

2. When women suffer real-life losses, they are motivated to express their felt emotionality in mutually accepting contexts.

3. In general, our society does not recognize the kinds of events that represent losses for women, and there is a general tendency to circumvent the authentic expression of sadness.

4. Chronic stifling of expressing sadness leads to isolation and potentially to depression.

5. With depression comes a lowering of self-esteem.

Since women with bulimic eating patterns experience anxious and disrupted attachments within their family, ambivalent relationships with peers, and are generally discouraged by their family and society from expressing their sense of loss, the depression, anxiety and low self esteem that accompanies bulimia is not surprising.

Miller (1984) notes that adolescence is a time when girls begin to shut down and "contract" rather than expand. A survey commissioned by the American Association of University Women (AAUW) found that as girls and boys grow older, both experience a significant loss of self-esteem in a variety of areas; however, the loss is most dramatic and has the most long-lasting effect for girls. While 60% of girls in 4th grade reported that they were always happy with the way they were, by 7th grade the percentage had fallen to 37%, and by 10th grade to 29%. Interestingly, Caucasian women, the group found to have the highest incidence of eating disorders, had the lowest percentage of self-satisfied girls, 22%, to Black girls 58% and Hispanic girls 30%. The study connects the decline in self-esteem among girls to the importance of physical appearance. It states that girls are nearly twice as

likely as boys to mention a physical characteristic as the thing they like most about themselves. Physical appearance is most important for girls in middle school, the time of greatest decline in self-esteem (AAUW, 1991).

Brown (1988) in her study of the development of the care voice in girls, found that a split between self and other begins in the seventh grade. It signaled a separation between self-authority and external authority that led to self doubt and disconnection with self-knowledge in tenth grade girls. Because they doubt what they know, the high school sophomores studied turned to external authority to define what was of value and what was legitimate knowledge. Gilligan (1990) holds:

> For girls to remain responsive to themselves, they must resist the conventions of feminine goodness; to remain responsive to others, they must resist the values placed on self-sufficiency and independence in North American culture. (p. 10)

That this remains true for college women is confirmed in a study by Skoe and Marcia (1988), who found that a strong sense of self in college women was related to voicing concerns about care and response in relationship while staying connected with both self and other.

Today's culture bombards young people with the image of success in today's society and that image is the Superwoman image, thin, successful at home and on the job, able to handle anything. In addition, the societal ideal in the bulimics' view is also supportive, gentle, kind, and does not cause hurt to others. The wide gap between ideal self and actual self noted above in women with bulimic eating patterns belies their guilt in recognizing that what they know is true for themselves does not meet that externally reinforced image. These women are well practiced in silencing their emotions, and instead experience high levels of guilt and shame (Schutz, 1986).

Interestingly, when judged in terms of traditional measures of social and cognitive complexity and the ability to coordinate multiple perspectives, the tenth graders ranked the highest on the developmental scale. Yet clearly they were the most unsure and felt the least in control. Brown (1988) attributes that to the suppression of the value of the voice of care as the adolescent takes on the cultural norm of autonomy, rated highly in traditional measures of development. Similarly, Teusch (1988), when examining the ego development of women with bulimic eating patterns using Loevinger's scale, found a high level of ego development that was comparable to a professional women's sample. She concluded that the bulimic's nonsatisfying interpersonal relationships and violations in psychological connectedness cause the bulimic to alter her behavior to a lower level of ego development so that interpersonal connections can be maintained.

Genetic Factors

Some researchers (Pope & Hudson, 1988) argue that bulimia is a variant of major depressive disorder caused by a genetically based abnormality and cite the prevalence of affective disorders in first and second degree family members. The evidence remains inconclusive, however. Swift, Andrews, and Barlage (1986), in a review of the relationship between bulimia and affective disorder, concede that there is a relationship between the two, but that the nature of the relationship remains unclear. Laessle, Kittl, Fichter and Pirke (1988), using path analysis, found that the depression frequently found in women with bulimic eating patterns was a result of the self-imposed pressure towards an ideal shape and weight and the negative self evaluation of one's body, rather than a predisposing factor to eating disorder. The consensus, however, seems to be that women with bulimic

eating patterns do experience affective instability that predates the eating disorder and that this instability is genetically related (Johnson, Tobin & Steinberg, 1989). Hudson, Pope, Jonas, and Yurgelun (1983) have noted that substance abuse problems are common among women with bulimic eating patterns and their first and second degree family members and posit that the poor impulse control frequently exhibited by women with bulimic eating patterns may also be inherited, but data are inconclusive.

The genetic risk which has been established most clearly for eating disorders is obesity (Mitchell & Eckert, 1987). They report that the high heritability for body mass index (BMI), both at an initial evaluation at the age of 20 years (heritability of .77) and again at a 25-year follow-up (heritability of .84) suggests that what a person weighs is under substantial genetic control. Women who are genetically programmed to be heavier than the svelte ideal will be at higher risk for bulimia than those who are naturally thin (Striegel-Moore et al., 1986).

The "Superwoman" image described by both the Wisewomen and the Superwomen groups has as an important component thinness. Our society values attractiveness and thinness, making obesity a highly stigmatized condition. These social norms are applied more stringently to women than to men (Striegel-Moore et al., 1986). The pursuit of thinness can serve both to promote social desirability and to act as a vehicle to express achievement and mastery of one's body. It also represents the cultural ideal of femininity, with one study finding that both Playboy models and Miss Americas were continually increasing in height and decreasing in weight to the point that by 1980 they were approaching the clinical definition for anorexia (Garner, Garfield, Schwartz & Thompson, 1980). In addition, weight control is often

perceived as being totally under voluntary control, and overweight people are seen as lazy and out of control (Polivy and Herman, 1987). Thus, when faced with the dilemma of integrating values of achievement, mastery and independence with an underlying self concept that is defined in terms of nurturance, physical attractiveness, and an entwinement of one's own identity with relationships to others, the pursuit of thinness can emerge as a concrete activity in which young women can both compete and gain social approval (Gordon, 1989; Johnson, Tobin & Steinberg, 1989).

Summary

Current research supports the hypothesis that the etiology of bulimia is multifactored. Insecure vertical attachments and family dynamics have been implicated in creating an environment which leaves a young woman unable to form satisfactory peer attachments and unable to voice her feelings or resolve conflicts. Modern culture gives her contradictory messages about how to fit in. The one clear message is that a young woman must be thin. Since her genetic heritage does not give her the requisite build, she must find a way to counteract her own biological destiny. The intrapsychic factors that accompany bulimia help to keep the young woman feeling isolated and inadequate and contribute to maintaining the syndrome.

Mutually empathic relationships are essential for a sense of overall well-being and for promoting healthy growth and development for women (Surrey, 1984). Several researchers define the core self-structure of women as 'self-in-relation', that is, as experienced and expressed in the context of human bonds and relationships (Surrey, 1984; Gilligan, 1982, 1988; Miller, 1984; Jack, 1987; Cole, unpublished manuscript). While this reflects a more traditional view of women, the attitudes and behaviors that accompany this

view have been devalued by Western society (Broverman, Vogel, Broverman, Clarkson & Rosenkrantz, 1972) and have left women economically and psychologically at risk. In response, a new vision of woman has emerged, the Superwoman. The attitudes and behaviors that undergird the Superwoman are competence, achievement, nonemotionality, independence and autonomy, values prized by society but often at odds with the responsive self. According to Steiner-Adair (1985), women who can reject parts of the Superwoman image, hear and respect their own inner voice, and integrate the values of the interdependent, connected self with the current ideal for women, appear to be less vulnerable to eating disorders.

However, during adolescence, some women find it impossible to accomplish that integration. With early childhood and family life not providing the mutually responsive relationship necessary for high self-esteem and confidence in these women, they enter adolescence at risk. The emotional suppression encouraged at home exaggerates the self-silencing found in mid-adolescence, and, unable to trust or perhaps even hear their own inner voice, they turn to external authority to define their reality. They find not only the Superwoman image, but the traditional image of the caring, self-sacrificing woman (Steiner-Adair, 1985). Even though the values and behaviors of these two images can be in opposition, the young women attempt to meet both sets of demands (Gordon, 1989). One arena that appears to meet the demands of both is weight, and the women begin the obsessive pursuit of thinness that marks bulimia. The impossible goals the women have set for themselves, however, are unreachable, and the result is an ego ideal that is far removed from their present reality and is accompanied by depression, shame and guilt.

The binge/purge cycle itself undoubtedly serves several functions. The hypervigilance required by the "False Self" creates an exhausting tension, and the binge would offer relief from that tension while the purge would insure the safety of the "True Self". Continual dieting would also create a physiological and an emotional tension (Polivy and Herman, 1987). Once the pattern of dietary restraint is broken, disinhibition occurs, and binging results (Herman & Mack, 1975). The binge/purge cycle also provides a safety valve for regulating emotions (Johnson, 1985; Gans, 1985). Bingeing can be seen as an act of individuality and rebellion, while purging again makes it a safe rebellion, one that protects from the alienation and isolation they fear would occur if they directly challenged the cultural norms and gained weight. The cycle appears to act as a relaxant during times of stress and emotional upheaval, allowing the bulimic to literally stuff down her feelings and then discharge them. Finally, during the cycle itself, the bulimic feels a tremendous sense of control, something that is tenuous at other times.

By analyzing self-generated moral dilemmas for the voices of care and justice and their relation to self, the present study continues to examine the paradoxical lives of these women during their college years. Its aim is to add to the understanding of the phenomenom of bulimia and thereby assist clinicians designing treatments that will be effective in combatting it.

III. METHODOLOGY

This chapter contains a description of the sample used for the study; the assessment devices, including the moral choice interview; procedures; and data analysis, including guidelines for the interpretation of texts.

Description of Sample

Women meeting the DSM III-R criteria for bulimia were recruited from counseling centers and mental health services of colleges and universities in Washington and Oregon. Twelve women who met the criteria and who agreed to be interviewed and to have the interview taped and transcribed comprised the sample of bulimic women.

The comparison sample was recruited from college women enrolled in a Career Awareness and Decision Making class (Liberal Studies 114) at Oregon State University. This sample, dubbed the career development sample, allowed comparison between women with bulimia who have chosen to seek help with women who have also self selected to receive some kind of help. At the same time, class participants were from a non-clinical population and thus minimized any confounding caused by other types of psychological distress, particularly depression and current relationship problems. The comparison sample consisted of twelve non-eating disordered women who volunteered to be interviewed and to have their interviews transcribed. Absence of eating disorders was determined by scores on the revised form of the Bulimia Test (BULIT-R).

Each participant was asked to fill out a short demographic form which was used for cross-coding tapes and transcripts (appendix 1).

They were also given and asked to sign an informed consent form explaining confidentiality and the purpose of the study (appendix 2).

Participants were given a four-digit code based on sample membership, place from which they were recruited, and order of interview. Sample membership was coded as below:

1 = Career Development Sample

2 = Bulimic Sample

The recruitment origin was coded as:

1 = Oregon State University Counseling Center

2 = Oregon State University Mental Health Center

3 = Western Washington University Counseling Center

4 = University of Oregon Counseling Center

Thus, the third woman with bulimia from Western Washington University who was interviewed was coded as 2303, and the eleventh woman from the career development class was coded as 1111. Quotations in the results and discussion sections will be identified by this coding system.

Instrumentation

Moral Conflict and Choice Interview. The 'Moral Conflict and Choice Interview' was developed at the Center for the Study of Gender, Education, and Human Development to elicit a description of a time in the interviewee's life when she experienced a moral conflict and was unsure about what was the right thing to do (Brown [ed], 1988). The interviewer asks a series of questions about the problem as she, the narrator, understood it, how she solved the problem and how she evaluated her decisions and actions. Additional questions are

designed to encourage a complete elaboration of the conflict, and the interviewee is asked to describe how she felt about her decision, what was at stake for her in the conflict, and what she learned by taking (or not taking) the actions she did to solve the conflict (see appendix 3). The interview itself is intended only as a guide. The interviewer is encouraged to develop questions as needed in order to allow the narrator to relax and explore her thoughts so that a complete understanding of the narrative and the perspective of the individual being interviewed can be obtained.

The Moral Conflict and Choice Interview was embedded in a longer interview that included sections on self description, unfairness/not listening/self-silencing, hurting others, and reflections on the interview (see appendix 4). The longer interview served three purposes: (1) It allowed the interviewer time to develop rapport with the interviewee and provided an atmosphere which facilitated the interviewee relaxing; (2) If the interviewee could not think of a conflict the interviewer could go on to other items and allow the interviewee time to think; and (3) It provided additional data which may be analyzed at a later time.

Bulimia Test-Revised. The Bulimia Test (BULIT) is a self-report inventory designed to identify individuals meeting the DSM-III criteria for bulimia in the general population. The BULIT-R is a revised version of the BULIT, updating the inventory to meet the new requirements of the DSM-III-R (Thelen, Farmer, Wonderlich, & Smith, 1989).

The BULIT-R is 36 items long, with 28 of the 36 items being used in the scoring (see appendix 5). The eight unscored items refer to specific weight control behaviors. All items are presented in a 5-point, forced-choice, Likert format where responses are mutually exclusive and exhaustive. In order to avoid false negatives, Smith and Thelen (1984) recommend a cut-off score of 88, while in order to avoid a false positive, they recommend using a cut-off score of 104 (Thelen et al., 1989). Since the primary purpose of the BULIT was to ensure that none in the comparison group were bulimic, the cut-off score of 88 was used. There were no members of the comparison group who scored above 88; however, one woman was dropped from the study because she was previously anorexic. In order to minimize the effect of therapy, women volunteering for the bulimic sample were dropped if they did not reach the criterion of 88 on the BULIT. Three volunteers for the bulimia sample were dropped from the study because their BULIT score was below 88. Test-retest reliability is .95 (Thelen et al., 1989).

Table 2 provides a summary of the predictive ability of the BULIT-R.

Table 2

Summary of Predictive Ability for the BULIT-R

Measure	Bulimic [a]	Control	Bulimic [b]	Control
BUILT-R score				
≥ 104	19	7	23	5
< 104	4	150	14	119
Predictive ability				
Sensitivity		.83		.62
False negative rate		.17		.38
Specificity		.96		.96
False positive rate		.04		.04
Positive predictive value		.73		.82
Negative predictive value		.97		.89

Note: BULIT-R -- Bulimia Test-Revised
[a] Referred by therapist.
[b] Based on raters' judgments.

In stage 2 of the validation study, college women were used as controls. Because it is probable that some of them were bulimic, the number of false positives is likely to be inflated. Likewise, in stage 4, a high number of women who scored close to the cut-off value were included in a retest. A general sample of college women would increase the number of subjects with low BULIT-R scores, thus increasing its predictive ability.

Five factors emerged in both phases of the validation study. Factor I included items pertaining to binging and control. Factor 2 contained items pertaining to general use of radical weight loss measures and body image, and included non-scored items which targeted fasting. In phase two Factor 3 included items on diuretic use and laxatives, where in phase four laxative use factored in with

vomiting, factor 4. Factor 5 was comprised of non-scored items concerning exercise. Interestingly, items dealing with overconcern with body shape and weight were dropped from the BULIT-R because they did not adequately discriminate bulimic from control subjects.

Using a self-report inventory to diagnose bulimia is questioned by many (e.g. Cooper & Fairburn, 1987) who believe that only a diagnostic interview is adequate. Therefore, in the present study, the BULIT-R was used primarily as a back-up for those women already diagnosed as bulimic by therapists. The main purpose of the BULIT-R was to ensure that no women with bulimic eating patterns were included in the comparison sample.

Interpretive Guide. In conjunction with the "Moral Conflict and Choice Interview", the Center for the Study of Gender, Education, and Human Development has developed an interpretive guide, "The Guide to Reading Narratives of Moral Conflict and Choice", also known as the "Reading Guide", to provide researchers a methodology for evaluating the interviews for moral voice and self (Brown, [ed.], 1988). The Reading Guide allows a reader to track these two voices and to specify the ways in which a person views conflicts and chooses between the relational voices. It does not preclude other readings of the interview narratives, but rather clarifies one theoretical frame and highlights what it provides the researcher interested in self, relationships, and morality (Brown, 1988).

It is important to distinguish between this as an interpretive guide and other methods for counting or coding responses. The Reading Guide is a guide in the true sense of the word, providing an

approach to analyzing the material in the interview, questions that might be addressed, and examples of possible answers, but provides no criterion answers that must be matched and no highly structured coding scheme that must be followed. As Brown (1988) relates:

> "The sense of story or narrative account, and therefore the experience of a person telling a story of sometimes unresolvable and therefore tragic conflict, cannot be captured by coding systems that excise certain passages or ideas from the overall narrative. That is, coding systems offer no provision for including the speaker's own reflection on the meaning of the conflict to him/her. The physical reality of a speaker who, because of certain circumstances or life experiences, takes certain thoughts or feelings to be of major or minor importance is lost in such systems." (p. 15-16)

Three major assumptions underlie the methodological approach of the "Reading Guide":

> (1) There is a coherent story of moral conflict being told by the interviewee and that a careful reader has access to this story;
>
> (2) Each story has legitimacy and value; and
>
> (3) Since people share common concerns and a common language, there is the possibility of understanding and making sense of the narrator's story (Brown, [ed.], 1988).

The present researcher received training in interpreting interviews of moral conflict and choice and use of the Reading Guide in June, 1989, at the Center for Gender, Education, and Human Development. During the week-long training, participants discussed with Gilligan and her research assistants the theory, research philosophy and methodology of the Center, and had the opportunity to

interpret interviews and review those interpretations in small group meetings.

Procedure

Therapists at college and university counseling centers and mental health services in the Pacific Northwest were contacted and asked to give bulimic clients the informed consent sheet which included a general description of the research. Clients who agreed to participate filled out the bottom of the form and returned it to her counselor who forwarded it on to the researcher. The researcher then contacted the volunteers and scheduled a time for an interview. Those subjects who missed an interview appointment twice were dropped from the study. Although obtaining the bulimic sample out of a clinical population may bias the sample, Mitchell, Pyle, Eckert, Pomeroy, & Hatsukami (1988) report that bulimic patients and bulimic volunteers recruited for research were quite similar, differing only on the number of times treatment was sought for depression.

Non-bulimic subjects were recruited from the Career Awareness/Development class (LS114) at Oregon State University. These volunteers were also asked to sign an informed consent sheet and were contacted by the researcher to set up an interview appointment.

Each participant filled out the demographic sheet prior to the interview. Each sheet was numbered, and that number was used to identify the interview tape, the transcript and the BULIT-R inventory. The person was then interviewed using the interview in appendix 4 as the protocol. At no time during the interview was the interviewee

referred to by name. After the interview was concluded the interviewee was asked to fill out the BULIT-R.

All interviews were transcribed. Interviewer comments and questions were typed in capital letters, while interviewee remarks were typed in lower case letters.

Data Analysis

Individual Interview Analysis. Each interview was reviewed for four different themes or readings. Each reading brings a different aspect of the interview into focus and highlights its relational dimensions. The first reading is designed to establish the story told by the narrator in order to get an understanding of the overall story. Some of the questions associated with this reading are listed below.

1. The Narrative

   A. The story--What is the general sense of the story being told? What conflicts are revealed?

   B. General considerations--What relationships are discussed and what are the dimensions of those relationships, attachment/detachment or equality/inequality? What moral language, repeated words and themes, contradictions and key images are expressed?

The next three readings are designed to focus specifically on the ways in which the self and the two moral voices are represented in the interview. Before each respective reading, that theme is highlighted by underlining relevant references and passages in colored pencils: green for self, blue for justice, and red for care.

In the second reading the reader attends to the self, the "I" represented in the story, the "I" who appears as an actor in the narrator's story.

2. The Self

   A. The choosing, organizing self
      1. Does the narrator see or describe a choice? What is it? How is the decision made? Is self a victim or pawn? Is it a question of development, or is the lack of reflection because of a bad interview? Does the self back off, hesitate, become tentative, passive or uncertain or disclaim a previous position? Does the person switch from I to you or they - in what context? Does the person qualify her statements in an apparent reluctance to judge for another or assume she knows his/her terms?
      2. What is self describing herself as saying or doing?
      3. What is self considering or feeling? Is there a difference between what she said/did and what self thought/considered/felt she should do?

   B. Self in Relationship - What is the organizing frame?
      1. Equal/Unequal - Is self representing the relationship in terms of relative status or power? Is there inherent inequality or power differential in the relationship(s) so that one person appears less equal than the other? Does the person represent or emphasize this inequality; is it pertinent to the conflict or dilemma?
      2. Attachment/Detachment - Does self describe the relationship in terms that represent or emphasize interdependence or connection between persons?

   C. What is at stake for self? Does there seem to be a central issue that underlies the conflict, that makes it important or critical to the narrative self?

3. Justice

   A. Identification of justice orientation
      1. Distributive justice--Concern with the fair distribution of wealth, honor, etc.
      2. Commutative Justice--Attention to and concern with upholding voluntary agreement, contract, and

equal exchange, including obligations, duty, and commitment.
3. Corrective Justice--Application of corrective principle in private transactions and with crimes violating rights of involuntary participants.
4. Procedural Justice--A concern with balancing perspectives and making one's judgments reversible.
5. Non-interference in Others' Rights--A wish to respect the rights of others and to protect from interference the rights to life and self fulfillment.
6. Equality/Inequality--Attention to the power dimension of relationships, the wish to be treated fairly by those perceived as more powerful, and the fear of oppression.
7. Standards/Rules/Principles--Knowledge and concern with societal, family and/or organizational guidelines; application of such across differing situations.

B. Does the narrator show any of the vulnerabilities of the justice orientation?
1. Has the narrator mistaken a personal or traditional perspective or conventional standard for objective truth in solving the dilemma?
2. Has the narrator become vulnerable to exclusion, shutting out or becoming blind to the consequences of decisions in the service of justifying principles or standards?
3. Has the narrator lost sight of others or relationships with them in the search for justification or right solution?

C. Is justice clearly articulated? If justice is not clearly articulated, then what might represent it in this dilemma? Is the justice orientation rejected or disclaimed?

D. Does the self align with justice? Explicitly or implicitly? How do you know?

The fourth reading highlights the voice of care.

4. Care

A. General Identification of Care Orientation
1. Care of Self--Attention to and inclusion of one's own needs, desires, or beliefs in relational conflicts.

2. Inclusion--A wish for solutions to relational conflicts that include all involved and a desire to avoid exclusion.
3. Difference/Perspective--Appreciation of differences between people and a wish to understand another's thoughts, feelings, or way of seeing.
4. Not Hurting--A wish not to hurt people.
5. Interdependence--A focus on the nature of connections between people.
6. Welfare of others--An active concern for the well-being of others.
7. Attachment/Detachment--Attention to the psychological or emotional importance of relationships; a wish for love and care and a fear of abandonment or loss of a relationship.

B. Vulnerabilities of Care
1. Does the narrator become paralyzed or unable to act because she understands or knows too much about the other or his/her circumstances, or because she cannot define a standpoint or ground upon which to act?
2. Can the narrator acknowledge that her action might hurt another person?
3. Is self left out or excluded? Does the person describe herself as self-sacrificing?

C. Is the care orientation articulated? If not, how might care be articulated in this dilemma? Does the narrator reject or disclaim the care perspective?

D. Does the self align with care? Explicitly or implicitly?

During each reading, the reader filled in summary "Worksheets" (see appendix 6). The Worksheets are constructed so the reader can document pieces of the text and note observations and interpretations by the relevant passages. They are designed to highlight the move from the narrator's own words to the reader's interpretation or summary of them, and yet require evidence of the narrator's words to provide justification and foundation for the reader's interpretation. The interpretation of the reader is always grounded in the actual words of the narrator, which are always transferred as they appear in the text

and are never paraphrased. At the end of each section the reader recapitulates the major themes and interpretations of that reading.

After finishing the sections on justice and care the reader makes a summary interpretation of the relationship between the moral orientations and of the alignment of self with moral orientations. Finally, the reader makes an overall summary of self in relation to care and justice.

Reliability of Interpretation of Individual Texts. Since qualitative research does not have as its philosophical base general apodictic truths but instead argues that all knowledge is biased by values and language, the concept of reliability shifts in hermeneutic investigations (Polkinghorne, 1983). Packer and Addison (1989) suggest that while obtaining reliability "guarantees" in the positivistic sense is neither possible nor desirable, they do propose four approaches to the evaluation of hermeneutic accounts: (1) Requiring the interpretive account be coherent; (2) Seeking consensus among various groups; (3) Examining its relationship to external evidence; and (4) Assessing the account's relationship to future events. While none of these approaches guarantee reliability, they can be utilized to ensure that the interpretation is grounded in some sort of reality and not just wild conjecture. The present research will utilize the first two methods of evaluation.

Coherence is encouraged by the structure of the Worksheets. All interpretations are tied to the related text on the Worksheet, so that a trail of evidence for interpretations is always available. In

addition, the reader records contradictions so that they cannot be overlooked during interpretation, and, if justice or care considerations are not present, the reader must also imagine what would constitute care and justice in the narrative. This is a type of imaginative variation (Wertz, 1984) mentioned in the introduction.

Dr. Carol Sisson, Dr. Mariette Brouwers, and Dr. Cynthia Flynn volunteered to read and interpret 5 texts. Each reader used the Reading Guide and was instructed in its use by the researcher. One of the bulimic texts and one of the non-bulimic texts was read by all readers. Each reader also had three additional texts that only she and the researcher interpreted. Two texts, therefore, were read by everyone, and an additional nine texts were read by one auxilliary reader as well as the researcher. Of the eleven texts read by two or more readers, six were texts from interviews with women with bulimic eating patterns and five were texts from the comparison sample. Auxilliary readers were blind as to which texts came from the bulimic sample and which from the comparison sample. The researcher met with Drs. Sisson, Brouwers and Flynn to compare and review her interpretations of the texts with theirs. The goal was both to expand the interpretations of the researcher as well as to ensure grounded interpretations.

The other two methods of evaluation were not used because of their impracticality in the present situation. While the subjects could have been contacted to check the validity of the interpretations, they would first have to be instructed in the theory before any interpretation would make sense. Alternatively, observing actual behaviors is also

beyond the scope of the present investigation. Finally, evaluation in terms of future events is not possible.

Quantitative Analysis. Information from the data sheets and the BULIT-R will be analyed using T-tests. In addition, non-parametric statistical techniques will be utilized to analyze summary sheet and other worksheet data. The null hypotheses that were tested are:

1. There is no difference between the bulimic and the non-bulimic groups in the presence of the care and justice voices in the narratives.

2. There is no difference between the bulimic and non-bulimic groups in the predominance of the care or justice voices in the narratives.

3. There is no difference between the bulimic and the non-bulimic groups in the alignment with the care or justice voices.

4. There is no difference between the bulimic and non-bulimic groups in the organizing frame for the relationships described in the conflict.

5. There is no difference between the bulimic and non-bulimic groups in the demonstration of the vulnerabilities of justice and/or care in the resolution of the conflict.

6. There is no difference in mention of self-care between the bulimic and non-bulimic groups in the narratives.

Qualitative Analysis. Once all the individual texts have been interpreted, the Worksheets will be reviewed for common and divergent themes. In particular, the following specific questions will be addressed:

1. Are there recurring themes in the stories of women with bulimic eating patterns that are important to note? Do these differ from non-bulimics?

2. Are there commonalities in how women with bulimic eating patterns represent self in their narratives? Do these differ from non-bulimics? Are different things at stake for women with bulimic eating patterns?

3. Are there commonalities between the types of conflicts or stories described by women with bulimic eating patterns? If so, do these differ from those of non-bulimics?

4. How do these young women view morality? Is there any difference between the groups?

Finally, after answering the above, the following questions will be addressed:

5. How do the answers to the above questions inform us about the etiology and maintenance of bulimia?

6. Are there themes in the voices of both women with bulimic eating patterns and non-bulimics in this age group that are important to note?

IV. RESULTS

The results of this study are organized according to the following groups of research questions and data analysis:

1. Analysis of demographic variables and BULIT results.
2. Analysis of care and justice voices in the narratives.
3. Analysis of vulnerabilities of care and justice and self care in the narratives.
4. Analysis of conflicts and other important themes in the narrative.

Quantitative and qualitative data will be used as appropriate to report the results.

Demographic Variables and BULIT Results

Demographic Variables. Two demographic variables were obtained from the bulimic and career development groups: age and year in school. Means, ranges, and standard deviation for the two variables are shown in Table 3.

Table 3
Demographic Characteristics

Age

Bulimic Subjects	Career Development Subjects	t	p
$\bar{x}$ = 23.917	$\bar{x}$ = 18.917	3.891	.003
range 19-33	range = 18-20		
S.D. = 4.52	S.D. = .866		

Year in School*

Bulimic Subjects	Career Development Subjects	t	p
$\bar{x}$ = 3.75	$\bar{x}$ = 1.167	9.940	<.001
range = 2-5	range = 1-2		
S.D. = .866	S.D. = 0.389		

*freshman = 1 senior = 4
sophomore = 2 master's = 5
junior = 3

The students from the career development class were significantly younger ($p<.01$) than the students drawn from bulimic population. The comparison group was also very consistent in age, ranging from 18-20 years, while the bulimic group ranged from 19-33. Not surprisingly, the career development sample was also significantly different ($p<.001$) in year in school from the bulimic sample, with all of them being either freshmen or sophomores while the bulimic sample ranged from sophomore to master's level. The significance of these differences is unclear. There have been no studies that have examined the stability of moral orientations across different ages. However, since moral development and development of self concept are age related, some impact can be expected.

BULIT. The mean, range and standard deviation for the BULIT for the two groups are shown in Table 4.

Table 4
Bulit Scores

Bulimic Subjects	Career Development Subjects	t	p
$\bar{x}$ = 114.833 range = 89-128 S.D. = 13.231	$\bar{x}$ = 50.167 range = 34-83 S.D. = 13.044	12.881	<.001

As expected, the bulimic sample's score on the BULIT was significantly higher than the comparison group's ($p<.001$). To eliminate the possibility of including a woman with an eating disorder in the comparison sample, all women in the career development group had to score below 88 to be included in the study. Although one woman was eliminated because she was previously anorexic, all others scored below the criterion. In order to minimize that therapy had achieved its goal in reducing bulimic behaviors

and changing associated ideation among those who volunteered for the bulimic sample, all those who scored below 88 were eliminated. Three volunteers for the bulimic sample scored below 88. One additional volunteer for the bulimic sample was dropped because of a malfunction in the taping of her interview.

The answers on several items on the BULIT emphasize the importance of appearance in young women today, even among those who do not have an eating disorder. Half of the women in the career development sample answered 3 or higher on a five point Likert scale (3=occasionally, 4=seldom and 5=never) that they were satisfied with the shape and size of their body. Likewise, half indicated that they hated the way their body looked after they ate too much (from frequently to always). Seven disagreed from a little to strongly that they were satisfied with their eating patterns, and seven also felt that when they try to keep from gaining weight they feel that they have to resort to vigorous exercise, strict dieting, fasting, self-induced vomiting, laxatives, or diuretics (from occasionally to always). One third of the comparison group agreed with the statements "I am obsessed about the size and shape of my body" and "I feel tormented by the idea I am fat or might gain weight" (from frequently to always) and a third also reported that "I eat a lot of food when I'm not even hungry' (from occasionally to frequently). These students did not reach criterion on the BULIT, and their answers underscore the prevalence of concern about appearance and diet even among young women who do not have an eating disorder.

Analysis of Moral Orientation

After completing the Worksheet (see appendix 6) for each subject, the reader filled out a Summary Coding Sheet (appendix 7). Agreement between the major researcher and the other readers for the eleven protocols read by two or more readers for the moral orientation variables on the Coding Sheets and the vulnerability and self care variables on the Worksheets is summarized on Table 5.

Table 5

Agreement between Major Researcher and Readers on Coding Dimensions, Vulnerabilities and Self Care

	Reader 1	Reader 2	Reader 3	Overall
Articulation	.80	1.00	1.00	.93
Predominance	1.00	1.00	1.00	1.00
Alignment	.80	.80	.80	.80
Frame	.80	1.00	1.00	.93
Vul. of Justice	.80	.60	.80	.73
Vul. of Care	.80	.80	1.00	.87
Self Care	1.00	1.00	1.00	1.00

Presence. The information from the coding sheets were translated into numerical values for ease in data collection and reporting. The numerical codes for identifying the articulation of the care and justice orientations in the narratives are:

	Justice Yes	Justice No
Care Yes	1	2
Care No	3	4

Information from the coding sheets was then analyzed by means of Chi Square contingency tables. The results are summarized in Tables 6-9.

Table 6

Frequency of Care and Justice Articulation for Career Development and Bulimic Samples

	1	2	3	4	
Career Development	10 (.83)*	1 (.08)	1 (.08)	0	12 (0)
Bulimic	10 (.83)	2 (.17)	0 (0)	0 (0)	12
	20	3	1	0	24

*Numbers in parentheses represent the percentage of the sample in that category.

Note. χ^2 (df=3, N = 24) = 1.333, p>.10

There was no significant difference between the two samples on articulation of the care and justice orientations; in fact, both samples were almost identical. Themes of both justice and care were articulated in the narratives of ten of the twelve subjects in both samples, with two subjects in each sample articulating only one orientation in their stories.

Predominance. Information about the predominance of the justice and care orientations in the narratives were coded numerically as indicated below:

A. Justice Predominant	1
B. Care Predominant	2
C. Neither Predominant	3

Table 7

Frequency of Predominance of Care and Justice Orientation for Career Development and Bulimic Samples

	1	2	3	
Career Development	2 (.17)	8 (.67)	2 (.17)	12
Bulimic	2 (.17)	8 (.67)	2 (.17)	12
	4	16	4	24

Note. χ^2(df=2, N = 24) = 0.00, p>.10

The two samples were identical in the distribution of the predominance of the care and justice orientations in their narratives. In two-thirds of the narratives the care orientation was predominant, while the other third had the justice orientation predominant or neither justice or care predominant.

Alignment. The numerical codes for identifying the alignment of self with the justice and care orientations in the narratives are listed below. Alignment is defined as "what orientation is central to, or of most importance to, self in the narrative".

A. Justice Alignment	1
B. Care Alignment	2
C. Aligned with Both	3

Table 8

Frequency of Alignment of Self with Justice and Care Orientation for Career Development and Bulimic Samples

	1	2	3	
Career Development	2 (.17)	8 (.67)	2 (.17)	12
Bulimic	0 (0)	7 (.58)	5 (.42)	12
	2	15	7	24

Note. χ^2(df=2, N = 24) = 3.35, p>.10

There is no significant difference between the career development and the bulimic samples. There is, however, a slight trend toward more of the bulimic sample having an alignment with both the justice and care orientations.

Organizing Framework. The numerical codes for the organizing framework for relationships are listed below. A subject is identified as having an attachment/detachment framework if she describes the relationship in terms that represents or emphasizes interdependence or connection between persons. She is identified as having an equality/inequality framework if she represents the relationship in terms of relative status or power, and she emphasizes the inherent inequality or power differential in the relationships. This section reveals how the woman thinks about relationships and what is emphasized in the context of a difficult and conflicting choice, or, in other words, what aspects of relationships become important to her when the chips are down.

FRAMEWORK FOR RELATIONSHIPS

A. Equality/Inequality	1
B. Attachment/Detach.	2
C. Both	3

Table 9

Frequency of Attachment/Detachment and Equality/Inequality Relational Frameworks for Career Development and Bulimic Samples

	1	2	3	
Career Development	0	6	6	12
	(0)	(.50)	(.50)	
Bulimic	0	5	7	12
	(0)	(.42)	(.58)	
	0	11	13	24

Note. χ^2(df=2, N = 24) = .168, p>.10

There is no significant difference between the career development sample and the bulimic sample. It is interesting to note, however, that all the women in both samples had an organizing framework that was based either on attachment/detachment or both attachment/detachment and equality/inequality. The importance of attachment to the women in these samples is demonstrated by what was at stake for the women in the career development sample in their dilemmas. The numbers before the statements are the subjects' four digit identification code, and the number in parenthesis is the page in the transcript where the expression occurs.

Expressions of What Was at Stake
Career Development Sample

1102 (3) Losing someone that, you know, to be there for me when I needed someone there, that sort of thing, and the fact that whether or not there would be someone else, you know, or ever, ever, that I thought I liked.

1101(5) I would let them down and I don't want to do that.

1113(3) Probably friendships...

1112(5) Well, if I did take the challenge and got caught, my mom would be terribly disappointed with me, and that, that would kill me...and by not taking it, I feel better about myself.

1111(3) I guess it was seeing her feeling bad, I think, but seeing her feeling bad, but if I told her it, also her feeling bad if I told her, but also her not knowing was hard, too, but she....

1110(9) Losing my family...I don't want that part of me torn away.

1108(7) I mean I actually could do something and it made me feel good that I could do that, you know.

1107(3&4) I just wanted, you know, to kind of just, just kind of, I guess, just, um, I don't know. [NO, GO AHEAD FINISH THAT THOUGHT] I just, just wanted, kind of, I guess, kind of, to prove to myself that I could do something that I really wanted to do and that I really thought was right, you know.

1106(6) Just the relationships, I guess, between us, was at stake.

1105(3) Losing friendships, I guess, and kind of losing touch with my family. But I guess mostly friendships and just the feeling of security of being near home. So I didn't want to leave that security.

1104(8) If no one says anything, if no one ever says anything, she'll probably just waste away.

1103(5) Probably just not making it, failing, working at MacDonald's for the rest of my life. I wouldn't be satisfied with it.

These women are at the launching stage of the family cycle, and the complexity of separating from the family while maintaining relationships echoes throughout the narratives. Even the choice of college is fraught with difficulty: Three of the dilemmas centered on whether to choose a college which allowed them to develop their autonomy and independence more easily, or to choose a college which allowed them to continue their present relationships with family and friends more easily. These dilemmas echo what Gilligan sees as a central dilemma for adolescent girls today: how to include

both self and others (Gilligan, Hamner, & Lyons, 1990); and research by Skoe and Marcia (1988) who found that a strong sense of self in college women was linked to the ability to solve problems of care in relationship while staying connected to both self and others.

Analysis of Moral Orientation Vulnerabilities and Self Care Vulnerabilities of the Care and Justice Orientations. Each orientation has potential difficulties which may prevent the self from solving the dilemma in a way which allows the resolution of the conflict, maintains relationships, and recognizes the importance of self. These vulnerabilities often signal conflicts which recur in the woman's life, conflicts which do not reach a satisfactory conclusion. The presence of one or more vulnerabilities of the care and justice orientation was noted on the worksheets. Vulnerabilities of the justice orientation were defined as:

a. The narrator mistakes a personal or traditional perspective or conventional standard for objective truth in solving the dilemma.

b. The narrator becomes vulnerable to exclusion, shutting out or becoming blind to the consequences of decisions in the service of justifying principles or standards.

c. The narrator loses sight of others or relationships with them in the search for justification or the right solution.

If there was at least one vulnerability of the justice orientation present the narrative scored a yes; if no vulnerability was present it scored a no. Results were analyzed by means of Chi Square contingency table. They are summarized below.

Table 10

Frequency of Vulnerability of Justice Orientation for Career Development and Bulimic Samples

	yes	no	
Career Development	2	10	12
	(.17)	(.83)	
Bulimic	6	6	12
	(.50)	(.50)	
	8	16	24

Note. χ^2(df=1, N = 24) = 3.0, p<.10

More women with bulimic eating patterns than career development subjects demonstrated a vulnerability of justice. While this difference approached significance at the .05 level, it did not reach significance. Statements which exemplify a justice vulnerability are listed below.

Examples of Justice Vulnerability Phrases

A woman who was trying to decide whether to commit to a relationship:
2102(3) It was like I would set up these text book scenarios and I would be expecting him to give me the right answer.
(4) And I guess I wanted to say if I'm going to jump into this and we are going to make plans together I want to know that you are going to fit those ideals.
(4) And I want it to be this way and I want it to be perfect. And I want a guarantee that it is going to be perfect and you can't do that.

A woman who had an unplanned pregnancy:
2302(3) And there, too, I would have brought the family's name down if they'd see me walking around pregnant. ...if I'd had a baby it would have affected me in one way, but it would have affected them so much greater in another way.
(5) My family's reputation I think. And my own reputation. Cause I'd heard what people had said with other girls that had gotten pregnant xxxx and what would the people over at school have thought and that whole thing. And also the guy that I was with over there, what people would have thought of him and his family.

A woman who was trying to decide to transfer to her boyfriend's school and thereby continue to have sex with him:
2304(4) They're gonna say, how much can I trust your standards or your--how much can I stand--how much can I trust what your word means in the future, your own self willpower.
(5) [AT STAKE WAS] My reputation, my own self-esteem, my own personal respect, cause I disrespect myself after. You know, knowing that I've let down--same with food, I disrespect myself again for not keeping discipline, knowing what's healthy, knowing the good and doing the bad.
(6) He's depending on me to put barriers and standards, and there are none....I have to show him I have decisive boundaries.

Vulnerabilities of the care orientation are defined as:

a. The narrator becomes paralyzed or unable to act because she understands or knows too much about the other or his/her circumstances, or because she cannot define a standpoint or ground from which to act.

b. The narrator cannot acknowledge that her action might hurt another person.

c. The self is left out or excluded. The person describes herself as self-sacrificing.

The results of the analyzation of the vulnerability of the care orientation are summarized in Table 11.

Table 11

Frequency of Vulnerability of Care Orientation for Career Development and Bulimic Samples

	yes	no	
Career Development	6 (.50)	6 (.50)	12
Bulimic	11 (.92)	1 (.08)	12
	17	7	24

Note. χ^2(df=1, N = 24) = 5.04, p<.05

Significantly more women with bulimia demonstrated one or more vulnerabilities of care in their moral dilemmas than did women from the career development class. Statements from the narratives which exemplify these vulnerabilities are listed below.

Examples of Care Vulnerability Phrases

A woman who was trying to decide whether to break-up with her boyfriend:
1102(1) I felt I deserved to be treated a lot better but I thought I liked him and so I didn't want to lose that.
(5) I kept thinking, I've seem him one way, I just know he can be that way. So, you know, he's not bad to me all the time.
(4) I pushed my friends away, and I wasn't really thinking about mine [feelings].

A woman deciding whether to tell a friend she saw her boyfriend with another woman:
1111(2) Well, if I should, if,.... It was hard to know whether to tell her or not because I didn't know if I, it, it was like, if I told her, she'd be hurt but if I didn't tell her, she wouldn't know and that's something that she should probably know about.
(3) Oh, yeah, I guess, it was seeing her feeling bad, I think, but seeing her feeling bad, but if I told her it, also her feeling bad if I told her, but also her not knowing was hard, too, but she....

A woman deciding whether to tell her parents her brother used drugs:
2306 (3) Um, probably because in my family my brother was very dominant, he's hyperactive, and he's very dominant, and I kind of was the one that just kind of blended in and got good grades and didn't cause any trouble, you know, and finally I was like stepping out into the spotlight and saying and kind of shaking the foundation.
(5)....I really wanted to help him, too, and I told my parents I wouldn't go to college if they had to pay for it out of their pockets.

A woman with an unplanned pregnancy:
2104(8) I think it was because I tend to see myself, or I have seen myself, from other people's perspective, and trying to please people has been very important to me, particularly within my family, trying to please my dad, and, and, you know, make my parents happy by doing well in school...
(9)....I've always wanted to please somebody else rather than pleasing myself. I never really considered whether I was pleased or not, that wasn't important, but I, the fact other people need to be made happy was really kind of in the forefront of my mind....

A woman deciding whether to live with her mom or dad:
2402 (3) And so ever since I was little I tried to make everyone happy so I wouldn't get left or people wouldn't think bad about me or be angry with me. And if you make everyone happy then that doesn't happen.
3) It was kind of hard because I knew I needed something for myself but I had to push that aside and try to figure out how to make everyone else happy with my decision because, you know, if everyone else is happy that's all that matters, you know.

It is interesting to note the difference in the type of vulnerabilities expressed by the career development and bulimic samples. Five of the women in the career development sample expressed the first type of care vulnerability, i.e., they were paralyzed because they understood the other's viewpoint, too well or because they could not define a standpoint from which to act. One woman from that sample described herself as self-sacrificing. Ten of the women in the bulimic sample, however, described themselves as self-sacrificing, while one could not acknowledge that her action might hurt another. The justice vulnerabilities expressed demonstrate a similar pattern for those in the bulimic sample, i.e., a principle is held to be more important than self.

A Chi Square analysis was performed to see if there was a significant difference between the two samples on the number of women who exhibited both the care and justice orientation vulnerabilities. The results are summarized below.

Table 12

Frequency of Both Care and Justice Orientation Vulnerabilities in the Career Development and Bulimic Samples

	yes	no	
Career Development	1 (.08)	11 (.92)	12
Bulimic	6 (.50)	6 (.50)	12
	7	17	24

Note. χ^2(df=1, N = 24) = 6.76, p<.05

Not surprisingly, significantly more women with bulimia demonstrated both vulnerabilities in their moral dilemmas.

Although the major theme of the vulnerabilities among the bulimic sample was one of self sacrifice, a minor theme occurred as well. This theme was related to the third justice vulnerability where the narrator loses sight of relationships in the search for the right solution, and the second care vulnerability, where the narrator cannot acknowledge that her actions may hurt another. It was sometimes phrased as the narrator not caring what happened to others, a repudiation of the pleasing others, self-sacrificing stance, and sometimes phrased as anger at others because the narrator felt that others expected them to please at the narrator's expense. A woman with bulimia who is deciding whether to stay home where it's safe or leave and go far away to college provides an example:

2201(3) I just knew, at the one hand I was so dependent on them, on the other hand I really hated them a lot, and they knew that I hated them, so I wanted to get out of there and I think that meant more to me.

(7) [HOW DID YOU FEEL ABOUT IT FOR YOUR FOLKS] Actually, I really didn't care. I was just, I really did not care. It didn't matter.

In other cases both self sacrifice and the reaction to self sacrifice are present.

A woman deciding whether to live with her mom or dad says:
2402(3) And so ever since I was little I tried to make everyone happy so I wouldn't get left or people wouldn't think bad about me or be angry with me. And if you make everyone happy then that doesn't happen.
Then later adds:
(7) [HOW DID YOU FEEL ABOUT IT FOR OTHERS?] Actually I really didn't care. I, I cared about my friends and that was basically about it...I didn't care about the family, I mean they were secondary.

A woman who is debating whether to tell her parents about her eating disorder so she can get the money to get help:
2105 (4) Again, because I'm their perfect little girl, I mean, I just don't want to wreck things.
(5) And I'm getting more and more mad at my parents.
(6) I mean, they [parents] really put a lot of pressure on me, and that's not fair.
(11) I think everybody should be like they are. Everybody should leave them alone.

Self Care. Evidence of self-care was also noted in the worksheets. Like the vulnerabilities, if self-care was present in the narratives it was marked as a yes, while absence of self-care was marked as a no. The results were analyzed using Chi Square contingency tables and are summarized below.

Table 13
Frequency of Self-Care in the Narratives of the Comparison and Bulimic Samples

	yes	no	
Career Development	11 (.92)	1 (.08)	12
Bulimic	9 (.75)	3 (.25)	12
	20	4	24

Note. χ^2(df=1, N = 24) = 1.2, p>.10

Considering that so many of the women in the bulimic sample describe themselves as self-sacrificing, it is surprising that there is no significant difference between the two groups on the self-care variable and that most women in both samples showed evidence of self-care. However, this is one area where the coding schema does not pick up the qualitative difference between the two samples. Listed below are the statements for the bulimic sample of what was at stake for them. Contrast these with the statements of what was at stake for the career development sample which were listed earlier as examples of the importance of attachment.

AT STAKE: BULIMIC SAMPLE

2102(6) Me. I can answer that one, I was at stake. My biggest fear was losing me and my independence and losing about how I feel about myself.

2302(4) I guess my whole identity was at stake and my unconscious, I guess.
(4) I guess it was my rejection, I guess.

2307(7) If I wouldn't have stood up for myself and been true to myself I would have been lying to myself and being caught up in using energy that would be stealing from my time and more important aspects of myself.

2402(2) It was trying to figure out what I needed and not being able to really get everything I needed in one place and have to try and choose, that was hard.

2401(4) Well, I mean, my education, my family....so I think there were a lot of things at stake, my whole life.
(5) Probably just my future.

2104 (14) ...this child represents for me, kind of, represented myself to me, and whether or not I was going to, to allow myself to grow and reach out and, and get some help....safe the way you are and, and, in your sort of protective state, in your cocoon, and you're going to stay that way and you're not going to risk anything.

2105 (7) And then, I guess, I won't look as perfect as everyone thinks my life is right now...I guess the mask's going to have to come down....that I'm going to have to do something about it.

2101 (13) Overall, our friendship was at stake in one aspect; the other way was getting into trouble with school and things like that.

2304 (2) The conflict is me maintaining my own standards of purity.
(4) I had said to myself...it hurts too much emotionally to let them run off and know they've used you and run off.

2201(6) My future and whether I'm going to take the first step or keep wimping out.

2306 (4) I would say the whole family structure was at stake.
(3) I was the one that just kind of blended in and got good grades and didn't really cause trouble, you know and finally I was like stepping out into the spotlight and saying and kind of shaking the foundations. It was kind of defiant.

2303(3) And then I kept thinking too, it's like, am I going to have to live with this and could I really get rid of something that was started, but I wasn't that far along.
(5) My family's reputation. And my own reputation..... And also the guy that I was with over there.

While more of the career development sample emphasized the importance of attachment and balancing others' needs with their own, much of what was at stake for the women in the bulimic sample was preservation of self, and balancing their needs against the needs and desires of others was emphasized. The women in the career development sample assumed self-care and focused on balancing that with the care of others. The women in the bulimic sample assumed care of others and focused on balancing that with care of self. Thus, even though the women with bulimia described themselves as self-sacrificing, their struggle for self-care often formed the heart of the moral dilemma they described.

Analysis of Conflicts and Other Important Themes

Conflicts. A short summary of the major conflicts expressed by both samples is shown below:

Summary of Conflicts

Career Development Sample

Whether or not to split up with boyfriend
Whether or not to tell a friend she saw her boyfriend with another
Need to help injured girl v. doubts about ability
Whether to change major and give up on childhood dream or stick it out despite misery and poor performance
Dad is buying her a house; should she trust original roommate agreements or find new roommates
Where to go to college
Stay at present college or transfer
Whether to intervene with a bulimic friend or not
Where to go to college
Not drink vs. risk friendships
Move out senior year of high school vs. risk being disowned
Whether to shoplift or not

Bulimic Sample

Leaving home vs. staying, being safe and dependent
Whether to commit to a relationship or not
Whether to tell her parents about brother's drug use or not
Whether or not to report roommate for selling drugs
Whether to have sex with boyfriend or not
Whether to have an abortion or not
Whether to have an abortion, carry baby to term and adopt, or carry to term and keep
Whether to tell parents about eating disorder in order to get money for treatment
Whether to get lost in a romantic fantasy or take responsibility for self
Whether to stay in CA with mom or move to Kansas with dad
Whether to have an abortion or not
Whether or not to have sex with every boy who asks

Compared to the career development group, the bulimic sample's conflicts appear to be more critical, i.e., three involved decisions about abortion, two about sex, and another two about a friend or family member's drug use. Again, while many of the conflicts of the women in the career development sample were focused outside of self, many of the conflicts expressed by the women with bulimia dealt with issues that were extremely critical to the self and self-preservation. Although this may be an artifact of

age, there is evidence that women with bulimic eating patterns put themselves at greater risk than non-eating disordered women (Root and Fallon, 1988), and that risk is reflected by the types of conflicts the women with bulimia had to resolve.

Relationship with father. Although there were no specific questions in the interview about family, family relationships were frequently a critical part of the moral dilemmas the subjects raised. Eight of the Career Development women and eleven of the women with bulimia brought up their families in the narrative. Among the women in the bulimic sample, a problematic relationship with both mother and father or father alone was a common theme. A Chi Square analysis of the differences between the two groups on this dimension is shown below.

Table 14

Frequency of Problematic Relationship with Father for Career Development and Bulimic Samples

	yes	no	
Career Development	1 (.08)	11 (.92)	12
Bulimic	9 (.75)	3 (.25)	12
	10	14	24

Note. χ^2(df=1, N = 24) = 10.97, p<.01

There were significantly more mentions of a problematic relationship with father or father and mother in the narratives of the bulimic sample than in

the narratives of the career development sample. Examples of statements about father, both good and bad, are listed below.

Father Exemplars

Career Development Sample
Positive Mentions of Father
1103 But it would cost a lot of money, it would be really hard on my parents, my parents are paying for it.

1101 I really don't want to let him feel that this isn't what I want.

1106 This is what my dad said, he didn't want me to leave, you know, cause I was his only girl and the youngest, and he just didn't want me to leave.

1113 Plus, well, another con would be that I'd have to live with my parents, but that's a pro, too, because I like my parents.

1105 I just felt like we need to keep that tied between us, so I wanted to be close to him.

Negative Mentions of Father
1110 ...and he would pretty much disown me. But I mean I wanted to get out of the situation so bad because it was just so hard for me, you know, dealing with school and problems and everything and then having to come home and argue with my dad over little things that happened and that didn't seem important to me.

Bulimic Sample
Positive Mentions of Father
2102 And they would have [been there for me] and I knew they would have been and they never would have turned around and said, I told you so, either, but it's, you could see it in their faces or something like...I don't know, it was just kinda weird. And a lot of it is maybe I'm just too sensitive or I read too much into it.

2101 Wanting to tell them, because I was upset. I usually like to tell my parents when I'm upset. They usually know. I wanted to talk about it to them but at the same time I didn't want to paint a bad picture of my friend.

Negative Mentions of Father
2201 I usually let my Dad make all my decisions for me, and I felt like if I stayed there that's what I would be doing. Depending on him, you know, the same old friends, same family, yeah. I would have been pretty pathetic.
(3) I just knew, at the one hand, I was so dependent on them, on the other hand I really hated them a lot, and they knew that I hated them, so I wanted to get out of there and I think that meant more to me.

2306 My dad, I knew, that, uh, he'd be very disappointed and he and my brother didn't have that much in common to begin with. Well, that was the first time that we went through with counseling and I just realize how much our family is dysfunctional. You know, we don't communicate a lot, don't show our feelings to each other.

2303 He's just doing what all he knows, he doesn't know better. He hasn't grown up in a home that, you know, you've got to share and share alike and consider others.

2104 ...trying to please people has been very important to me, especially within my family, trying to please my dad, and you know, make my parents happy by doing well in school...that mainly in a sense just to, uh, I guess keep them happy so that I wouldn't get into trouble or something (laughter), you know, that, so that the, um, so they wouldn't disapprove of me, or uhm, think that I wasn't worth their time or something.
I hadn't even mentioned it to them, because I knew they wouldn't think it, they wouldn't like the idea, but of keeping the baby, you know, and raising him myself, they were definitely against that, so, and we didn't even tell my dad.

2303 ...if I'd had a baby it would have affected me in one way, but it would have affected them [her parents] so much greater another way.
My dad still doesn't know about it but my brother and sister found out a bit later.

2105 And my dad would probably just flip out...And how, you know, he had the perfect family and now...

2307 I didn't develop, I don't think, a proper relationship with a male from my relationship with my father and my religious background.

2402 And they got divorced because my father didn't feel like he would be a good father and I guess it was my fault because it was when I was born.

2401 My dad doesn't know about it to this day...My brother knew first, then my mom, then my boyfriend. And then dad never knew.

The tenor of the family relationship is quite different for the two samples. When family is mentioned in the Career Development sample there is much more of a feeling of closeness and warmth, and often the women are concerned with pleasing their parents out of love. Even in the narrative of the woman who describes a problematic relationship with her father there is contact. It is characterized by frequent arguments, but the

woman decides to stay with her father because "family is important" and "even though we argue a lot, I know his love for me is still there".

In contrast, the relationship with the father among the women with bulimia is characterized not so much by argument and open conflict as by lack of communication and emotional distance. Among the three women who had unplanned pregnancies, not one father knew, even though everyone else in the family, including brothers, knew. The woman who decided to keep her baby chose not to tell her father even after she had her baby. Even among the two women who mention both their parents in a positive fashion, there is evidence that clear communication patterns do not exist, i.e., they both refer to inferred communication. Like the career development sample, the bulimic sample often mentioned the desire to please their parents, but the motivation seemed to be more to avoid rejection than out of love.

Views of Morality. Each subject was asked to define morality. A summary of their definitions is listed below.

MORAL PHRASES

Bulimic Sample

2102(8) And it is such an individual thing, that, that's really hard.

2201(7) Absolutely. It's totally individual.

2101(16) Sort of when, I think, when it potentially hurts someone or a lot of times when it goes against the beliefs I've grown up with, I guess.

2306(7) Um, I don't know, it's kind of like a personal code, I think, of what, um, gosh, society, society, like a rule, unwritten rules of society. It's your own personal feelings about, I don't know, those types of things.

2304 (9) To me moral keeps standards, you know. We'd all be animals, the inner bestiality would come out. So morality to me is a protective thing; it's healthy.

2303 (8) It's a moral issue just because I think it ties in everyone and the feelings. And like I said, you know, with religion like I know--cuz like in the Bible it says it's wrong and you shouldn't be doing that. But then it ties in the other part, too. I don't know.

2105 (8) A person's own judgment of right and wrong.

2302(6) It's a situation in which you would try to tell which is right or wrong, I guess. And if they're wrong -- I don't know, I guess it'd be right or wrong for you.....So I guess, right and wrong for yourself, how you feel about it yourself.

2307(8) What I believe is justifiable behavior that is based on what I believe are my principles for choosing right and wrong based on observation of what society says and what my family and religious background have said. Taking those, I like to synthesize them and listen to how I feel and what my mind tells me is right.

2402(9) I guess being moral is -- I want to say it's being yourself and doing what you would do, but I don't do that and I still consider myself moral....I guess doing something you know blatantly is wrong; I guess it's something like that.

2401(8) Well, I guess it's something that has to do with how you live your life, what you feel is right or wrong. So morality is going to be different for people.

Career Development Sample

1102(8) Doing things the right way for the right reasons and you know, your beliefs, your values, and having all that in mind when you're doing whatever it is. Doing it, doing it just because, not because you have to but because you think that that is right as far as who you are...I just have feelings of what's right and what's wrong from past experiences and just parents, and friends, and everybody.

1103(8) Basically stuff that's taken from, almost from society's view of everything, you know, how they see you and that's not morally right, you know, on big issues, personal issues.

1104(8) If the future of someone is at stake, like a person or an animal or even like the environment, like something happening to the environment. That's going to be our future, the future of the human race.

1105(5) Morals just seem to be a stereotype lesson of life. And values just seem to be more personal.

1106(10) Yeah, just dealing with your, just like the guidelines of your life. You know what I mean. The do's and the don'ts.

1107(7) I mean, each person has different ones. And I think it's kind of, you know, morals and stuff are kinda set by the environment you lived in or who you grew up with and stuff, and maybe where you lived kinda learned your morals from that.

1108(8) Well, when you think of morals, I think as what are my beliefs, what I feel strongly in. Well, probably religion, kind of religion problem.

1110(14)...my morals didn't really come into it, because it wasn't whether it was a right or wrong situ--it was a choice that I had to make, but I didn't feel like one thing was totally right and one thing was totally wrong, whereas I feel that with a moral problem you're kind of looking at, well God, is this right or is this wrong....Because I guess I describe it as morals, that a situation that I feel very strongly about, and that I feel I can never do just because I don't feel that that's right, you know, it's my set of morals.

1111(6) Doing the right thing. People have different morals so it's hard to distinguish between...Some people think one thing's right, some people think that it's wrong, so it's basically for yourself....I don't know, things are just right or wrong. I mean, it's what you learned to think before you learn it, they are right and wrong.

1112(9) Just what I believe is right or wrong, I guess. My opinions about certain issues and things like that, I guess.

1113(7) I would think of morality as something that's right for me. Is that kind of -- you know, my feelings about things?

1101(7) I guess what your beliefs are about situations.....If it involved more that just yourself; if it involves other people.

It was clear during the interviews that the women were not accustomed to thinking about morality and struggled to define it. There is, however, a different flavor to the definitions given by the career group and the bulimic group. The career group was much more likely to reflect a conventional level of moral development (Colby and Kohlberg, 1987), where things were just right or wrong according to society's or religion's rules. Interestingly, many of the women in the bulimic sample would have scored at the preconventional level, a level typified by an egocentric point of view while being aware that other individuals also have their own unique points of view. The

preconventional level is ranked lower than the conventional level in Kohlberg's hierarchy of moral development.

Language. The language used by the participants deserves special mention. In 1975 Robin Lakoff published the results of her research on women's language and concluded that women's language is weaker, more tentative and hesitant than men's (Margolis, 1988). Certainly the patterns noted by Lakoff were prevalent in the narratives. "You know", "kind of", "I don't know", "I guess", and other qualifiers peppered the stories told by these women. Gilligan holds that these words reflect the interpersonal world of young women that has been forced underground, a concern with a relational world that is subtle and complex (Gilligan, Lyons, & Hanmer, 1990). Some of the most egregious examples are listed below.

1107(3&4) I just wanted, you know, to kind of just, just kind of, I guess, just, um, I don't know. [NO, GO AHEAD FINISH THAT THOUGHT] I just, just wanted, kind of, I guess, kind of, to prove to myself that I could do something that I really wanted to do and that I really thought was right, you know.

1110 (9) Umm, having to, umm, tell my friends that there's nothing wrong when they could tell that, you know, there was, and having to, um, having to work through my problems while filling out college stuff, um, you know, trying to get through all my courses that were required, trying to, you know, deal with everything. ("You know" was used 95 times in this woman's narrative.)

2302(4) I guess it was my rejection I guess....And I just lose who I am to even have that happen, I guess. I guess my whole identity was at stake and my unconscious, I guess.

2104(13) Um, gosh, I think, um, in a way, it came down to what I, what I felt was my, I don't want to say soul, because it, it wasn't exactly the sense of a, a soul, but what I felt was like, my essence, my being, or something, that it came down to the fact of whether or not I was going to deny that I had a real, that I had strong feelings and desires and wishes in this particular case, you know, that I knew that they were there, and I knew that I wanted to do it, but was I going to do it, or was I going to, to shut off that part of myself and just say no, I'm going to do what I think everybody else wants me to do, and, you know, and terminate the pregnancy and do the right thing, quote, unquote, right thing, you know, as my parents, and who knows else, as I thought other

people would tell me to do, and, I think that it came down to for me, even if those outside pressures really weren't there, I thought they were, and that came down to deciding for me whether or not, I guess, and I kinda thought in a spiritual sense, too, that I felt that, that I was going to either open myself up to the possibility of, of, of, the o--or God, ...etc. (Sentence continues for another half of the page.)

V. DISCUSSION, SUMMARY AND RECOMMENDATIONS

This chapter includes a summary of the study and a discussion of the three questions posited in the introduction:

1. Is there a relationship between the voice of care and/or justice and self that is unique to women with bulimic eating patterns?

2. How does that unique relationship inform us about the etiology and maintenance of bulimia?

3. Are there themes in the voices of both women with bulimic eating patterns and non-bulimics in this age group that are important to note?

In addition, the overall implications and recommendations are discussed.

Major Research Questions

Important Themes. The recent literature on women's development has emphasized the central importance of relationships in women's lives and in their development of self-esteem (Miller, 1976, 1984; Gilligan et al, 1988, 1990). That importance was echoed throughout the narratives both of the career development and the bulimic samples. At adolescence, however, women are faced with a special challenge of inclusion: How to include both self and others. As Stern (1990) relates:

> If some sort of breaking away is a central concern of adolescence while connecting to others is a central concern for females, then we expect that for female adolescents, the conflict between these opposing tendencies will create a major existential dilemma. (p. 75)

The difficulty of adolescence for women is confirmed by the AAUW (1990) study which found a dramatic fall in self-esteem in high school girls from their fourth grade levels. The dilemma, however, is not independence and autonomy in direct opposition to caring and dependence, but rather how to blend the two so that the needs and rewards of both are realized. Maturity and independence involve,

then, the ability to reframe relationships in light of the consideration of others and of self.

The dilemmas of both samples reflected this struggle. The focus of the struggle, however, was different for the two groups. While the career development group described dilemmas that attempted to consider the needs and benefits to others while assuming the importance of self, the opposite was true for the bulimic group. For them, pleasing others was the important message carried from childhood, and the problem at adolescence became how to include self. This problem was so acute for the bulimic sample, in fact, that most of the women in that sample described what was at stake for them as preservation of self.

The language, while appearing to be hesitant and tentative, can also be interpreted as language of inclusion. The frequent use throughout the narratives of "you know", which is described by Gilligan (1990) as the "code of membership" to the world of young women, seemed to signal a desire by the participants to include the interviewer and to express the desire that she understand what was being related. "Kinda", "I guess", and "I don't know", other expressions which resonated throughout the narratives, seemed to reflect a desire not to exclude self by stating something too directly, an act which might cause disagreement.

As mentioned earlier, another theme important to note is the value placed on physical appearance and eating habits by the two groups. All of the bulimic sample and one third of the career development sample agreed with the statements that they were obsessed about the size and shape of their bodies and feel tormented by the idea they are fat or might gain weight.

Only five of the women in the career development sample were satisfied with their eating patterns and felt they did not have to use extreme methods to keep from gaining weight; none of the bulimic women felt that way. Only half of women who do not have an eating disorder felt like they were satisfied with the size and shape of their bodies most of the time, while no women with bulimia were satisfied with their bodies. It is clear that in our society physical appearance is an important dimension for self-acceptance for young women, and that many feel they fall short and must resort to rigid eating patterns and/or extreme measures to approximate the ideal.

The Voices of Justice and Care and Bulimia. Both the career development and the bulimic samples articulated the justice and care perspectives in equal numbers, and the pattern of predominance of either orientation and the organizing framework for relationships were the same for the two groups. While there was no significant difference between the two groups on alignment with self, there was a trend toward the women with bulimia to align themselves with both orientations more often than the comparison group, a result predicted by Steiner-Adair's 1987 study of eighth grade girls. The tension between the traditional and developmental values of connectedness and interdependence and the current societal values of autonomy and separation mentioned by Steiner-Adair (1987) and Gordon (1989) were present but were expressed in a different way, i.e., through the opposing tension caused by vulnerabilities of the care and justice orientations and the need for self care.

The difference between the career development sample and the bulimic sample approached significance on the expression of one or more vulnerabilities of justice, and the difference reached significance on the

expression of one or more care vulnerabilities and when both vulnerabilities were present. The women with bulimia clearly had beliefs that resulted in difficulty integrating the needs of self and others into a satisfactory solution. The major tenor of these beliefs differed from those vulnerabilities expressed by the career development women, and emphasized the importance of pleasing others or following the rules over consideration of the needs and desires of herself. Despite this, eleven out of the twelve women with eating disorders related that her self or some aspect of her self was at stake in the dilemma, and three of the women had a counter theme of not caring at all what happened to parents or anger over the expectation of pleasing them, which in two of the cases was still combined with the pleasing, self-sacrificing theme. The problem of including both self and others that becomes so acute at adolescence remains for these women. Because the self-sacrificing message of childhood is so strong, the push for autonomy and self-care that occurs at adolescence and is reinforced by our present cultural ideals results in conflict for the self, and the two are not successfully integrated. It is as though the importance of attending to her own needs and desires must be shouted to be heard above the din of pleasing others and self-sacrifice. The guilt and depression that is frequently seen in bulimia can be understood in this light. The bulimic feels guilty if she attends to her childhood imperatives but ignores her developmental and cultural imperatives, and she feels guilty if she attends to her developmental and cultural imperatives but ignores her childhood imperatives.

The women with bulimic eating patterns in the present sample developed different ways to cope with this no-win situation. Some, as noted before, denied caring about the effect of their behavior on parents. The most

common solution, however, was to put distance between herself and the source of the dilemma. The woman who had been acting promiscuously moved to a new school in a different state to start a new life. A woman whose roommate was selling drugs moved to a new school across the country. Several of the women in the sample chose colleges far away from their primary home. Another switched schools after an abortion. Their inability to deal directly with the conflict between self and other led them to chose escape, and their dilemma was solved without being resolved.

Family Relationships. The importance of the family in the etiology and maintenance of bulimia was reiterated by the present study. Even though the bulimic sample was older, more women from that sample mentioned family in their dilemmas than did women from the comparison group. What they said about their families was important as well. Significantly more women from the bulimic group mentioned a troubled relationship with their father or their father and mother than did the career development women. This study confirmed Boskind-White and White's (1983) contention that lack of intimacy with their fathers was an important component in bulimia. The lack of intimacy appeared to create some interesting dynamics within the family structure. Lacey (1985) remarks that bulimic patients often find themselves allied with their mothers who burden them with parental anxieties. A similar pattern was mentioned by several of the women in this study; however, the mother and daughter in these cases seemed to be allied to exclude the father from information that might be upsetting to him. Another common theme among the bulimic sample was the fear that not pleasing the father would lead to their rejection by him, and so pleasing him, or at the very least, not letting him know about behaviors or situations that did not please him,

became very important. These two dynamics led to disturbed communication patterns in the families, particularly communication with the father, which was not open or direct.

The role of the father in the family differs from that of the mother in the family, and the security of attachment to the father is unrelated to the security of the attachment to the mother (Hartup, 1989). While it is more common for the mother to be the main caregiver in the family, the father often controls the recreational, intellectual and disciplinary aspects of family life, and is more task-oriented. In other words, while the mother provides the center connection point of the family, the father provides the opportunities to explore the boundaries and sets limits to that exploration. The disturbed relationship with the father, then, may at least partly explain the egocentricism of bulimic sample's definitions of morality. Without a safe relationship with the father through which to explore the world outside her family, the young woman fails to develop rules outside of herself on which to base her decisions. She is thus left to decide according to her own feelings. This is particularly dangerous for women who believe so strongly they must please others. Skilled at reading non-verbal as well as verbal cues to decipher what might make another happy, it becomes difficult to separate one's own feelings from the other person's feelings. As one bulimic reports:

2102(3) I'll call home and my mom will be a little upset about, well, not upset about something but I'll tell her about something and she'll kind of get that tone in her voice like xxx, you know, like she is kind of disappointed a little or upset about it. And it will affect my mood for the rest of the night.

Without firm external guidelines and with feelings so responsive to others, the bulimic is vulnerable to situations which may be dangerous or result in great conflict.

One arena where this manifested itself with the present sample was sex. Three of the twelve women had experienced unplanned and unwanted pregnancies, one was troubled by her promiscuous behavior, and one was concerned about how to control the sexual relationship with her boyfriend since she didn't believe in premarital sex. It has long been established that young men and young women approach sexual choices differently, and that even with today's mores of greater sexual permissiveness, attachment and relationships are of pivotal importance in young women's sexual behavior (Bollerud, Christopherson & Frank, 1990). Salzman (1990) holds that where attachment has proven to be an unsatisfying source of nurturance, young women may use sexual involvements as a substitute. As the woman concerned about her indiscriminate sexual behavior states:

2302(2) And so that was like the big problem and I think cause I was just doing it for the wrong reasons, it wasn't out of love, it was -- well, I wanted love but that isn't the right kind of love that I wanted. It never satisfied me, it was just never ending.

This longing for attachment combined with the absence of firm moral boundaries may help explain why women with bulimic eating patterns are frequently victimized (Root and Fallon, 1988). In their longing for attachment and with their beliefs about pleasing others, they are easy targets for those who would take advantage of them. Unskilled at expressing their own feelings in situations, they have not developed the skills to help them evaluate and extricate themselves from potentially dangerous or harmful situations.

The Etiology and Maintenance of Bulimia Revisited. A secure attachment to parents has been found to be critical for the healthy emotional development of children. Hartup (1989) concludes that good socialization outcomes

depend more on a stable relationship with the primary caretakers than on friendship relationships. John Bowlby (1980) has hypothesized that when the child's early attachments to parents are disturbed, the child "edits out" certain feelings that might threaten the attachment, feelings such as anger or neediness. When a child suffers a major loss, the manifestations of the anxious attachment are particularly obvious. Bowlby (1980) has identified three particular manifestations of this anxious attachment: 1. anxious, ambivalent dependence, characterized by a combination of longing, fear, and anger; 2. compulsive caregiving, characterized by the child's insistence on taking care of a fragile, bereaved parent and denying his or her own wishes for care; and 3. false self-sufficiency, characterized by avoidance of caregivers and insistence on an exaggerated independent stance.

Salzman, in her 1990 study of girls with problematic parental attachments at the Emma Willard school, has modified Bowlby's model to better fit the stuggles of inclusion of self and others she found in young girls. The three coping styles she reports include: 1. Role reversal, similar to Bowlby's compulsive caretaking and characterized by women judging themselves harshly while extending extreme compassion toward others; 2. Hostile avoidant, similar to Bowlby's false self-sufficiency and characterized by a strongly self-protective stance that tends to ignore the claims of others; and 3. transformation, a healthy integration of the needs of self and others beyond anxious attachment that has no correlate in Bowlby's schema. Salzman's paradigm is useful for understanding some of the contradicting tendencies seen in bulimia.

There is strong evidence from the present research and other studies that the parental attachment for women with bulimic eating patterns is

impaired. These difficulties are compounded by family dynamics that include impaired communication and lack of opportunities for expression of feelings and conflict resolution. The effect is to deny the young girl the chance to resolve differences between self and others in a constructive manner, and coping styles which sacrifice the needs of the self or denigrate the effect on others develop. When adolescence is reached, and the young woman must master the task of integrating the needs of self and others, she has not developed the necessary skills or knowledge to do so and is unprepared for the task. Among the women with bulimia in this study, both an exaggerated concern for others and an exaggerated concern for self was evident, and their dilemmas presented either/or situations: Either I please others at the expense of self or I preserve myself. Unlike the young women in Salzman's (1990) study who tended to use one coping style or the other, several women in the present study indicated that they used both styles at different times.

At adolescence, the problem of including self and others becomes particularly acute. The problem may be compounded by loss. Pyle, Mitchell and Eckert (1981) found that 88% of their sample of women with bulimic eating patterns attributed the onset of bulimic behavior to a traumatic loss or separation from a significant person in their lives. Seeking attachment but unable to solve the dilemmas of connection, the young woman seeks a way to belong. The message to young women today is that to belong, you must be thin and eat right. Thinness fulfills two functions: it pleases others and it provides the image of self-sufficiency, both important to the coping styles of women with bulimic eating patterns. Striving for thinness and "eating right" also gives the young woman the feeling of control in a life that otherwise feels out of control.

But the goals set by the woman with bulimia are unrealistic. She may not be genetically programmed to have the perfect thin body, and/or she may have set her diet goals too stringently, and even if she attains what others may consider the 'right' look, she cannot accept it because it does not result in the desired connection. Failure implies isolation, so the young woman, anxious to belong, is willing to try any behavior that will keep her safely within the bounds of cultural expectation. Binging is a natural result of the constant restraint of eating (Polivy & Herman, 1987), and purging, she believes, will protect her from gaining weight. The binge/purge cycle begins.

As the disorder evolves, the binge/purge cycle undoubtedly fulfills other physiological and psychological purposes that contribute to its addictiveness. The obsessive pursuit of thinness, one of the markers of bulimia, continues, promising connection through pleasing others, particularly men, and the image of self-sufficiency. However, while the bulimic may develop good social skills and have many friends, her relationships lack the intimacy she both desires and fears (Boskind-White & White, 1983). Unable to attain her goals, depression often ensues.

The narrative of one of the women in the bulimic sample did indicate that she may have developed Salzman's (1990) transformation coping style. Interestingly, she was the oldest participant in the study, and although her score on the BULIT-R, which asked about behavior over the past 3 months, still qualified her to participate, she had not binged or purged recently and felt like she no longer would. She was the one woman from the bulimic sample who did not demonstrate a vulnerability of care. In her dilemma, she deals directly with a married professor who she feels is flirting

with her. When asked if how she handled it now was different from how she would have handled it when her eating disorder was active she replies:

2307(6) Yes, I think my response would have been different. But I would have gone and eaten over it rather than dealt with it. That would have been my way out. And I wouldn't have known what to say, I would have thought it was my fault that he was giving me this attention. And I probably would have tried to get his attention, but I wouldn't have known I was. Because I like to have male attention, but appropriate male attention.

Implications for Therapy

As frequently occurs, theory lags behind practice. Most of what will be suggested below has been suggested by a therapist specializing in eating disorders at one time or another. However, the purpose of the following section is to tie in some key therapeutic issues with the present research.

Family Issues. Although many women with bulimic eating patterns no longer live with their parents by the time they enter therapy, family issues are still critical to them and should be addressed in therapy. If possible, family therapy sessions should be included along with individual and group sessions (Schwartz, 1987). If not, including family issues, particularly issues about the relationship with the father, are important components of therapy. Boskind-White and White (1983) and Lacey (1985) suggest having male and female cotherapists for some group sessions to facilitate the process of confronting family messages and dynamics.

Transference Issues. Bulimic women often have an approach-avoidance conflict about therapy and the therapist. While they may want desperately to break binge/purge cycle, they are afraid if they do they will gain weight and thus be isolated. Likewise, while the therapist is often viewed as a powerful person who can tell them how to get out of their dilemma, they fear rejection and so utilize their usual coping mechanisms, pleasing the therapist or

escaping from what they perceive are the demands of the therapist to reveal themselves and change their behavior. The picture the therapist gets is often one of ambivalence. After what feels like a particularly productive session, the bulimic client may not show up for the next session, or she may have an irregular pattern of compliance.

Two approaches may help reduce this apparent ambivalence. One is to predict the response to the client, therefore putting her feelings about the therapist in perspective with everything else that is happening. This approach assists in reducing the client's guilt both about not getting better immediately and about wanting to avoid therapy.

Another method is to reduce the intensity of the psychotherapeutic alliance by utilizing a psychoeducational group approach. This format has been a very popular therapeutic modality in recent years because it accomplishes several goals. Besides reducing the intensity of the transference, it gives the woman some structure, offers her realistic information to help counteract some of the more harmful socio-cultural messages about appearance and diet, helps her identify and challenge some of her beliefs and thinking patterns that contribute to her disorder, and provides concrete ways to break the binge/purge cycle. The group format also lets the bulimic know she is not alone. Many women, however, are reluctant to commit to a group since they fear they must appear self-sufficient and take care of all members in the group. This dynamic is one that surfaces frequently in eating disorder groups and must be addressed by the therapist.

Multimodal Approach. In general, treatment of bulimia takes a long time on an out-patient basis (Schwartz, Barrett, & Saba, 1985). This makes sense, considering its roots are in early childhood. However, the trend today,

particularly among college and university counseling centers, is toward shorter, time-limited therapy, particularly individual therapy. A multimodal approach not only alleviates the pressure on individual therapy, but gives the client many resources for addressing the different factors that contribute to bulimia. A multimodal approach would include medical support, individual and group counseling, family therapy if possible, and continuing self-help or support groups.

Since bulimia has potentially lethal effects on the body, medical support is important to follow the physical well-being of the client. In addition, a doctor with experience in prescribing psychotrophic medications can help evaluate if anti-depressants are advisable.

Individual and group therapy can work in tandem with each other. Individual therapy can introduce and prepare the client for group therapy, and help the client explore some of her particular relationship issues and coping styles, while group can provide information and give the client a chance to connect with other women like her. If family therapy is impossible or unavailable, family issues can also be addressed through group and individual sessions.

Finally, some on-going type of support group helps prevent relapse and gives the bulimic a chance to continue to explore intimacy and connectedness in a new way. Some caution must be exercised, and it is often good for the therapist to have periodic 'check-ups' with the client to monitor the efficacy of these groups.

Suggested Areas for Research

This study was a beginning look at the importance of the self-in-relation developmental theories in the etiology and maintenance of bulimia.

More work on a wider scale is needed, particularly among women who have experienced bulimia for long periods of time. Although there have been many studies of bulimia, few, if any, have been longitudinal. Using the Eating Attitudes Test, Steiner-Adair (1985) was able to identify adolescents in the seventh and eighth grade who had attitudes congruent with eating disorders. Following young women thus identified over 10 years would help identify what factors were particularly crucial in why some develop bulimia and some do not.

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VII. APPENDICES

APPENDIX 1
Demographic Sheet

NAME_____ RESEARCH #_____

BIRTHDATE _____ COLLEGE MAJOR _____

YEAR IN SCHOOL_____EXPECTED GRADUATION DATE _____

ADDRESS _____

_____

PHONE # _____

APPENDIX 2

Informed Consent

Dear Student,

I am a doctoral student working on my dissertation. I am looking for women who are willing to be interviewed to help me with my research. I invite you to participate on a voluntary basis. Your participation, or lack thereof, will in no way affect the grade in this class, and you can withdraw from the study at any time without penalty. Participation in the project would take about an hour to an hour and a half and would include the following:

1. Completion of this form.

2. An interview which will involve answering questions about different situations in your life and you thoughts and reactions to those situations. I am truly interested in what you have to say.

3. Agreeing to have the interview audiotaped. Your name will not be used to identify the tape and you will not be referred to by name during taping to ensure complete confidentiality.

4. Completion of a short, 36 item inventory.

5. Completion of a brief information sheet.

The taped interview and the inventory will be identified by number only. I will need your name on this form so I can contact you and on the information sheet in case something happens that interferes with a clear recording and I need to contact you again. The sheets with your name will be shredded when this research is completed and the tape will be erased. Until then, they will be kept completely confidential and identifying sheets will be kept separate from the tape and the inventory.

The interview will give you a chance to reflect on situations in your life and some choices you have made. Participants generally find that this reflection results in some useful insights. There is a remote chance that your insights might be unsettling and you may find that you wish to explore them in greater depth. If you do, I will be happy to help schedule you with a counselor so you may do so.

The results of this study will be published and available in the OSU library under my name when my dissertation is finished, hopeful by next fall. Thank you for taking the time to consider this request. I greatly appreciate it!

Researcher: Candice Wiggum, M.A.
Ph.D. Candidate, Dept. of Counseling

I have read the above description and agree to participate in the study.

Signature _____

Name (please print)_____

Phone_____(If no phone, please put address)

Address (optional)_____

APPENDIX 3

Moral Conflict and Choice Interview

MORAL CONFLICT AND CHOICE (Plan about 25-30 minutes)

All people have had the experience of being in a situation where they had to make a decision, but weren't sure of what they should do. Would you describe a situation when you faced a moral conflict and you had to make a decision, but weren't sure what you should do?

1. What was the situation? (Be sure you get a full elaboration of the story). About how long ago did this happen?

2. What was the conflict for you in that situation? Why? Anything else you considered?

3. In thinking about what to do, what did you consider? Why? Anything else you considered?

4. What did you decide to do? What happened?

5. Do you think it was the right thing to do? Why/why not?

6. What was at stake for you in this dilemma? What was at stake for others? In general, what was at stake?

7. How did you feel about it? How did you feel about it for the other(s) involved?

8. Is there another way to see the problem (other than the way you described it)?

9. When you think back over the conflict you described, do you think you learned anything from it?

10. Do you consider the situation you described a moral problem? Why/why not?

11. What does morality mean to you? What makes something a moral problem for you?

APPENDIX 4

Complete Interview

I. Introduction

II. Describe yourself to yourself. (Plan 10 minutes)

How would you describe yourself to yourself? (If needed: So that if you were going to play this tape again, you'd say, "Yeah, that's me.")

Is the way you describe yourself now different from the way you saw yourself in the past, say a year or two ago? (Have you been the same all the way along?) How?

What led to the change? (How come?)

Has your experience at the University changed the way you think about yourself? In what way?

III. MORAL CONFLICT AND CHOICE (Plan about 25-30 minutes)

Transition: We've been talking about how you would describe yourself and how you've changed. Now I'd like to ask you about a choice you've made.

All people have had the experience of being in a situation where they had to make a decision, but weren't sure of what they should do. Would you describe a situation when you faced a moral conflict and you had to make a decision, but weren't sure what you should do?

1. What was the situation? (Be sure you get a full elaboration of the story). About how long ago did this happen?

2. What was the conflict for you in that situation? Why was it a conflict?

3. In thinking about what to do, what did you consider? Why? Anything else you considered?

4. What did you decide to do? What happened?

5. Do you think it was the right thing to do? Why/why not?

6. What was at stake for you in this dilemma? What was at stake for others? In general, what was at stake?

7. How did you feel about it? How did you feel about it for the other(s) involved?

8. Is there another way to see the problem (other than the way you described it?)

9. When you think back over the conflict you described,do you think you learned anything from it?

10. What does morality mean to you? What makes something a moral problem for you?

III. UNFAIRNESS/NOT LISTENING/SELF-SILENCING (plan 15 mins.)

Transition We've been talking about a conflict you've experienced and about morality. Now I'd like to ask you about some other situations in your life.

1. Can you tell me about a situation where something happened that you thought was unfair? What was unfair about it?

2. What would have been the fair thing to do? Why?

3. What did you do or say, if anything? Why/why not?

4. Is there anything that could have been done about this situation?

5. Do you wish you had spoken up, or are you glad you didn't? Why?

6. Can you tell me about a situation where you thought you (or someone else) were not being listened to? How did you know?

7. Why weren't you being listened to?

8. Why do you think _____ didn't listen?

9. What do you think should have happened?

10. How could that have happened?

11. Can you tell me about a situation where you wanted to say something, or felt you should say something, but didn't?

12. Do you wish you had spoken up or are you glad you didn't?

IV. HURTING OTHERS

In this part of the interview, I'd like to shift the focus a little.

1. Has there ever been a time when a decision you made hurt another person? Can you tell me about that?

2. How did that person react to you? How did you react to that person?

3. Are you satisfied with your decision? Why/why not?

4. What was at stake for you in this situation? for the other person?

5. If a situation like that came up again, would you make the same decision? Why/why not?

V. REFLECTIONS ON BEING INTERVIEWED (about 10 minutes)

1. Before we began, did you have any ideas about what the interview was going to be about? How did the actual interview compare to your expectations?

2. Describe for me the experience of being interviewed today?

3. Do you think being interviewed has had any affect on you? In what ways?

APPENDIX 5

The BULIT-R

Answer each question by filling in the appropriate circle on the computer answer sheet. Please respond to each item as honestly as possible; remember all of the information you provide will be kept strictly confidential.

1. I am satisfied with my eating patterns.

    1. agree
    2. neutral
    3. disagree a little
    4. disagree
    5. disagree strongly

2. Would you presently consider yourself a "binge eater"?

    1. yes, absolutely
    2. yes
    3. yes, probably
    4. yes, possibly
    5. no, probably not

3. Do you feel you have control over the amount of food you consume?

    1. most or all of the time
    2. a lot of the time
    3. occasionally
    4. rarely
    5. never

4. I am satisfied with the shape and size of my body.

    1. frequently or always
    2. sometimes
    3. occasionally
    4. rarely
    5. seldom or never

5. When I feel that my eating behavior is out of control, I try to take rather extreme measures to get back on course (strict dieting, fasting, laxatives, diuretics, self-induced vomiting, or vigorous exercise).

    1. always
    2. almost always
    3. frequently
    4. sometimes
    5. never or my eating behavior is never out of control

6. I use laxatives or suppositories to help control my weight.

    1. once a day or more
    2. 3-6 times a week
    3. once or twice a week
    4. 2-3 times a month
    5. once a month or less (or never)

7. I am obsessed about the size and shape of my body.

    1. always
    2. almost always
    3. frequently
    4. sometimes
    5. seldom or never

8. There are times when I rapidly eat a very large amount of food.

    1. more than twice a week
    2. twice a week
    3. once a week
    4. 2-3 times a month
    5. once a month or less (or never)

9. How long have you been binge eating (eating uncontrollable to the point of stuffing yourself)?

    1. not applicable; I don't binge eat
    2. less than 3 months
    3. 3 months - 1 year
    4. 1 - 3 years
    5. 3 or more years

10. Most people I know would be amazed if they knew how much food I can consume at one sitting.

    1. without a doubt
    2. very probably
    3. probably
    4. possibly
    5. no

11. I exercise in order to burn calories.

    1. more than 2 hours per day
    2. about 2 hours per day
    3. more than 1 but less than 2 hours per day
    4. one hour or less per day
    5. I exercise but not to burn calories or I don't exercise

12. Compared with women your age, how preoccupied are you about your weight and body shape?

1. a great deal more than average
2. much more than average
3. more than average
4. a little more that average
5. average or less than average

13. I am afraid to eat anything for fear that I won't be able to stop.

1. always
2. almost always
3. frequently
4. sometimes
5. seldom or never

14. I feel tormented by the idea that I am fat or might gain weight.

1. always
2. almost always
3. frequently
4. sometimes
5. seldom or never

15. How often do you intentionally vomit after eating?

1. 2 or more times a week
2. once a week
3. 2-3 times a month
4. once a month
5. less than once a month or never

16. I eat a lot of food when I'm not even hungry.

1. very frequently
2. frequently
3. occasionally
4. sometimes
5. seldom or never

17. My eating patterns are different from the eating patterns of most people.

1. always
2. almost always
3. frequently
4. sometimes
5. seldom or never

18. After I binge eat I turn to one of several strict methods to try to keep from gaining weight (vigorous exercise, strict dieting, fasting, self-induced vomiting, laxatives, or diuretics).

1. never or I don't binge eat
2. rarely
3. occasionally
4. a lot of the time
5. most or all of the time

19. I have tried to lose weight by fasting or going on strict dieting.

1. not in the past year
2. once in the past year
3. 2-3 times in the past year
4. 4-5 times in the past year
5. more than 5 times in the past year

20. I exercise vigorously and for long periods of time in order to burn calories.

1. average or less than average
2. a little more than average
3. more than average
4. much more than average
5. a great deal more than average

21. When engaged in an eating binge, I tend to eat foods that are high in carbohydrates (sweets and starches).

1. always
2. almost always
3. frequently
4. sometimes
5. seldom, or I don't binge

22. Compared to most people, my ability to control my eating behavior seems to be:

1. greater than others' ability
2. about the same
3. less
4. much less
5. I have absolutely no control

23. I would presently label myself a 'compulsive eater', (one who engages in episodes of uncontrolled eating.

1. absolutely
2. yes
3. yes, probably
4. yes, possibly
5. no, probably not

24. I hat the way my body looks after I eat too much.

1. seldom or never
2. sometimes
3. frequently
4. almost always
5. always

25. When I am trying to keep from gaining weight, I feel that I have to resort to vigorous exercise, strict dieting, fasting, self-induced vomiting, laxatives, or diuretics.

1. never
2. rarely
3. occasionally
4. a lot of the time
5. most of the time

26. Do you believe that it is easier for you to vomit than it is for most people?

1. yes, it's no problem at all for me
2. yes, it's easier
3. yes, it's a little easier
4. about the same
5. no, it's less easy

27. I use diuretics (water pills) to help control my weight.

1. never
2. seldom
3. sometimes
4. frequently
5. very frequently

28. I feel that food controls my life.

1. always
2. almost always
3. frequently
4. sometimes
5. seldom or never

29. I try to control my weight by eating little or no food for a day or longer.

1. never
2. seldom
3. sometimes
4. frequently
5. very frequently

30. When consuming a large quantity of food, at what rate of speed do you usually eat?

1. more rapidly than most people have ever eaten in their lives
2. a lot more rapidly than most people
3. a little more rapidly than most people
4. about the same rate as most people
5. more slowly than most people (or not applicable)

31. I use laxatives or suppositories to help control my weight.

1. never
2. seldom
3. sometimes
4. frequently
5. very frequently

32. Right after I binge eat I feel:

1. so fat and bloated I can't stand it
2. extremely fat
3. fat
4. a little fat
5. OK about how my body looks or I never binge eat

33. Compared to other people of my sex, my ability to always feel in control of how much I eat is:

1. about the same or greater
2. a little less
3. less
4. much less
5. a great deal less

34. In the last 3 months, on the average how often did you binge eat (eat uncontrollable to the point of stuffing yourself)?

1. once a month or less (or never)
2. 2-3 times a month
3. once a week
4. twice a week
5. more than twice a week

35. Most people I know would be surprised at how fat I look after I eat a lot of food.

1. yes, definitely
2. yes
3. yes, probably
4. yes, possibly
5. no, probably not or I never eat a lot of food

36. I use diuretics (water pills) to control my weight.

1. 3 times a week or more
2. once or twice a week
3. 2-3 times a month
4. once a month
5. never

APPENDIX 6

Work Sheets

I. FIRST READING - UNDERSTANDING THE STORY

A. Please Make Notes Here on the First Reading - e.g., relationships, general moral language, repeated words and themes, contradictions, and key images and metaphors. Include here your reactions to story and narrator that might influence your interpretations.

Interpretation

B. Note All Stories and Conflicts in Stories in the section of the interview entitled "Moral Conflict and Choice" (please cite page numbers where found).

Interpretation

Summary Interpretation - Conflict(s)

II. SECOND READING - SELF

A. Self and the Narrative of Action - What actions does self take in the conflict?

1. Choosing self - Does the narrator see or describe a choice? What is the choice? How is the choice made? — Interpretation

2. What is self describing him/herself as saying and/or doing? — Interpretation

3. What is self thinking or considering or feeling? Interpretation

B. Self in Relationship

1. What is the organizing frame for the relationship(s) described in the conflict? Interpretation

C. What is at Stake for Self? Interpretation

Summary Interpretation - Reading for Self

III. THIRD READING - JUSTICE

A. Is the Justice Orientation Articulated?

--What evidence do you have? Does the narrator reject or disclaim the justice orientation? Interpretation

B. Does the narrator show any of the vulnerabilities of the justice orientation? How?

Summary Interpretation - Justice Voice

C. If Justice is Not (Clearly) Articulated?

--What would constitute justice in this conflict? Interpretation

D. Does Self Align with Justice? How do you know?

--Is the alignment explicit or implicit? What evidence do you have? Interpretation

Summary Interpretation - Self and Justice Voice

IV. FOURTH READING - CARE

A. Is the Care Voice Articulated?

--What evidence do you have? Does the narrator reject or disclaim the care perspective? Interpretation

B. Does the narrator show any of the vulnerabilities of the care orientation? How?

C. Is there evidence of self-care? What?

Summary Interpretation - Care Voice

D. If Care is Not (Clearly) Articulated?

--What would constitute care in this conflict? Interpretation

E. Does Self Align with Care? How do you know?

--Is the alignment explicit or implicit? What evidence do you have? Interpretation

Summary Interpretation - Self and Care Voice

V. BOTH JUSTICE AND CARE - SUMMARY INTERPRETATIONS

A. The Relationship Between Moral Orientations: Summary Interpretation

B. Alignment of Self with Moral Orientation: Summary Interpretation

--How would you characterize the relationship between self and moral voice in this interview-narrative?

SELF IN RELATION TO CARE AND JUSTICE: OVERALL SUMMARY INTERPRETATION

APPENDIX 7
Summary Coding Sheets

Case # _____ Reader _____ Narrative Type _____

I. The two moral orientations and how they are represented:
   1. Is the justice orientations articulated? Yes _____ No _____

   2. Is the care orientation articulated? Yes _____ No _____

II. The relationship between the two moral orientations: (check one)
   1. Justice predominates _____

   2. Care predominates _____

   3. Both justice and care present, neither predominates _____

III. The narrative self:

   1. Does the narrative self express an "alignment" in the conflict? (What orientation is central to, or of most importance to, self in the narrative? What types of issues are at stake for the narrator? Finally, this "alignment" can be determined by the narrative self rejecting the values of another.)

      Yes _____ No _____

   2. What terms/orientation does the narrator use to frame this "alignment" in the conflict?

      Justice _____ Care _____ Both _____

IV. Relationships

   1. What is the organizing frame for the relationships described in the conflict?

      inequality/equality _____
      attachment/detachment _____
      both _____
      neither _____