Emotional abuse and eating disorders.

Leponis, Annette Frances

EMOTIONAL ABUSE AND EATING DISORDERS

By

Annette Frances Leponis

Thesis submitted to the University of Wales for the degree of Doctor of Philosophy

August 2004

Department of Psychology

University of Wales, Swansea

ProQuest LLC.
789 East Eisenhower Parkway
P.O. Box 1346
Ann Arbor, MI 48106 – 1346


LIBRARY

Declaration

This work has not previously been accepted in substance for any degree and is not being concurrently submitted in candidature for any degree.

Signed .... (Candidate)

Date .....27/08/04.....

STATEMENT 1

This thesis is the result of my own investigations, except where otherwise stated. Other sources are acknowledged by footnotes giving explicit references. A bibliography is appended.

Signed .... (Candidate)

Date .....27/08/04.....

STATEMENT 2

I hereby give consent for my thesis, if accepted, to be available for photocopying and for inter-library loan, and for the title and summary to be made available to outside organisations.

Signed .... (Candidate)

Date .....27/08/04.....

Acknowledgements

First and foremost an enormous thank you goes to my supervisor Prof. David Benton for his unwavering belief that I could do a PhD. Thank you for all your (often quite bad) jokes and motivational pep talks that have kept me going when I thought I was never going to reach the end, and when I thought my brain was going to fall out of my head. Thank you also to Dr. Stephen Edwards for his supervision.

I would also like to say very special thanks to the rock star in my life, Darren (Razzle Dazzle) James without whom I might have cracked up a long time ago. Thank you for buying me flowers and chocolate and listening to me moan when I was (quite often) having 'PhD blues'. Thank you for feigning interest in my research (most of the time), endless pep talks, support and renditions of 'Moley, Moley' which always cheered me up.

Thanks to all my close friends: Madeleine, for indulging my passion for very bad chick flicks. Amy, my long suffering housemate who patiently listened to every twist and turn of my research and always looked interested, even on the very boring bits: Charlotte, for also believing that the perfect break from our PhD's was to conquer Everest (or base camp at least): Buffy (AKA Hannah), for being the best office mate a girl could ask for (especially as I got a holiday to Spain out of it).

Thank you also to my family for always being proud of me.

Thank you to everyone in the Psychology Department at Swansea University for making my time here such good fun and helping me with any problems I've had, especially Dr. Gordon Hodson; there'll never be another lunch buddy like you, and Dr. Alan Beaton for introducing me to real ale.

Enormous thanks go also to the participants in my research who were willing to talk to me about very difficult times in their lives. Thank you to the EDA for distributing my questionnaires and to all the people who completed them. Without any of you my research would not have been possible.

For my Dad

Although not by my side, always in my heart.

I hope this makes you proud.

Contents

Summary

Events of eating disordered peoples' lives, prior to the development of their eating disorder were examined to see if pre-existing factors contributed to their disorder. Six women who currently had or had recovered from an eating disorder were interviewed and the transcripts analysed using Interpretative Phenomenological Analysis. Five super-ordinate themes were identified: negative parental behaviour, child's emotional response to her parents' behaviour, child's behavioural response to her parents, trigger and eating disorder as a coping strategy. These themes formed a theoretical model: emotional abuse beginning a process leading to an eating disorder.

The need for a multi-dimensional measure of emotional abuse was highlighted. Questions regarding parental emotional abuse were factor analysed. A mother and father version of the questionnaire was produced, each with three factors: Emotional coldness, control and psychological punishment. An upset scale was included that measured emotional affect. Emotional abuse was found to correlate with physical abuse and neglect, and eating disordered people had higher emotional abuse scores than their matched controls.

The final study examined the relationships between different types of abuse, perfectionism (a sub-theme of the 'child's behavioural response to her parents') and eating disorder symptoms. The results indicated that emotional abuse rarely existed independently of other types of abuse. Multiple regression analysis indicated that a mediated relationship existed (through negative perfectionism) between mother psychological punishment and body dissatisfaction in the non-eating disorder group that supported Kent, Waller and Dagnan's (1999) findings that emotional abuse may be central to all types of abuse associated with unhealthy eating attitudes.

Eating disordered people were more likely to have been emotionally abused. In the non-eating disorder group psychological punishment by the mother was related to body dissatisfaction through negative perfectionism. It was concluded that emotional abuse creates a vulnerability, although a further trigger is necessary to induce an eating disorder.

Chapter 1

Literature Review

1.1 Introduction

It is a common assumption that prevalence rates for anorexia nervosa (AN) have steadily increased over the past couple of decades (Turnbull, Ward, Treasure, Jick and Derby, 1996; Morande, Celada and Casas, 1999; Ung, 2003). However Devaud, Michard and Narring (1995) suggested that since 1990 more in depth criteria have been available to identify eating disorders, therefore the rates have not increased but are merely more readily identified. The Eating Disorder Association (EDA; 2000) estimated that in the year 2000 90,000 people received treatment for eating disorders in the UK compared to an estimated 60,000 in 1992; many more were not diagnosed. They also reported that in the year 2000 19,000 people called the EDA helpline and 1450 called their Youthline, they supported 3000 members and 6100 people used their self-help network.

1.1.1 Anorexia Nervosa

The DSM IV diagnostic criteria for AN include maintaining a weight that is less than 85% of one's normal body weight for their age and height, harbouring an intense fear of fatness (even though they are underweight), having a disturbance in the way one's body weight and shape is experienced, or denying the seriousness of one's current low weight, and amenorrhea for at least three menstrual cycles (American Psychiatric Association, 1994).

1.1.2 Bulimia Nervosa

Bulimia Nervosa (BN) is diagnosed firstly by recurrent episodes of binge eating. Binge eating is characterised by eating more rapidly than normal, eating until one feels uncomfortably full and eating large amounts of food even when not physically hungry (American Psychiatric Association, 1994). To be diagnosed with BN the individual must use compensatory behaviours (such as laxatives, diuretics, excessive exercise, purging/vomiting) that must occur at least twice a week for three months, and self-evaluation must be (consistently) overly dependent on weight and shape.

Theories concerning the cause of eating disorders range from body image disturbance, biological dysfunction and personality disorders to faulty attachment patterns, dysfunctional family environments and abusive experiences (sexual, physical and emotional). This chapter discusses the literature to date regarding each of these eating disorder development theories.

1.2 Physiology and Eating Disorders

Some brain functions of anorexics and bulimics are different to non-eating disordered people (Treasure, Uher and Campbell, 2003; Steiger 2004). However it has been difficult to elicit whether dysfunctional brain systems are a cause or a symptom of the eating disorder. One such example of this debate was the finding that anorexics had a dysfunctional hypothalamus (Mecklenbury, Loriaux, Thompson, Anderson and Lipsett, 1974). The hypothalamus is important in feeding and hormonal function. However Mecklenbury et al (1974) found that when anorexics' eating and weight returned to normal so did their hypothalamus function, indicating that hypothalamus dysfunction may have been an effect rather than a cause. The same has been reported for the other

abnormalities of AN such as growth hormone secretion and monoamine metabolism (Wakeling, 1985). In the case of BN it has been suggested that binging may be the body's way of regaining homeostasis after being food deprived, or that dieting is the result of feeling full after a binge (Logue, 1998).

It seems that although there may be a genetic component to eating disorders it does not explain why some people develop an eating disorder and others do not. In which case there must be other factors that are relevant; these are discussed below.

1.3 Body Image and Eating Disorders

Body image disturbance is a central feature in eating disorder psychopathology. Although anorexics have a body weight lower than 85% of their recommended body weight they perceive themselves as fat. Drive for thinness is another defining factor of AN. Body dissatisfaction and the fear of gaining weight often mediates between general psychopathology (such as self-esteem, depression, obsessive-compulsive behaviour and perfectionism) and eating disorders.

1.3.1 Body Image and Culture

Studies by Parker, Nichter, Vuckovic, Sims and Ritenbaugh (1994) and Henriques, Calhoun and Cann (1996) found that African American women in the USA maintained a more positive body image than White and Latino women. However, Crago-Shisslak and Estes (1995) and Thompson (1996) suggested that it may not be the ethnic group *per se* that protects against poor body image but other factors associated with them such as self-esteem and socio economic status (SES).

Abrams and Cook-Stormer (2002) studied African-American, White, Asian and Latino women's responses on the Sociocultural Attitudes Towards Appearance Questionnaire (SATAQ; Heinberg, Thompson and Stormer, 1994). The questionnaire measured awareness of dominant societal standards of appearance and the internalisation of these standards. They found that ethnicity interacted with the SES and educational attainment of the caregiver to affect body image. However the African-American women were only protected against poor body image perceptions if they only mixed within their ethnic group.

1.3.2 Body Image and the Media

Becker, Burweel, Herzog, Hamburg and Gilman's (2002) Fijian study is often quoted in the debate over the media's role in the development of eating disorders. The Fijians had not seen any television until the mid nineties. Becker et al (2002) found that since the introduction of television body image concerns in the Fijians had increased, and 83% of them felt that it was the television that had influenced their thoughts about body image.

The effect of western culture exposure in Fiji may be reflective of the events in Japan. After World War Two Japan underwent a period of 'westernisation' regarding physical attractiveness (Mukai, in press), 'that is smaller headed and longer legged' or 'hattou shin beauty' were considered more attractive. Today women in Japan have levels of body image concerns equal to American women (Mukai, Kambara and Sasaki, 1998) and over the past 40 years western media (through magazines and advertisements) have been much more prevalent in Japan. However it is not clear which is the pre-disposing factor; whether the want of a more western figure created a market for the western media, or that the media created the want of a more western figure.

Although research has linked media images of thin models and television personalities to influencing body image perceptions in the general population (mainly females; Cusumano and Thompson, 2000), and although body image concerns are central to eating disorder pathology, the connection between the media and eating disorders is still not clear. Lavin and Cash (2001) had a particularly relevant finding in this respect that "women who were schematically invested in their physical appearance were susceptible to the deleterious effects of the appearance information". It may be that the people with a vulnerability towards general psychopathology may be the people that are more prone to being affected by the media, this perhaps then leads to subsequent eating pathology (Tiggermann and Pickering, 1996). The suggestion that general psychopathology is related to eating disorders has been studied at length, in particularly with regard to personality disorders.

1.4 Personality and Eating Disorders

Eating disordered people often present with maladjusted personalities. Goldner, Srikameswaran and Schroeder (1999) measured personality pathology in eating disordered patients and found that overall personality pathology was higher in the eating disordered group than the control group. The eating disordered patients were split into clusters: rigid, severe and mild. The 'rigid' cluster was characterised by compulsivity, restricted expression, intimacy problems and low stimulus seeking. 78% of the cases in this cluster were restricting anorexic and 42% were bulimic. 18% of the patients fitted the 'severe' cluster, which featured borderline personality pathology, however the type of eating disorder the patients had was not specified. 32% of the patients met the criteria for the 'mild' cluster that included pathology that was not diagnosable as a disorder but

that suggested personality disturbance, including affective instability, anxiousness, identity problems and narcissism.

Co-morbidity of personality disorders and eating disorders is also very common and is best considered by splitting personality into its three clusters (as determined by the DSM-IV). Cluster A (paranoid, schizoid and schizotypal) is rarely, if ever associated with eating disorders. Cluster B (antisocial, borderline, histrionic and narcissistic disorders) is most strongly associated with BN and cluster C (avoidant, dependent and obsessive compulsive behaviour) is most strongly associated with AN.

1.4.1 Cluster B

Herzog, Keller, Sacks, Yeh and Lavori (1992) studied anorexic, bulimic and AN/BN outpatients and found that none of the anorexics had borderline personality disorder (BPD) diagnoses, while 8% of bulimics and 12% of the AN/BN patients were diagnosed with BPD.

Whether BN causes BPD or vice versa, is difficult to say. Kernberg (1985) proposed that inconsistent parental interaction (e.g. academic support but not emotional support) in childhood causes the child to develop an insecure ego, which instils a need in the child for constant reassurance and attention. He proposed that these characteristics may later develop into BPD, and research supports his view (Patrick, Hobson and Dastia, 1994; Silk, Lee, Hill and Lohr, 1995). Through parental rearing studies dysfunctional emotional interaction has also been indicated as a factor in the development of BN (Waller, Calam and Slade, 1988; Waller, Calam and Slade, 1989; Bulik, Sullivan, Wade and Kendler, 2000).

Another commonality of the two disorders is the experience of sexual and physical abuse. Schmidt and Telch (1990) reported a significant difference in the prevalence rates of the two, 24.6% of bulimics reported sexual abuse experiences compared to 50% of bulimics with BPD. Whether the experience of abuse is a predisposing factor for the disorders is still under debate.

BPD is rarely thought of as a symptom of BN because it continues after BN has been treated. This suggests that the two are either independent of each other (Matsunaga, Kiriike, Iwasaki, Miyata and Matsui, 2000) or that BPD predates BN, in which case it may be that BPD is a predisposing factor for BN development.

1.4.2 Cluster C

AN is most commonly associated with obsessive compulsive disorder (OCD). It seems difficult to claim that an eating disordered person, who by the nature of their disorder constantly thinks about food, plans their food consumption to the last calorie and excessively exercises, does not have OCD. However, the DSM-IV makes a clear distinction between eating disorders and OCD, "when individuals with anorexia nervosa exhibit obsessions and compulsions that are not related to food, body shape or weight, an additional diagnosis of OCD may be warranted" (O'Brien and Vincent, 2003).

Prevalence rates of OCD in people with eating disorders differ across the literature. But it is consistently found to occur at a significantly higher rate in eating disordered people than in control samples (Rubenstein, Pigott, Altemus, L'Heureux, Gray and Murphy, 1993). Furthermore Solymon, Freeman and Miles (1982) found that anorexics had scores on an OCD measure as high as those diagnosed with OCD. Evidence also

suggests that eating disordered people display significantly higher rates of OCD than other psychiatric groups (Cassidy, Allsopp, Williams, 1999). Thornton and Russell (1997) found that in 86% of cases OCD preceded the onset of an eating disorder, which was supported by Cassidy et al (1999) who reported that 65% of OCD scores were higher than 'normal' in anorexics on the first diagnosis.

Due to a paucity of longitudinal investigations into OCD in eating disordered populations, the causality debate continues. Speranza, Corcos, Godart, Loas, Guilbaud, Jeammet and Flament (2001) reported that in 65% of cases OCD preceded the eating disorder diagnosis. Thornton and Russell (1997) reported that this diagnosis is usually made 5.4 years earlier, which is concurrent with Swedo, Rapport, Leonard, Lenane and Cheslow (1989) who stated that the diagnosis of OCD occurred 6 years prior to the eating disorder diagnosis. The findings support the view that OCD may be an antecedent of eating disorder development.

Alternatively, the malnutrition and starvation caused by an eating disorder may subsequently cause OCD (Fahy, 1991). However, people who have OCD and not an eating disorder are physically healthy. Speranza et al (2001) argued that these increased rates of OCD in bulimics (compared to non-clinical controls) suggested that denutrition was not the cause. OCD is a relatively rare disorder. The fact that it shows elevated rates in eating disordered patients suggests a potential link between the two, and therefore possibly a causal effect. Especially as OCD symptoms often persist when the eating disorder has been treated and the individual has recovered (Kaye, Weitzin, Hsu, Bulik, McConaha and Sokiewicz, 1992). No correlation has been found between Body

Mass Index (BMI) scores and OCD symptomology, casting further doubt that OCD is born out of eating disorders.

1.5 Perfectionism

Just as body image is an integral part of an eating disorder, so is perfectionism.

1.5.1 Aetiology of Perfectionism

People who are perfectionistic are described as setting unrealistically high standards, rigidly adhering to them and defining their self-worth in terms of achieving these high standards (Burns, 1980a). In real terms perfectionistic people are characterised by believing people will think less of them if they make a mistake, doubting their performance, not being able to achieve their (excessive) standards and over-emphasising the importance of order (Frost, Marten, Lahart and Rosenblate, 1990). However being a perfectionist can be positive (Slade and Owens, 1998). World-class athletes display high levels of perfectionism that are necessary to motivate and drive a high level of performance. Perfectionism becomes a psychopathological characteristic when "the setting of excessively high standards for performance [is] accompanied by overly critical self-evaluation" (Frost et al, 1990).

The behaviour and attitudes of parents have been implicated as an integral part of the development of perfectionism in children (Hamchek, 1978; Barrow and Moore, 1983). Four early childhood experiences summarise the parents' role in perfectionism: 1) being overly critical and demanding, 2) having excessively high expectations and standards of performance and being indirectly critical, 3) not offering approval, or it being

inconsistent or conditional, 4) perfectionistic parents acting as models for perfectionistic attitudes or behaviours (Shafran and Mansell, 2001).

1.5.2 Types of Perfectionism

Perfectionism is a multidimensional phenomenon that is both positively (to gain praise) and negatively (to avoid criticism) rooted (Hamchek, 1978). Its three dimensions are self-orientated perfectionism (a drive to set goals and targets for oneself), other-orientated perfectionism (having unrealistically high standards for the behaviour of others) and socially prescribed perfectionism (a perception of goals and targets being set for oneself by others).

Terry-Short, Owens, Slade and Dewey (1995) found that in eating disordered people (there was no distinction between type of eating disorder) high positive perfectionism was associated with high levels of negative perfectionism. In athletes high levels of positive perfectionism were associated with low negative perfectionism. However personal (self-orientated) and social perfectionism was high in the eating disordered group and in the athletes. Terry-Short et al's (1995) study highlights the importance of treating perfectionism as a multidimensional construct; different manifestations of the dimensions may produce different psychopathological outcomes such as being an athlete or developing an eating disorder.

1.5.3 Perfectionism and Eating Disorders

There is a body of literature that suggests that perfectionism may be genetically predetermined. Lilenfield, Kaye, Greeno, Merkingras, Plotnicov, Pollice, Rao, Streober, Bulik and Nagy (1998) found that relatives of anorexic patients had high levels of

perfectionism. Further research is needed to consolidate the argument for a genetic component in perfectionism. If it is a reliable finding then it would shed light on the popular belief that perfectionism is an antecedent to eating disorders; Bastiani, Radhika, Weltzin, Kaye, (1995) and Srinvasagam, Kaye, Plotnicov, Greeno, Weltzin and Rao (1995) found that self-orientated perfectionism was higher in weight-restored and recovered anorexics than in a normal population.

Research suggests that perfectionism acts as a mediator between weight and self-esteem and eating disorders (Hewitt, Flett and Ediger, 1995; Joiner, Heatherton, Rudd and Schmidt, 1997; Vohs, Bardone, Joiner, Abramson and Heatherton, 1999), for example, self orientated perfectionism (a central feature of AN and BN) manifests itself in the eating disordered person through their major body image concerns that in turn motivates their drive for thinness. By losing weight they believe that they will gain social acceptance (a manifestation of social perfectionism), that will subsequently increase their self-esteem. Because of the unrealistically high standards and overwhelming self-criticism that eating disordered people impose on themselves, any failure (which is inevitable under those circumstances) is likely to occur more frequently and be perceived as a devastating event (Hewitt and Flett, 1993a; Hewitt et al, 1994). The more imperfections an eating disordered person perceives, the harder they aim for perfection.

1.5.4 Perfectionism Summary

Demanding, critical or perfectionistic parents seem to be central to creating a perfectionistic child. It is generally accepted that perfectionism predates eating disorders and may be used as a strategy (albeit a malfunctioning strategy) to improve self-esteem

and gain social acceptance or to avoid social rejection. It plays a central role in the development of eating disorders and maintenance of them.

1.6 Attachment

A child's bond with their primary caregiver is undoubtedly one of the most important bonds they will ever have. It is this relationship that teaches the child primary social skills and that acts as a template for relationships in later life (Parkes and Stevenson-Hinde, 1982). If this attachment is dysfunctional it may effect the child's psychological development (Salzman, 1997; Ward et al, 2000).

Ainsworth, Blehar, Waters and Wall (1978) described three attachment patterns that resulted in different personality characteristics. Secure attachment to the caregiver allows the child to feel safe not only in the presence of the caregiver but also when they are exploring away from them. The caregiver is consistently emotionally and physically attentive, responsive and available and the child understands that the caregiver will be supportive and helpful if he/she is faced with an adverse situation. The next two patterns of attachment do not offer the benefits of a secure attachment. When an 'anxious resistant' attachment exists the caregivers are inconsistently responsive and available. The child is never sure whether their interactions with the caregiver will be positive or supportive. This is especially detrimental to the child if they are faced with a challenging situation because they will not be able to rely on their caregiver for the appropriate help and thus may develop deviant coping strategies in the face of 'life' difficulties. If the caregiver displays consistently rejecting behaviour, involving unavailability and unresponsiveness (whether intentional or not), the attachment formed in one of anxious avoidance. Ainsworth et al (1978) explained that this attachment style results in the child

attempting to exist emotionally independently of any attachment. He/she is prone to developing a skewed sense of the world (such as anxious resistant attachments) and dysfunctional coping mechanisms. These dysfunctional attachment patterns will appear 'normal' to the child and the child's personality will deviate in line with their sense of 'normality'.

1.6.1 Attachment and Eating Disorders

Research into attachment and eating disorders has consistently shown a relationship between the two. Eating disordered patients generally report experiences of avoidant and / or ambivalent (resistant) attachments (predominantly referring to the mother – daughter relationship) whereas the control groups describe secure attachments (Latzer, Hochdorf, Bacher and Canetti, 2002; Chassler, 1997). Anorexics and bulimics are often treated as one group when being compared to controls. Some studies simply do not distinguish between the two eating disorders (Friedberg and Lyddan, 1991; Chassler, 1997) and some studies do not identify any differences between them (Latzer et al, 2002).

Eating disordered patients describe their early experiences with their attachment figures as being "significantly less responsive, available and trustworthy" (characteristics of anxious attachments) than controls, they felt "unwanted, alone and helpless" (Chassler, 1997). These early experiences clearly pre-date the development of eating disorders. However factors such as age of the patient and the stage of disorder may be important in the patients' perception of their attachment and consequently the statistical relationship between attachment and eating disorders may be affected. Issues such as the age of the patient and the stage of the eating disorder are not always taken into consideration

(Ward, Ramsay and Treasure, 2000). Bowlby (1973) however, stated that one attachment pattern is usually predominant in a relationship, so factors such as age of assessment and stage of disorder are not generally seen as confounding factors.

1.6.2 Attachment Summary

If a dominant attachment pattern is established in a child's early years it may be considered as a predisposing factor in eating disorder aetiology. According to Ainsworth et al (1978) feeling unloved and unwanted (Chassler, 1997) are consequences of an insecure attachment. Insecure attachments can lead to skewed coping mechanisms which are often employed by eating disordered people, highlighting a potentially causal relationship between dysfunctional attachment patterns and eating disorder development.

1.7 Family Functioning and Eating Disorders

The literature consistently suggests that family functioning in a family that has an eating disordered member is worse than in control families. There is less family cohesion, more tension and poorer communication and interaction (Waller et al, 1988; Waller et al, 1989; Bulik et al, 2000). Stuart, Laraia, Ballenger and Lydaird (1990) found that bulimics felt rejected by both parents. Their mothers were described as cold and their fathers were described as over-controlling; their family environment was 'conflictual' and 'not demonstratably supportive or self-enhancing'.

More recently, Neumark-Steiner, Story, Hannan, Beuhring and Resnick (2000) investigated family functioning and abuse experiences in adolescents with disordered eating. They found that when family dysfunction was controlled for, the association

between disordered eating and sexual and/or physical abuse was weakened. Family functioning was highlighted as a potential moderator in eating disorder development, especially as they found that a supportive family environment protected against developing disordered eating.

'Family dysfunction' is an umbrella term for a multitude of negative/inappropriate behaviours within the family. A study by Gupta, Gupta, Schork and Watteel (1995) investigated a specific dysfunctional behaviour concerning parent-child interaction that illustrates the diversity of parental dysfunctional behaviours. They compared body image and perceived touch deprivation in eating disordered women and controls. The perception of lack of tactile nurturing (for example, hugging and cuddling) from parents and the level of body image concerns were significantly greater in the eating disordered group than in the control group.

1.8 Physical Abuse

Physical abuse studies in eating disordered people or people with unhealthy eating attitudes (but not clinically diagnosed) are generally carried out on people with BN rather than AN. Despite the common belief that the two are associated, the overwhelming consensus is that physical abuse may be a risk factor in eating disorders only through its connection with other forms of abuse and other psychiatric disorders (Schaaf and McCanne, 1994; Rorty, Yager and Rossotto, 1995; Kent, Waller and Dagnan, 1999; Welch and Fairburn, 1996).

1.9 Sexual Abuse

Sexual abuse occurs when a person inappropriately interacts sexually with someone who is non-consenting to these actions. It is a common assumption that sexual abuse experiences are important in the development of an eating disorder, however it may not only be the physical experience *per se* that is important, but also the events surrounding it.

1.9.1 Covert Sexual Abuse

Sexual abuse does not have to be a physical. Covert sexual abuse occurs when there is an unwanted 'sexually charged emotional interaction' (Weiner and Thompson, 1997). The victim, who is almost certainly left feeling emotionally uncomfortable, has no observable proof that they have been abused. Most sexual abuse questionnaires do include some items regarding covert abuse (Finkelhor, 1979; Sexual Events Questionnaire), but Weiner and Thompson (1997) draw particular attention to the importance of it because they believe it can be identified before a physical display of abuse occurs. In terms of eating disorders positive correlations were discovered between covert sexual abuse, eating disturbance and body image that added significantly to the affect of overt sexual abuse (Weiner and Thompson, 1997).

1.9.2 Disclosure of Sexual Abuse

The first step towards recovery for people who have experienced a trauma is to tell someone, but this alone can be traumatic (Browne and Finkelhor, 1985). The victim is often embarrassed, upset, ashamed and even self-blaming (Finkelhor and Browne, 1985). If the person listening to the disclosure does not respond appropriately it can negatively affect the victim (Everill and Waller, 1995; Browne and Finkelhor, 1986). Waller and

Ruddock (1993) found that eating disordered women who had had adverse responses to their disclosures had greater eating dysfunction. In 1994 Everill and Waller attempted to replicate Waller and Ruddock's (1993) findings. They interviewed undergraduate victims of sexual abuse about their disclosure experiences. Those who reported an adverse disclosure experience had significantly higher oral control (control over what they ate), therefore suggesting that the victims were trying to gain internal control to compensate for the previous lack of external control that they felt during their abusive experiences (Slade, 1982; Waller, 1998).

There is little evidence to suggest that sexual abuse is associated with AN (Waller, 1991). More evidence suggests that it is associated with binge eating disorder (BED; Berstein and Fink, 2001), but the relationship is strongest with BN. The binging/vomiting cycle is thought "to 'block out' the heightened awareness of [the sexual abuse] experience" (Waller, 1991).

1.9.3 Evidence that there is No Relationship between Sexual Abuse and Eating Disorders

Waller and Ruddock (1995) predicted there would be an association between the nature of abuse, self-blame, disclosure attempts, recall and AN and BN. Although the participants who had been sexually abused in the eating disorder group had higher rates of bulimia compared to the comparison group, overall no association was found. Pope and Hudson's (1992) literature review on sexual abuse and bulimia stated that "current evidence does not support the hypothesis that childhood sexual abuse is a risk factor for bulimia nervosa".

Those who found a relationship between sexual abuse and eating disorders found that the relationship either weakened (Kent et al, 1999) or disappeared (Perkins and Luster, 1999), when other factors were introduced. However, it is possible that there is an indirect relationship between sexual abuse and eating disorders and despite the studies previously mentioned, some literature supports a sexual abuse/eating pathology association.

1.9.4 Evidence that there Is a Relationship between Sexual Abuse and Eating Disorders

Bryam, Wagner and Waller (1995) suggested that abused women (in a non-clinical sample) who already had unhealthy eating attitudes may have been pre-disposed to respond to their abusive experiences by developing a body image disturbance, and may subsequently have developed an eating disorder. Subsequently Waller (1998) added that perceived control maybe what linked sexual abuse and eating disorders, adding to Bryam et al's (1995) findings. Waller (1998) found that those participants who presented with sexual abuse experiences demonstrated a more external locus of control and more severe eating pathology (within the abused group), whereas no such association was found in the women in the non-abused group. It is reasonable to suggest that those people who feel they have little control over their lives may in turn feel they have little control over their weight and thus be more dissatisfied.

Coffey, Leitenberg, Henning, Turner and Bennett (1996) suggested that the impact of childhood sexual abuse (particularly the level of physical activity involved) and future psychological distress was mediated through perceived stigma and self-blame because of "an increase of being 'damaged goods' and taunted due to a greater sense of personal and societal violation". In the case of self-blame, people who were more frequently

abused "may feel they had more opportunity to stop the occurrence of the abuse, and consequently experience greater levels of self-blame".

The studies carried out by Byram et al (1995), Coffey et al (1996) and Waller (1996) all highlight a possible 'chain of events'; abuse leading to low self-esteem, depression, self-blame and powerlessness, which may lead to the victim being unhappy and promote vulnerability.

1.9.5 Sexual Abuse Summary

The literature illustrates the complexity of the sexual abuse and eating pathology association. It is not realistic to assume that there is a clear cut link between the two. The relationship may be mediated by other psychopathology common to both sexual abuse and eating disorders (e.g. self-esteem). But it may also be mediated by events and experiences surrounding the abuse such as disclosure experiences or negative emotions (such as self-blame and feeling ashamed). It may be that sexual abuse is an important risk factor in some eating disorder cases but not others.

1.10 Emotional Abuse

The American Professional Society on the Abuse of Children (APSAC, 1995) defined emotional abuse as "a repeated pattern of caregiver behaviour or extreme incident(s) that convey to children that they are worthless, flawed, unloved, unwanted, endangered, or a value only in meeting another's needs." They further listed six forms of psychological (emotional) abuse: spurning, terrorizing, exploiting/corrupting, denying emotional responsiveness, isolating and mental, health, medical and educational neglect. Other definitions list behaviours that are similar to the behaviours listed by the APSAC; for

example Hart and Brassard (1990) listed rejection, terrorism, isolation, exploitation and mis-socialisation (for further examples see Hart, Germain and Brassard, 1987; Garabino, Guttmann and Seeley, 1986; Glaser, 1995; McGee and Wolfe, 1991; Thompson and Kaplan, 1996).

As illustrated in the first APSAC definition of emotional abuse (that highlighted the emotional effects of emotional abuse), there are a culmination of factors that should be considered when defining emotional abuse other than the actual behaviours carried out.

1.10.1 Age

Many define emotional abuse in childhood terms, indicating parents and caregivers as the perpetrators and the children as the victims, such as in the Community Services in Melbourne (1989) who stated that "emotional abuse includes [specific behaviours] by the parents or caregiver, to such an extent that the child's behaviour is disturbed...". This definition fails to mention that abuse can occur at any age and by anyone (see Schumacher, Smith-Slep and Heyman, 2001, review of 'Risk factors for male-to-female partner psychological abuse).

1.10.2 Intention

Whether the action of emotional abuse is intentional is the second point in contention. Portwood's (1999) study of child maltreatment definitions led her to discover that the National Research Council stated that "whether the perpetrator intends to harm the child – was viewed by participants as a substantially less important consideration", a considerable advancement on Garabino et al's (1986) definition that stated "psychological maltreatment is a concerted attack...".

1.10.3 Severity and Persistence

The level of detail involved in the definition of emotional abuse goes beyond the victim's age and the intentions of the perpetrator. Although single events of severe emotional abuse occur which are intensely emotionally damaging to the victim, such as rape, that is often followed by Post-Traumatic Stress Disorder (PTSD, Hanson, Resnick, Saunders, Kilpatrick and Best, 1999), day-to-day emotional abuse takes a 'milder' form. Thus there is the issue of severity and when an emotionally aversive behaviour becomes emotionally abusive. One instance of isolation, perhaps a parent 'grounding' a child for a day for breaking a curfew, would not constitute emotional abuse for the majority of people. The definition published by the Home Office, Department of Health, Department of Education and Science and Welsh Office (1989; in Thompson and Kaplan, 1996) specified that actions must be "persistent or severe" to be classed as emotionally abusive.

1.10.4 Emotional Effects

The downfall of including persistence in the definition is that it implies that until an emotionally adverse behaviour has occurred for a specific amount of time it is not abusive and subsequently does not warrant intervention. Thus it seems reasonable to expect reference to the emotional effects of the adverse behaviour in conjunction with a statement about its persistence. O'Hagan (1995) provides an in-depth definition of the effects of emotional abuse:

"emotional abuse...it inhibits the child from spontaneous, appropriate, positive, emotional feeling and emotional expression. It impairs emotional development, that is, the child's continuing ability to experience an increasing range of emotions, to regulate and modulate emotional experiences, and to express them appropriately... The child's

perception and understanding of emotion become distorted, whether it be the child's own emotional experiences or the emotional expressivity of others."

1.10.5 Emotional and Psychological Abuse – are they synonymous?

Emotional abuse and psychological abuse are almost always used synonymously. But O'Hagan (1995) in particular argues that they are different and should be treated as such. He argued that while emotional abuse affects childhood development (as stated in the above definition), psychological abuse damages mental development such as "intelligence, perception, attention, recognition, and memory". O'Hagan's distinction is undoubtedly correct, but the studies that use the terms 'emotional abuse' and 'psychological abuse/maltreatment' often use them interchangeably and clarify their meaning.

1.10.6 Epidemiology of Emotional Abuse

Emotional abuse is most commonly studied in conjunction with sexual abuse, physical abuse and neglect. The rates of each type of abuse vary depending on the definition used, the place and the people tested and the method of data collection. But overall it cannot be disputed that the figures are universally rising, most probably due to better symptomology recognition.

1.10.7 Culture

Garabino et al (1986) stated that "psychological maltreatment depends heavily upon social and cultural context". The highest rates of emotional abuse exist in western cultures. The UK department of Health (2000) listed approximately 33,000 children on the 'at risk' register in England and Wales. In England 13% were listed because of

sexual abuse, 20% for physical abuse, 18% for emotional abuse and 36% for neglect. Similarly in Wales 11%, 25%, 20% and 34% were listed for each type of abuse respectively. According to Childhelp USA (2000) 63% of children had experienced neglect, 19% physical abuse, 10% sexual abuse and 8% emotional abuse. However Claussen and Crittenden (1991) found that 90% of children who reported physical and sexual abuse had also been psychologically maltreated (emotionally abused).

In non-western cultures it is unlikely that the rates of reported child abuse are reflective of the actual rates of child abuse (e.g. in Arab cultures corporal punishment within the family is acceptable). National statistics for abuse are not available from these countries but research suggests that there is a gap between actual abusive behaviour and perception of abusive behaviour; in terms of emotional abuse, agreement that parental behaviours are abusive is low (Atta and Youssef, 1998).

The rates of abuse reported above are probably grossly under-estimated, especially in the case of emotional abuse (as Clausen and Crittenden (1991) illustrate). Possible reasons for the under-reporting of emotional abuse are discussed below.

1.10.8 Seriousness

When a suspected case of abuse is being assessed the intensity of the abuse is an important consideration. The National Study of the Incidence and Severity of Child Abuse and Neglect carried out by the U.S. Department of Health and Human Services (1981), found that 39% of reported cases of child maltreatment were 'not serious enough' for further action to be taken (Gracia, 1995).

1.10.9 Missed Diagnosis or Mis-Diagnosis?

Before the introduction of an operational definition of emotional abuse (the behaviours listed on page 15), clinicians relied on their own conception of emotional abuse or on legal guidelines rather than empirical evidence (Thompson and Kaplan, 1999). Thompson and Kaplan (1999) illustrated that too often the primary form of abuse is noted as the problem and emotional abuse (if noticed at all) is unintentionally overlooked. They found that when clinicians were asked to report their concerns on 76 cases (reviewed with view to emotional abuse by the investigators), 22 cases were highlighted for experiencing general abuse and 12 specifically for emotional abuse. When the clinicians were given the diagnostic dimensions of emotional abuse (Glaser, 1995) they identified 31 cases that they had concerns about, 16 of these had not previously been identified as causing concerns.

Gracia (1995) noted that teachers did not report suspected cases of abuse because they did not always know how to detect abuse and feared the ramifications of the family and school boards if they did report abuse. Her study illustrated that if there is trouble about reporting sexual and physical abuse, which have structured and accepted diagnostic definitions, a child suffering emotional abuse is in the very unfortunate position of never being noticed.

1.10.10 Emotional Abuse and Eating Psychopathology

There is a paucity of literature regarding the relationship between emotional abuse and eating disorders. Four studies to date have investigated the association, two using bulimic participants (Rorty, Yager and Rossotto, 1994; Hartt and Waller, 2002) and two using non-clinical samples (Kent et al, 1999; Witkiewitz and Dodge-Reyome, 2000).

In chronological order, Rorty et al (1994) reported higher rates of psychological (emotional), physical and multiple (experiencing more than one type of abuse) abuse in bulimics compared to a control group. Apart from concluding that "psychological abuse may be the most entrapping, persistent, and destructive form of childhood abuse" and that there was a need for more research in the area, nothing was proposed as to whether emotional abuse had a direct affect on eating pathology or about the nature of the affect.

The importance of emotional abuse and eating psychopathology highlighted by Rorty et al (1994) was confirmed by Kent et al (1999) when they reported that "emotional abuse was the only form of childhood trauma that predicted unhealthy eating attitudes". They found that neglect, physical and sexual abuse may only be related to unhealthy eating attitudes through their strong correlations with emotional abuse.

Emotional abuse in the previous two instances was investigated in relation to parents as a single unit rather than mother and father separately. Kent et al (1999) suggested that by investigating mother and father emotional abuse independently, an assessment could be made of whether emotional abuse from just one parent can promote eating pathology, or, if the non-abusive parent can buffer against the affects of the other parent's abusive behaviour. Witkiewitz and Dodge-Reyome (2000) measured emotional abuse by mothers and fathers in college undergraduates with unhealthy eating attitudes. Perfectionism (measured using the Eating Disorders Inventory; EDI) was strongly correlated with all the dimensions of psychological maltreatment (or emotional abuse). Mother neglect was significantly correlated with bulimic symptomology while mother rejection significantly correlated with drive for thinness. Father neglect correlated strongly with introspective awareness; however father isolation and rejection did not

correlate with any of the eating disorder scales except perfectionism. Although the role of the mother/daughter relationship is well documented throughout the eating disorder literature (Smith Mullis and Hill, 1995; MacBrayer, Smith, McCarthy, Demos and Simmons, 2001), the role of the father is not. Witkiewitz and Dodge-Reyome (2000) highlighted this potentially influential factor in eating psychopathology.

Unfortunately Witkiewitz and Dodge-Reyome (2000) used a non-clinical population in their study so the conclusions regarding the role of emotional abuse in a clinically diagnosed eating disordered population must be considered with caution. Although Rorty et al (1994) did use a clinical population, they did not include anorexics or go into the level of depth that Witkiewitz and Dodge-Reyome's study did (such as investigating mothers and fathers separately or dividing emotional abuse into its appropriate dimensions).

Just as it seemed that a stable pattern of results was being built regarding the emotional abuse / eating disorder association, a recent study did not find an association in bulimics (anorexics were not studied; Hartt and Waller, 2002). However their results should be interpreted with caution because they used a small, heterogeneous group.

1.10.11 Emotional Abuse Summary

Studies that have directly focused on emotional abuse have, in general, found that it plays a significant role in disordered eating perhaps over and above other forms of abuse. The need for further more in depth investigation of the relationship between the two was highlighted.

1.11 Neglect

Neglect is considered as a form of abuse in a similar manner to physical, sexual and emotional abuse. However there is very little research into its affects on eating psychopathology. Kent et al (1999) included neglect in their study of childhood abuse and unhealthy eating attitudes. Its association with unhealthy eating disappeared when emotional abuse was entered into the analysis. Mazzeo and Espelage (2002) similarly found neglect had an indirect relationship with disordered eating.

1.12 Conclusion

Eating disorders do not have a simple cause or cure: they are complex and individual to each person. It is generally agreed that the core components of an eating disorder are drive for thinness, body image disturbance, low self-esteem and perfectionism. There is also acknowledgment that eating disorders can co-exist with other personality and anxiety disorders, although which is the pre-cursor is not 100% clear. Dysfunctional attachment patterns and family functioning have also been indicated as pre-cursors of eating disorders.

There is a paucity of literature regarding a link between abuse and eating disorders, but exactly how abuse impacts on their development is unclear. Sexual abuse has been given a substantial amount of attention in the literature, but little research has been carried out on physical abuse, emotional abuse and neglect.

Theories of eating disorder development that reflect a culmination of integrated factors (such as Kent et al, 1999; Tiggemann and Pickering, 1996) are probably the most realistic and plausible.

1.13 Aims of Current Research

The literature review highlighted many theories about the factors that may predispose, precipitate and perpetuate eating psychopathology. However the overwhelming message was that despite the knowledge available about eating disorders, there is still uncertainty about how all the factors fit together.

There was great diversity of theories of eating psychopathology that could be tested. However it seemed that despite the theories, there was a paucity of studies that had actually asked eating disordered people what they thought was important in their eating disorder development. Accordingly it seemed reasonable to interview eating disordered people to explore their views about their lives and eating disorders before developing a theory of their aetiology.

The initial aims of the research were to:

- phenomenologically explore the events of eating disordered peoples' lives prior to the development of their eating disorders.

- Theoretically examine whether there were any pre-existing factors that may have contributed to the development of the participants' eating disorders.

Based on the findings of the qualitative study new hypotheses were developed. The hypotheses aimed to quantitatively explore the dominant themes presented in the study and attempt to generalise the findings to the wider eating disorder population (see section 2.4.5).

CHAPTER 2

A Qualitative Study of 'Life before an Eating Disorder'

2.1 Introduction

The use of quantitative studies in psychological research has encouraged the consideration of psychology as a science. The macro level at which quantitative methodologies function allowed theories of behaviour to be established. This is true of eating disorder research which has been dominated by quantitative studies. Hepworth (1994) described the 'absence of qualitative analysis in mainstream research on eating disorders [as] a weakness in developing theory and clinical practice.'

Eating disorders are deeply personal and individualistic. Standardised questionnaires about eating disorders are developed to suit the majority and thus fail to measure potentially poignant experiences, beliefs or feelings personal to the eating disordered individual. Altabe (1998) combined qualitative with quantitative methodology (at a basic analytical level). She asked her participants to list traits that they associated with their actual physical appearance, ideal appearance and their perception of what their culture idealised. She argued that if she had used a standardised questionnaire, the differences she found between the ethnicities would have been missed.

Serpell, Treasure, Teasdale and Sullivan (1999) drew attention to the emphasis that cognitive behavioural models place on positive reinforcers in maintaining an eating disorder and the discrepancy between this and what the literature attends to. Most quantitative research has concentrated on the negative aspects of eating disorders, such

as the Eating Disorders Inventory (EDI; Garner, Olmstead and Poilvy, 1983) that measures body dissatisfaction and ineffectiveness. By asking eating disordered patients to write two letters to their anorexia nervosa; one treating it as a friend and one treating it as an enemy, Serpell et al (1999) were able to elicit what important beliefs (positive and negative) maintained the patients' eating disorder. The 'pro-themes' (from the friend letter) were the themes that illustrated the value that anorexics attached to their disorder; how it helped them. The 'anti-themes' (from the enemy letter) were the themes that illustrated the negative affects of the disorder felt by the patients. The clinical implications of this study are evident. Clinicians could use this information to elucidate which beliefs to disassemble and which beliefs to modify, to motivate recovery.

Eating disorder research could be enhanced by the wider use of qualitative research. Quantitative methodologies are restricted to using a limited number of questionnaires and investigating variables in isolation. Qualitative research adopts a more holistic approach; it is therefore more likely to identify underlying processes in eating disorders that quantitative research may overlook.

2.1.2 Methodology

Interpretative Phenomenological Analysis (IPA) was chosen for the current study over other popular methods of qualitative methods, such as grounded theory, first and foremost because of the nature of eating disorders (being a very individualistic experience) and secondly because of the small sample size (which was unavoidable).

Grounded theory (GT) is an inductive process, it seeks to understand and create hypotheses about the data and how it is ordered; then it tests the ideas deductively with

further data collection and analysis (Chamberlain, 1999). IPA appears to get 'closer' to the data than GT. It allows each individual's case to be studied in depth. It allows understanding to develop from all the data without forcing the themes from one individual onto another. In the present study it was very important that each story was analysed independently because eating disorders are such a personal experience.

It seemed clear that the participants' stories would differ due simply to their different upbringings and different life experiences. Therefore if similar themes were present in each participant's story there would undoubtedly be 'gaps', for example, differences in how the themes were expressed. IPA allows for 'gaps' in the data because it is not concerned with fitting people into categories or general models. The gaps are interesting in IPA because they may explain why a participant behaved or felt differently to another participant. GT does not allow for differences within the themes. It is concerned with reaching 'saturation' so that all the data is accounted for and there are no 'gaps' in the theory proposed. It does this through discriminate sampling which is the deliberate and directed selection of further data to confirm and verify themes so that a core category can be identified.

IPA enables a much greater intimacy between the researcher and the data that would be impossible using GT. Although IPA is similar to GT in that it believes that theory should be data-driven, it goes further because it does not force the data into theory by discriminate sampling but allows the personal world of each participant to be explored whether their themes are the same or dissimilar and lets the dissimilarities between the participants be investigated.

The present study aimed to elicit subjective accounts of the lives of people who had personal experience of an eating disorder. Semi-structured interviews were conducted that centred on the participants' lives before their eating disorder and the participants' perception of their disorder.

2.2 Method

2.2.1 Participants

Six women were recruited from two eating disorder self-help groups. The length of time the participants had attended the groups ranged from six months to several years. The participants' age ranged from 23-35 years. Participant A (PA, participants were named PA to PF) and PB were recovered anorexics, PC was recovering from bulimia nervosa, PD was recovering from anorexia nervosa, PE was a controlled bulimic (she considered herself to be able to control her disorder, but did not think she would ever fully recover) and PF was recovering from binge eating disorder (BED). All participants had received counselling away from the groups. Both group leaders wrote a letter of consent on participants' behalf to guarantee their anonymity. Ethical approval for the study was given by the relevant ethics committee.

2.2.2 Environment

The interviewer was female and 22 years old at the time of the interviews. She attended the first self-help group as an observer several times. The second group was attended once only, the participants in this group had participated in other research and were comfortable talking to the interviewer without building up a relationship first. The interviews were held in private, in rooms that were comfortable and familiar to the

participants. Each interview was tape recorded (with the participants' permission) and lasted from 30 minutes to 1 hour 30 minutes.

2.2.3 Interview Schedule

The participants were told that the interviewer was conducting research on eating disorders and would like to ask them general questions about their childhood and their eating disorder.

The semi-structured interviews were conducted that asked a series of broad questions: Can you describe your home environment as a child? Can you describe the type of relationship you had with your parents and siblings as a child and their relationships with each other? What were your relationships like with people outside your family, such as extended family and friends? How do you think your eating disorder developed? How did you feel prior to the development of the eating disorder, why did you feel this way and for how long? These questions guided the interview, but other questions were asked based on the participants' responses.

2.2.4 Data Analysis

The interviews were transcribed verbatim and were analysed using IPA (for examples see Smith, 1996; Smith, Harré and Langenhove, 1995; Smith, Flowers and Osborn, 1997). The first transcript was read through several times, each time it was annotated with thoughts about the data which developed into noting potential themes. These themes were then collated into a list and compared to elucidate whether they were connected or how they were connected. The themes were then clustered into thematic categories.

The process followed for the first transcript was repeated for each transcript. IPA is a cyclical process; each time a new master list of themes was established it was compared to the previous transcript(s), thus new themes were constantly being tested against the previous transcripts. The comparison of master themes enabled the emergence of final super-ordinate themes that applied to all the transcripts.

The transcripts were read by an independent reviewer who compiled a list of themes. Comparisons were made between the independent reviewer's themes and the first reviewer's themes until there was agreement on a final list of super-ordinate themes.

2.3 Results

Five super-ordinate themes were identified from the interviews: negative parental behaviour, the child's (mental/emotional) response to their parents, good-girl syndrome, triggers and using an eating disorder as a coping strategy.

2.3.1 Negative Parental Behaviour

The negative parental behaviour theme referred to how the parents treated the participants. The theme incorporated five sub-themes (rejection, isolation, ignoring the child, cruelty and unresponsiveness). Each sub-theme seemed independently important to the participants, different participants had experienced the sub-themes in different ways and to different degrees, but all the sub-themes related to each participant.

2.3.1.1 Rejection

"I think I resented her on the grounds that she deserted me at a time when I needed her." (PD speaking about her mother)

"...my mother had this great habit of somebody being out of favour... [if we] had done something which she wouldn't like...we weren't really involved with the family..." (PE)

"As soon as she found out she was pregnant she didn't want me." (PF)

"...I knew that she didn't want me there and I knew I had nowhere else to go..." (PF)
"I had to ask permission to go out at night. I used to walk down the stairs and stand by the living room door, summing up the courage to actually, I had to knock to go in the living room to go out, and all the other family would be sitting there watching telly, and I-I just felt like I was a stranger, you know that I wasn't accepted." (PF)

2.3.1.2 Isolation

The term 'isolation' has obvious physical connotations, for example;

"I was never included in anything...I always seemed segregated from everything" (PF)

But the participants described emotional experiences of isolation. PE expressed her feelings of isolation most vocally by describing her feelings of loneliness:

"I was so isolated"

"...I did feel quite lonely..."

"I realise I was probably quite lonely and that I did wish I had somebody else to play with...my friends were books and teddies and things like that..."

"I felt out of place at school...everybody else seemed reasonably happy, I just felt different erm I didn't know why...I think it was because I was so isolated [pause] because I spent so much time alone at home with my parents who didn't do anything themselves, they didn't socialise, I think it was just that really, just isolation."

When PD entered puberty she described feeling confused about why she felt different to her friends. She felt isolated from her peers but also "alienated" because she had no one to talk to about the changes she was going through:

"I remember feeling this overpowering feeling of being alone, my mum was in work all the time, before that I'd always had her. My friends were, growing up the same as me but they were really interested in boys, for some reason I didn't follow the same interest as them and I just felt really alienated and isolated..."

2.3.1.3 Ignored

PB described her experiences of feeling ignored most effectively:

"I remember not being listened to"

"She says her point and then she ignores you" (PB speaking about her mother)

"The main thing was nobody ever seemed to listen to what I wanted to say like my point of view...They wouldn't listen to my reasoning why...they wouldn't see my perspective"

2.3.1.4 Cruelty

PF's description of her mother is one of a purposefully cruel woman:

"She used to say 'there wasn't enough [food] for you so you've got to have that'. So it was as if she still bought the same amount as she used to buy before [PF moved in], saying 'well I'm not spending extra on you'"

"She actually tried to stop me going to my brother's wedding"

"If I didn't ask for dinner money I was being awkward, if I did I was being a fat cow."

The other participants (except PB) did not mention their mothers as being the punitive parent, but they described a more general feeling of being frightened of their father:

"... she always used to degrade me..." (PB talking about her mother)

"I've always been scared of my dad...I would be scared of him now...he can say really awful things to me." (PA)

"I was always a little bit scared of him" (PC)

2.3.1.5 Unresponsiveness

The unresponsiveness sub-theme related to the parents' lack of (appropriate) response. PA's mother was extremely (inappropriate and) unresponsive to her daughter's needs in the example given. In the following quotes the parents did not act at all:

"I was raped...I phoned her up [pause] and I was hysterical [pause] and she just said [pause]... 'oh well go home it's not safe in the car' [pause]...the next morning I went to work and I don't know how I got there...I thought well I'd better ring mum, the last thing she heard was me hysterical in the middle of the night. And I phoned her up and she said... 'oh don't let it affect your day [pause], just get on, you love your patients, you love your job, just don't let it affect your day', and I was thinking, don't let it affect my day, it's going to affect my whole...life." (PA)

"Hugging and stuff like that; they stopped when I was six, seven or, eight." (PB)

"I'd say it's quite a bad relationship erm, in that he doesn't know his own daughter...he's just quite a distant father." (PB)

"My father was just always in the background." (PD)

"My mum...she would seem quite distant and cold." (PE)

2.3.2 Child's Emotional Response to her Parents' Behaviour

The second super-ordinate theme (child's emotional response to their parents' behaviour) was characterised by feeling unloved and unwanted.

"It was easier to love her than it was to love me" (PB talking about her parents' relationship with her sister)

"He didn't really want children anyway you know" (PC talking about her father)

PF: *"She was told I was her responsibility"*

Researcher: *"Did she want you?"*

PF: *"It was obvious from day one that she didn't."*

PE thought it was through duty that her mother cared for her, rather than because she loved her:

"She felt it was her place to be at home and look after the house and look after me."

"I think she just found me irritating"

PE did not believe that her mother loved her and she thought that this influenced her father's feelings for her:

"...[sigh] she never seemed to speak to me direct, she never seemed to want to look at me...[sigh] there was no love and affection of any kind..."

"I think he [father] was fond of me, he cared about me...I think he was held back by mum...[sigh] No I think dad probably loved me, maybe that's even, that's too strong a word. Erm I felt more affection from my dad, I don't think my mum loved me."

2.3.3 Child's Behavioural Response to her Parents

The 'child's behavioural response to her parents' theme consisted of two sub-themes; rebellion and 'good girl syndrome'. These sub-themes related to the course of action that participants' could take to combat their feelings of being unloved and/or unwanted,

or if they felt loved and wanted, as a direct response to their parents' negative behaviour. The 'good girl syndrome' was made up of three types of behaviour; the need to please, perfectionism and the need for achievement.

2.3.3.1 Rebellion

PB suggested that she did not believe she could change her relationship with her parents and so rebelled against them.

"There's no doubt about it, if there was a black sheep I would be it."

Although PB thought that she could not change her relationship with her parents, in that she describes them as ignoring her and loving her sister more, this did not mean that she was not affected by it:

"Annoyed me...well more than annoyed probably angered me...made me fell left out, made me feel worthless."

The previous quote implies a feeling of powerlessness, it seemed that PB's direct response to combating her powerlessness was to try and gain back power:

"I wouldn't stay grounded...I snuck out"

"it does feel like something, it's very childish...you feel as if you're doing something no-one else knows about, it's almost like sticking your fingers up at the world..." (PB talking about her eating disorder)

2.3.3.2 Good-Girl Syndrome

The 'good-girl syndrome' integrated three behaviours: the need to please, perfectionism and the need for achievement. Each of the behaviours was independent but inter-correlated with the others, they were cyclical, reinforcing and promoted each other.

2.3.3.2.1 Pleasing

Pleasing behaviour had a universal presence in the participants' lives, in the examples below PA felt she had to please the doctors whereas PC felt she had to please people so they would be her friends:

"I wanted to be the perfect patient that I wouldn't have dared turn up without saying anything so I went along to keep them happy, erm, just to fit into this little role of being good like I normally would be..." (PA)

"I always wanted to please them and used to try and make friends...you know, by giving people things" (PC)

With the exception of PB the strongest want to 'please' was described in relation to the participants' parents:

"I always wanted to please them." (PA)

"I only said it coz I knew it would be approval from them" (PA)

PF: *"I didn't know how to please them."*

Researcher: *"Did you try to please them? Was that conscious?"*

PF: *"As I was around eight, from eight onwards and I think it was conscious."*

"He made me a little bit more nervous and I think wanting to please...I think that's carried through with me...to my age now I think that maybe he didn't handle things sometimes in the best way with a young child." (PC)

"I always wanna please him and sort of, you know, do everything right." (PC talking about her father)

"I always had to be the good girl." (PD)

"I think partly that hearing everything my brother did wrong, I wanted to do the opposite" (PD)

The pleasing theme functioned at different extremes. PA and PE felt that although they tried to please their parents it was never enough, whereas although PB did not describe making a concerted effort to please, she still shared the same feelings of inadequacy with the other participants:

"he [father] *can say really awful things to me, erm, like a couple of weeks ago he said 'oh when are you going to do something worthwhile with your life', erm and really I think, I mean at the time I just went silent and was upset and said 'well, I dunno' and I thought well actually I am head of the department and I've got my own house and car*

erm, I don't depend on him financially for anything, but he can still make me feel like- make me feel like that. I'm a bit like, part of me is angry with myself that I didn't say 'well, [pause] well what have I got to do to be worthwhile to you?' or [pause] 'what's worthwhile?' or 'I don't ask you for anything' but I would just never have dared said it." (PA)

"She's that type of person you always feel you haven't quite done enough, or I always felt, less now, I thought I'd never quite done enough for her..." (PB)

"I always had this feeling of waiting for something to happen, waiting for her to, to tell me what I'd done wrong. I always had the sense I'd done something wrong." (PE)

"...I did feel...bit confused about how, what my parents were expecting of me, I didn't know how to please them, I didn't know what, what they wanted from me apart from just keeping out of the way it seemed." (PE)

2.3.3.2.2 Perfectionism

"...always wanting to be perfect...I'm really self-critical" (PC)

"I'm quite a perfectionist...I've always been quite critical of myself" (PC)

"I would see the grief he [brother] *caused my parents so I would try and be little Miss Perfectionist" (PD)*

"I just turned into a perfectionist" (PD)

"It's just whenever I do things I tend to take them to perfection. So I started this healthy diet and I took it to perfection." (PD)

"Once I've done something well I think I've always got to do well at it" (PD)

2.3.3.2.3 Achievement

The achievement orientated behaviour that the participants described seemed to be related to the want to please their parents and be perfect. PA thought that her father would only respond to achievement orientated conversation. PC was conscious that her parents had both been high achievers and secured professional careers. PD's need for achievement seemed to be born out of being a perfectionist because of her competitive personality and because she wanted to compensate for her brother's 'naughty' behaviour (see above quote):

"...I just remember trying to be, someone that was achieving and things...and have the label of 'good'" (PA)

"I would have to talk about things that were...like something in school I was achieving...it wouldn't have just been [pause] something that just didn't mean anything really...It was all about achievement really." (PA)

"...because they've done so well it's always been in my head..." (PC)

"I used to always have to compete. I've always had a competitive streak in me." (PD)

"He's [brother] *not been interested in school and never felt guilty about not achieving, whereas I always seem to, I don't know if I'm doing it for myself or my parents half the time." (PD)*

"I'm just forever setting myself targets." (PD)

The participants' achievement-orientated behaviour was important in their eating their eating disorder:

"I got a reward from not eating" (PA)

"I knew when I felt good and that was when I hadn't eaten. So if I didn't eat I felt good, so that was an achievement" (PB)

"...like I said... [you] *had a sense of something that other people couldn't touch which was an achievement, the invulnerability." (PB)*

2.3.4 Triggers

Each participant reported a stressful episode in their lives that occurred before their eating disorder began and which they described as being related to the development of their eating disorder. The episodes were very traumatic for the participants. A synopsis of each participant's triggering episode follow.

When PA was a teenager her best friend was diagnosed with leukaemia. Before the mother of PA's friend told her daughter she was ill, she told PA that she was the only

one who could help her friend. PA felt pressured and very upset. She described 'losing her appetite because she was 'unhappy'. She explained that she had not felt fat to begin with and explained that, in effect, the eating disorder became a coping strategy that helped her ignore other problems she did not want to deal with:

"a friend of mine that I was very, very close to got leukaemia, and I was the only person who knew, she didn't know at the time, her mum told me and was saying "you're the only person who can help" sort of thing and that felt like it was an awful lot of pressure on me. Then I went back to school and it was a very testing time, like why did she get cancer sort of thing. So that was the first time I had a problem [pause]...I just felt like I'm not eating coz I'm unhappy. Erm, and then I didn't think I was overweight when I started with it."

Researcher: "When you say you were under this pressure and it was a lot to deal with, why was it that you said you were unhappy and so you stopped eating, but is there any reason why, in a sense you thought stopping eating would make you..."
PA: "No I don't think that I thought stopping eating would solve things. I think it was just I was so, so upset and in shock about things that I just lost my appetite erm, as anybody I think-I mean people can lose appetites if someone's just died or whatever, erm, but it just went further, erm and then I got a reward from not eating and I got a high from the, numbness I suppose and blocked off from things which was quite nice to block off and not have to face anything...It became something different than what it started...in the end, yeah, and that was all I could think of and focus on and nothing else really mattered."

Years later PA was raped; her parents were non-sympathetic and she relapsed into her eating disorder.

"Years later there was something else [rape] *that upset me that just triggered me off, something can happen and it, and if I get upset by things I just don't eat."*

PB had been in a violent relationship for some years when she consciously decided not to eat. She described not having the emotional stability to cope, she felt she had no–one to talk to, and she 'enjoyed' the eating disorder because it gave her a sense of control and attention:

"I'd say that the bad relation-the violent relationship I had for three years erm, was definitely the trigger because I can-I can categorically remember actually thinking, planning what I was going to do. Erm, as in cutting my food intake down, but not for a diet, it was never to go on a diet."

Researcher: "You just decided you weren't going to eat?"

PB: "...did I make a definite decision then, or was it a reaction, to the, all-all the crap going on? I don't know, it was definitely at the same time erm. But of course if I'd had a more self belief, more erm, knowledge of emotions, more stable with someone to talk to about it erm. There must have been some importance in all the rest of that or I wouldn't have allowed my relationship to escalate or, if the violence had come up I would have addressed it in a more positive way rather than just keeping it all. So although I'm saying that it was the relationship that triggered it, really it was not-

there were no foundations for my personality there before the trigger if you know. Erm I wouldn't say-it's nothing to do with the media, nothing consciously to do with the media, I never looked at, I get quite annoyed with some of the people today, you know I never looked at sort of idols and thought oh I need to be as slim as her. It wasn't a diet that went wrong er, I don't diet, I'm not going to be told, its not that, erm, you know, it's not a diet. So, in my teenage years it happened and it happened because of a bad relationship and my foundation of my persona-I hadn't developed as a person and I didn't feel I could go anywhere erm.

Researcher: "When you say you couldn't go anywhere..."

PB: "To talk about it, to talk thing-you know, coz I didn't know what to do you see with the relationship, I mean I thought I loved him, I think I still do really...So, erm, I know it was a rollercoaster relationship but then perhaps I wanted some feelings [laughs] because I kind of existed in this vacuum probably you know. Erm or then maybe I didn't want the feelings and I climbed into the eating disorder to get away from it I don't, I really don't know...I mean it was my drug of choice yeah? Some people choose ecstasy to escape and it was my drug of choice probably; it was like an addiction, a control mechanism."

Researcher: "There wasn't any particular reason why you chose food?"

PB: "...Why did I choose? Well I suppose maybe it's secretive. For a start it's obviously the only one of the only things in your life that's in your own control. Erm, nobody really looks, unless you're involved in eating disorders people don't know what to look for, really, so you can get away with it. Erm, I could, living at home I could get away with it easily because I could say I'd eaten dinner erm, when I hadn't so then I

wouldn't eat tea erm and so on so forth so erm, probably because, maybe because it was so secretive I don't know, maybe again because people won't look for it [pause]. And also I suppose actually, this is quite an important reason, erm there is an aspect about becoming thinner yeah, so, to me that would be related to sexual desire erm, of-of-of boys towards me so [pause] I got quite a lot of attention erm [laughs] but what I was saying is I got the attention erm so then I was aware of the body shape there as well, so maybe that had a part to play as well because I wanted the, I wanted to be, I wanted attention [laughs] coz I wasn't having it off anyone else. But I realise now I'm conflicting myself because I wanted to be in the background as well, so it's really not that clear to me still."

PC found out her father was having an affair with someone her own age that she also knew. She was very upset and described that she did not know how to cope with the situation, especially as she had always thought her parents were a "fairytale couple" She went travelling but when she returned home her parents had not completely reconciled. After dieting and exercising she described that these were an effective escape mechanism from the stress at home and fluctuated between anorexia and bulimia nervosa:

"My mum told me one day that my dad was having an affair with a girl who was my sister's age, who I knew, who was a friend of, not a direct friend of mine but sort of a girl I knew, and erm, I think that, I had a problem dealing with that... but I just fell apart and couldn't cope with it really...So I think, I dunno if, I don't know if that's a direct thing on you know my disorder, I think that's something I found difficult to deal with, so sort of."

Researcher: "So when you found out and you stayed at home what was the atmosphere like, how did you cope, how did you react to it?"

PC: "It was really, I mean it was really hard because, my mum sort of, you know, said you can ask whatever questions you want, she was finding it really hard to deal with and erm and we did sit down and talk about it, but I found it really hard to ask my dad questions and I was struggling myself to understand and, I mean for quite a while I didn't talk to him. And there was always tension in the house for quite a while and then there was sort of, my mum, I just heard a conversation with my mum saying you know, are you having an affair with this person, that person. And I think it was just growing up and realising that relationships aren't perfect and my dad's not perfect and the marriage hasn't been and, it's survived now and they are happier. But I think I just really struggled, so, I think I just felt really insecure with it all and, didn't really deal with it well or didn't really try and deal with it just tried to bottle it up and ignore it but erm, never really came to terms with it like."

Researcher: "Did you ever have an outlet for how you felt or did you keep it all bottled up?"

PC: "I did start going out, you know, drinking loads and trying drugs and stuff when I was younger and that was definitely in response to. But that wasn't a long phase it was still, I wasn't really into drugs really so hugely that it became, but that was the first time I tried to do and that didn't really work. And then I was desperate to go away traveling and I went away and you know, completely sort of thought that would be the way of getting a new life. And then I came back and then obviously I probably walked back into similar feelings you know of worrying about how the family was and the odd arguments here and there it just all came to a bit of a head really and, I dunno I

suppose its taken a little while to get my head around certain things. But, I think it's coz I went from something that was so, it seemed clean cut to me to being the opposite way, I didn't grow up you know like some of my friends with, being aware of family problems or aware of things that would go on in marriages, of how hard marriages were, I think I grew up with a, I think maybe a naïve attitude towards it."

Researcher: "Erm, how old were you when this happened?"

PC: "I was sixteen. And when I came back from travelling I was nineteen."

Researcher: "And then that's when your eating disorder started?"

PC: "Yeah. I mean I think, I know I came back from travelling after my A-levels and when I was at university I started using like exercise extremely and started monitoring my food, quite obviously. But first there was a reaction to sort of people around me being so slim and me feeling so big and sort of and then. It wasn't just a, I mean I don't think it ever is, it wasn't just a physical thing but it was emotional, I was really confused, I didn't know where I was going, I dropped out of university and just didn't know what to do, so I think it became a way of, something to put my energies into and you know trying the usual things first, by looking at, I dunno to try and stop eating or you thinking ah, I've done well today, I haven't eaten or I don't know, I started to get a really different mentality that I hadn't had before."

PD always had a close relationship with her mother. She relied on her mother to discuss her problems with. When she entered puberty and had the 'normal' feelings of instability she relied on her mother even more. However her mother went back into full time work leaving PD with no ally through this difficult time. PD described feeling deserted and

lonely and different to others, she found everything except her food intake uncontrollable:

"I can pinpoint it back to when I was about thirteen my mum went back to work and at the same time I started my periods, I started developing and I remember feelin' this overpowering feeling of being alone, my mum was in work all the time, before that I'd always had her. My friends were, growing up the same as me but they were really interested in boys, for some reason I didn't follow the same interest as them and I just felt really alienated and isolated, and [pause] I think it was my way of coping, my way of not growing up....I think I resented her on the grounds that she'd deserted me at a time when I needed her... I couldn't control my teenage years, I couldn't control the feelings like that I wasn't interested in blokes in the same way my friends were, or so I thought at the time, and so I could control the food, I could control the exercise, I could control my school work and I just ploughed myself into those."

PE found mealtimes traumatic from a very early age because she was often made to eat her food in a separate room to the rest of the family. She remembered feeling fat in her pre-school years and later feeling guilty for enjoying food because through her childhood it had always been an uncomfortable experience:

"When I was little [pause] meals were very formal, you'd all have to sit at the table and you didn't get down until you'd finished...I can remember my parents, well my mother in particular was always saying to me "stop playing with your food, you're not eating it properly" and the classic one was she always used to say, "you're giving me indigestion, I'm going to take you into the other room until you've finished". So I used

to get taken into another room and sat at a coffee table in a wicker chair with my plate and I'd be left in there 'til I'd finished...it was my mother who used to take me to the other room and stick me in the chair and leave me there and tell me I wasn't eating properly, that I was causing her to be upset, erm...so I used to hate meal times, sitting round the table."

Researcher: "How do you think the eating disorder actually developed?"

PE: [Sigh] "I think I saw food as a, as a trial, as a torture, that it wasn't, eating wasn't a pleasant experience, it was something to be endured erm, and it was not a time of day I would look forward to. And although I would enjoy things outside mealtimes, mealtimes themselves were something to dread and I think it was that that made it begin. And, I can also remember again, this is pre-primary school age that I was fat, and I don't know where I got that from coz I don't remember my mum telling me but that was how I felt, I could see it in the mirror, yet I know now looking back at old photographs that I wasn't fat, I was just normal, normal size little girl, but that was how I felt, there seemed to be this feeling even then. I think I used to feel, I think it developed then from feeling guilty about [pause] enjoying food, because I'd always seen mealtimes as difficult it was, somehow it didn't seem quite right that I enjoyed eating some things."

Researcher: "Can you remember what age you were sick?"

PE: "I can definitely remember being sick about twenty-two. Erm, but I know I used food as a comfort food before then, erm, sixteen, seventeen and I can remember experiencing some death by chocolate because I needed something to comfort me."

Researcher: "Why would you need comforting?"

PE: "Erm, I felt out of place, that was when I was at school. And I just felt that everybody else was cleverer than me, everybody else knew what they wanted to do erm, and everybody else seemed reasonably happy, I just felt different erm, and I didn't know why."

Researcher: "Looking back do you know why you felt like that?"

PE: "I think it was because I was so isolated [pause] because I spent so much time alone at home with my parents who didn't do anything themselves, they didn't socialise, I think it was just that really just isolation....[pause] I did see it as a way to control weight, that I could still eat things and yet not put on weight, and I think it was also erm a way to keep testing myself that I could still do it, that I could still make myself sick, that sounds silly but, it was almost as if, I had to keep doing it so I didn't lose the technique. Coz I could see it as an advantage, if I could be sick after eating, erm, but it, it was, the way I saw being able to eat things I enjoyed and not put on the weight that I would have done otherwise....I can see it more now that it was [pause] a way I punished myself, I felt guilty for eating, or for anything else, I-I used it as a way of punishing myself. I know control sometimes comes into it, I'm not so sure about this, how it felt for me that it was a control, a way of controlling my life. I think it was more about erm [pause] whether it was control for myself."

When she married she felt her life was stable and her eating became regulated again, but when she began having marital problems she needed to gain control once more and did so by 'practising' vomiting after food to remind herself that she 'could still do it.'

"I think it gradually built up where I wasn't happy in my marriage and just wasn't happy with life in general and I began to get more and more stressed and I didn't have any other kind of outlet. Erm, I couldn't really talk to my husband or anybody else and so I think I sort of took some comfort in food but was just too frightened of putting on weight so the vomiting began again, and it built up like that."

Until her teens PF was brought up by her grandfather, whom she thought was her biological father and to whom she was very close. When he died PF began to binge as a comfort response. She was then told that her auntie was actually her mother and she would have to live with her. PF felt that it was clear from the beginning that she was unwanted and was there because her mother had been told PF was her 'responsibility'. At mealtimes she described having to eat different meals to the rest of the family because her mother refused to buy extra for her. When PF was old enough to care for herself she sought comfort and independence through buying her own food and eating what she wanted:

"When I was young there was never a lot of food in the cupboard...now I always have to have me cupboard stocked up, whether I eat it or not, it's got to be there, I've-I've got to always feel like the cupboards full er, because there was never anything, it was just bought on the day and, I would never say, I never went hungry there was always a meal on the table, but you'd never always be full after it, and that's all there was. So I think that's what must have developed the interest in food when I was able to sort of start buying my own, er. I would say it stemmed from the time when my dad passed away and I used to comfort eat then...to make myself feel better.

Researcher: "Was it continuous from then, did it carry on?"

PF: "Yeah, I would say it escalated from there... looking back and can see that I did use food as a comfort... Well the childhood trauma... of losing me granddad, having to go to someone who didn't want me. I suppose they were the two main reasons."

2.3.5 Eating Disorders as a Coping Strategy

The super-ordinate theme of 'eating disorders as a coping strategy, consists of three sub-themes: avoidance technique, control, numbing/blocking. The participants felt that their eating disorder was highly effective in giving them a sense of control. They described using it as an avoidance technique and as an 'activity' that blocked out other thoughts that they did not want to deal with:

2.3.5.1 Avoidance Technique

"...something to concentrate on and you've got something to put-for me it was something to put my energies into..." (PC)

"But I know in the end that I didn't have to focus on anything real because all I was focusing on was whether I could put two feet in front of each other without passing out and could I get to work and could I walk somewhere without having a bucket." (PA)

2.3.5.2 Control

"Things were predictable, safe and nothing unexpected really happened coz you were in control." (PA)

"For a start it's one of the only things in your life that you can control" (PB)

"I was in control of what was happening, but that year I was really quite controlled...I was very rigid...I couldn't be flexible..." (PB)

"It gave you a sense of power and control." (PB)

"I do monitor my food...if I just go that little bit out of control thinking I've eaten too much it's like feeling like everything's out of control." (PC)

"I couldn't control my teenage years...I could control the food, I could control the exercise." (PD)

2.3.5.3 Numbing/Blocking

"...numbing things off, giving you a high, blocking things out..." (PA)

"If I did know it I blocked it out or it would have come out in the food." (PB)

"You were on a real high...as if everything else was just gone and it was just you and the food." (PF)

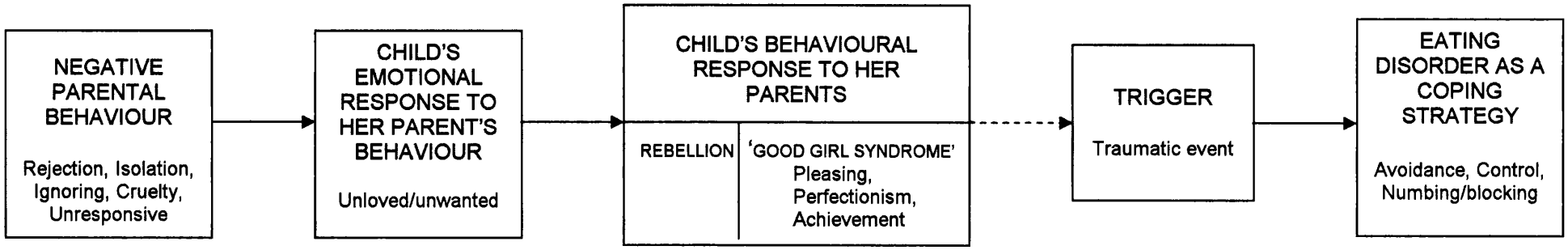
"You didn't think about the end [of the binge], *you only seemed to think about that moment, and at that moment it did actually make things better." (PF)*

2.3.6 Summary

When the super-ordinate themes were considered collectively they seemed to form a process that led to the participants' eating disorders (Figure 2.1). The parents' negative

behaviour towards their children seemed to begin a sequence of negative feelings (unloved/unwanted) and dysfunctional beliefs and behaviour (for example perfectionism) in the children. Common to each participant was the presence of personally traumatic events that occurred directly prior to the beginning of their eating disorder. The eating disorder itself seemed to provide a sense of emotional protection for the participants, which meant that they did not have to deal with emotionally uncomfortable thoughts.

Figure 2.1: A preliminary theoretical model of the development of eating disorders based on qualitative super-ordinate themes.



⟶ = Related path - - - -▸ = Unrelated path (the trigger stage was unrelated to the previous stages but was necessary for the eating disorder to develop)

2.4 Discussion

2.4.1 Methodology

IPA led to a richer understanding of the data because it allowed individual differences to be explored. This exploration was important in the current study because each aspect of each theme held differential importance for each participant; for example, all the participants experienced the first super-ordinate theme, negative parental behaviour. However, PF described the cruelty (by her mother) sub-theme in detail whereas the sub-theme of feeling rejected was central to PD's life. Furthermore GT would have documented similar themes between the participants, but may have by passed differences that in IPA are important because they explain why a participant behaved in a particular way or felt different to the others. These different feelings or behaviours may be important in each person's progression into their eating disorder, for example PB rebelled instead of trying to please her parents. IPA allowed the researcher to identify the reason why PB rebelled and the other participants did not (the reason being that she had a different understanding of her situation and relationship with her parents to the other participants).

IPA achieved a level of intimacy with the data from each participant that GT may not have achieved. GT purports that there should be one core category (Glaser, 1978) and it is this core category that ties all the other themes together. Although the starting point seemed to be the same for each participant, the process of reaching their eating disorder differed from within each theme. However, all of the participants' individual experiences within each theme were crucial to the process of developing their eating disorder. Had GT been used on the data the subtle pathway differences may never have been identified.

2.4.2 Themes

The first super-ordinate theme (negative parental behaviour which was also the first stage of the model) included behaviours that are listed in the operational definition of emotional abuse; rejection, isolation, terrorism (psychological cruelty) and unresponsiveness. These behaviours seemed to be persistent and in some cases severely inappropriate (for example the parental response to PA's rape, PF's mother's attitude toward PF), satisfying what would be considered by clinicians to be emotionally abusive behaviour. Furthermore the findings support Chassler's (1997) findings that eating disordered people reported their attachment figures (in the present study both mothers and fathers) as being "less responsive" and "trustworthy".

As previously discussed, research has shown that emotional abuse may be a predictor of unhealthy eating attitudes (Kent et al, 1999; Witkiewitz and Dodge-Reyome, 2000). The present study may extend previous findings as the results seem to be indicative of a predictive link between emotional abuse and eating disorders.

Kent et al (1999) suggested that an indirect relationship existed between emotional abuse and unhealthy eating attitudes, that the relationship was mediated by depression, anxiety and dissociation. Although the present study supported the presence of a mediated relationship, there as no evidence that Kent et al's mediators had an influential role in the relationship dynamic. Instead it was suggested that emotional abuse was related to eating disorders through a different culmination of mediators that formed three of the super-ordinate themes: emotional response to parents, behavioural response to parents and triggers.

The child's emotional response to their parent's behaviour highlighted a parsimonious association between the attachment and emotional abuse literature. Both have in common that dysfunctional attachment patterns and the emotional effects of emotional abuse impair the child's emotional development. The child feels 'unloved' and 'unwanted' (feelings that resulted from the negative parental behaviour theme in the present study) and becomes unable to 'regulate' and 'modulate' their emotional experiences (demonstrated through the child's behaviour in the 'good girl syndrome' sub-theme in the present study; Ainsworth et al, 1978; Chassler, 1997; O'Hagan, 1995). The result of the above is a skewed sense of the world, an inability to cope with stressful life events and ultimately, dysfunctional coping strategies (such as an eating disorder).

The good girl syndrome sub-theme seemed to be a response to feeling unloved which had been brought about by the parents' negative behaviour toward the participants. The participants' response of trying to please and be perfect was supported by previous suggestions that parents' attitudes and behaviours are primary contributors to the development of perfectionism (see section 1.5). Shafran and Mansell (2001) laid out four early childhood experiences that summarise the parents' role in the development of perfectionism. These four experiences seemed to encapsulate the participants' experience in the present study; for example, PA felt that her father would only respond to achievement orientated conversation, he would ask each of his children only about their academic achievements and would become angry if PA did not understand her homework. All these behaviours seemed reminiscent of Shafran and Mansell's second childhood experience, that parents have high expectations and standards of performance and are indirectly critical. PC stated that she was aware that her parents were high achievers with professional careers and felt that she needed to achieve the same level of

success. PC's feelings seemed to be reminiscent of the fourth childhood experience that perfectionistic parents act as models for perfectionistic attitudes and behaviours.

The participants' perfectionism seemed to be driven through the want of approval from others, primarily their parents. Terry-Short et al (1995) found that eating disordered people had high levels of social perfectionism which seemed to support the findings of the present study. The present model suggested that if the participants could gain approval from their parents (which they were trying to do through achievement and being perfect; an example of social perfectionism) they would then be loved and wanted by their parents, a theory that uses similar principles to that of Vohs et al (1999), Joiner et al (1997) and Hewitt et al (1995; see section 1.5) who suggested that by being perfect the person gains social acceptance and in turn increase their self-esteem.

The discussion of the first three themes of the model illustrate that the participants did not have a 'stable base' (Bowlby, 1988) which meant that faulty beliefs were able to develop (such as perfectionism and rebellion). This theory is in line with Salzman (1997) and Ward et al (2000) who suggested that dysfunctional attachment might effect the child's psychological development. More directly the 'trigger' super-ordinate theme supported Ainsworth et al's (1978) findings that because the child cannot rely on the parents for support, when faced with life difficulties they may develop deviant coping strategies. It appeared that the trauma triggered extreme feelings such as the need for internal control and to block out unwanted thoughts. In turn these feelings promoted a more extreme and dysfunctional coping strategy; the eating disorder. However, recently it has been found that post traumatic stress disorder (PTSD) may a play a unique role in the development of an eating disorder (Black-Becker, DeViva and Zayfert, 2003).

However Black-Becker et al did not research why the connection existed between PTSD and eating disorders, it may be that the current theoretical model sheds light on the reason for the connection.

Crisp (1980) writes that a 'sense of control and confidence' comes from restrained eating. He argued that an eating disorder 'is the only way in which...control can be exercised', it gives 'a sense of independence and autonomy – as well as a sense of controlling the environment'. The components of the final theme; eating disorder as a coping strategy, seem to support Crisp's theory and there is a plethora of past literature that also supports his theory, finding that the severity of eating disorder symptoms (in non-eating disordered and eating disordered populations) are linked to more feelings of external locus of control (Williams and Ricciardelli, 2003; Fouts and Vaughan, 2002; Horesh, Zalsman and Apter, 2000).

The participants in the present study described using their eating disorder as a method of avoiding unwanted feelings, essentially 'distracting' their thoughts away from intrusive thoughts and feelings. Further support for the final super-ordinate theme can be found in Ghaderi's (2003) structural modelling analysis regarding what factors predicted an eating disorder; he found that escape-avoidance coping (blocking/ignoring unwanted thoughts and memories) was a significant predictor. Andrews, Troop, Joseph, Hiskey and Coyne (2002) also found that those who used distraction as a coping strategy (for example, concentrating on calorific intake and exercise in the case of an eating disorder) were more successful in avoiding thinking about the past trauma.

2.4.3 Conclusion

In summary it seems that negative parental behaviour (potentially emotionally abusive behaviour) contributed to the development of a dysfunctional parent-child attachment, which led to the participant developing dysfunctional techniques to correct the attachment. This lack of a secure base, meant that when faced with traumatic life events the participants dealt with them in an emotionally inappropriate way. Through their eating disorder the participants attempted to gain internal control and avoid negative thoughts. The perfectionistic characteristics they had previously learnt enabled them to maintain the strict regime involved in the disorder.

The model presented by Kent et al (1999) is the only other model linking emotional abuse to eating disorders. Kent et al's findings that depression and dissociation mediated the relationship between emotional abuse and unhealthy eating were not supported; however they were also not challenged. The current model represents only one route to an eating disorder, it does not dismiss that there may be other routes.

2.4.4 Limitations

There may have been a selection bias in the recruitment of the participants in the present study. As all the participants attended self-help groups, they may have been more motivated to recover (if they have not already done so) or have different levels of psychopathology to those eating disordered people who do not attend any kind of therapy. However, there was the possibility that the participants' opinions about their parents might have been influenced by their therapist. The therapist's own beliefs about eating disorders may have influenced the way they carried out their therapy. They may have led the participants to view their parents in a particular way or placed importance

on associations between life events and their eating disorder that may not have been important. However, none of the participants had been treated by the same therapist so this limitation should be viewed with caution. It may have been an advantage that the participants had attended counselling outside the groups. It may mean that they were able to speak with more insight and more freely about their disorder than perhaps someone who had not had counselling.

2.4.5 Further Analysis

The themes and subsequent model that have been presented seemed to be grounded in a vast quantity of literature. However it was recognised that the present study was conducted at a micro level. The model presented was theoretical and therefore could not be generalised to the wider eating disorder population. Quantitative analysis was necessary to provide empirical evidence to support the model. The model was therefore used as a framework for the following analysis.

In light of the model proposed, and the suggestion throughout the literature that general psychopathology is associated with both abuse and eating psychopathology, the following chapter reviewed the current literature on childhood abuse and how it impacts eating psychopathology through its connections with other forms of pathology. The aims of the subsequent research were stated at the end of chapter three.

Chapter 3

Literature Review: The Relationship between Emotional Abuse and Eating Psychopathology

3.1 Introduction

The adult psychological effects of childhood sexual abuse have perhaps been the most widely studied consequences of all the abuses (Briere and Runtz, 1990; Rorty, Yager and Rossotto, 1994). However, Mullen, Martin, Anderson, Romans and Herbison (1996) commented that 'a focus on sexual abuse should not be allowed to obscure the possible relevance of emotional and physical abuse to adult problems'. In the late 1980's the trend changed somewhat and the effects of physical and emotional abuse, both in isolation and cumulatively, began to be studied in more depth.

It has been widely accepted that early abuse has a damaging effect on adult psychopathology (Moeller, Bachmann and Moeller, 1993; Mullen et al, 1996; Rosen and Martin, 1996; Kent et al, 2000). In terms of general health Rodgers, Lang, Laffaye, Satz, Dresselhaus and Stein (2004) found that combined sexual and emotional abuse was correlated with risky adult health behaviour. Moeller et al (1993) found that abused women's subjective opinions that they had more physical and psychological problems than non-abused women were substantiated. Moeller et al (1993) found that an increase in the types of abuse experience increased the women's chances of illness and being hospitalised.

In the 1980s, connections were being made between emotional abuse and general psychopathology that relates to eating psychopathology. Briere and Runtz (1988) noted

that emotional abuse was associated with depression and anxiety, and in 1990 they demonstrated a connection between emotional abuse and self-esteem, as did others (Hart et al, 1987; Egeland, Sroufe and Erickman, 1983; Mullen et al, 1996).

3.2 Self-esteem

Self-esteem plays a fundamental role in eating disorders (Bruch, 1973; Fairburn, Marcus and Wilson, 1993a, b; Vitousek and Manke, 1994; Fairburn, Welch, Doll, Davies and O'Connor, 1997; Fairburn, Cooper, Doll and Welch, 1999; Quadflieg and Fichter, 2003). A strong association has been identified between emotional abuse and low self-esteem (Egeland et al, 1983; Hart, Germain and Brassard, 1987; Mullen et al, 1996; Thompson and Kaplan, 1996). As self-esteem is a common denominator of both emotional abuse and eating psychopathology, the possibility arises that there is a link between the two.

The connection between self-esteem and emotional abuse is thought to occur because of the insidious nature of emotional abuse. Children exposed to emotional abuse are thought to internalise it as their own fault (Hartt and Waller, 2002). If internalisation takes place it is likely that the child will develop a sense of low self-worth (or self-esteem; Polivy and Herman, 2002). Root and Fallon (1988) suggested that bulimia may be a way of coping with feelings of powerlessness. Kent and Waller (1999) proposed that a behaviour such as perfectionism (strongly associated with eating disorder psychopathology) may be used to counteract low self-worth.

3.3 Depression and Anxiety

Depression and anxiety are often co-morbid with eating disorders (Raffi, Rondini, Grandi and Fava, 2000; Polivy and Herman, 2002). It has been suggested that they mediate between emotional abuse and eating psychopathology (Kent et al, 1999).

Both Beck (1967) and Ingram (1984) stated that early exposure to negative messages, such as consistently telling the child he/she is stupid, worthless or ugly (comments considered emotionally abusive in the current definitions, see section 1.10), was likely to make an individual more prone to depressive episodes than those not so exposed. In Thompson and Kaplan's (1996) review of childhood emotional abuse, they stated that the presence of emotional abuse makes people vulnerable to a mixture of psychiatric disorders, one of the most notable being depression. They reported that depressed maltreated children reported more parental psychological unavailability and more parental rejection than non-depressed maltreated children.

Anxiety is another outcome of emotional abuse experience. Arrindell, Emmelkamp, Monsma and Brilman (1983) and Arrindell, Kwee, Methorst, van der Ende, Pol and Moritz (1989), Bruch and Heinburg (1994) and Bandelow, Torrente, Wedekind, Broocks, Hajak and Rüther (2004) among others found higher rates of anxiety in those whose parents were less caring, rejective and overprotective. Hostile and threatening behaviour on the part of the parent have also been found to predict anxiety (Scher and Stein, 2003).

Although the studies mentioned report an association between emotional abuse, depression and anxiety, few indicate why there is an association. Young, Ableson, Curtis and Nesse (1997) stated that although they found a correlation between early trauma and

anxiety there was a greater incidence of familial psychiatric disorders that may have confounded their results. Young et al's (1997) point was picked up by Bandelow et al (2004) who listed further reasons why poor rearing styles were associated with anxiety disorder; such as the child may be more sensitive to rejection and criticism, shy children may provoke overprotectiveness, the individual may be trying to find an understandable reason for their anxiety disorder, or psychotherapy may have triggered an increase in preoccupation with the individual's parents.

Alternatively, insight into coping strategies may explain the association between emotional abuse, depression and anxiety. Spertus, Yehuda, Wong, Halligan and Seremetis (2003) stated that 'emotional abuse and neglect thwart development and over time [this] leads to a decreased repertoire of adaptive behaviours and poor-self care'. Emotion-focused-coping is often highlighted as one such maladaptive coping strategy (Nolen-Hoeksema, 1987). Unlike problem-solving coping where the person tries to change the source of the stress and tackle the problem, emotion-focused coping is characterised by passive avoidance of, and distraction from, the problem. The relationship between emotion-focused coping and psychological distress is 'the most consistent finding in the coping literature' (Coyne and Racioppo, 2002). Emotion-focused coping has been linked to poor parental bonding experience, depression and eating psychopathology (Shatford and Evans, 1986; Troop, Holbrey, Trowler, Treasure, 1994; Wlihelm, Roy, Mitchell, Brownhill and Parker, 2002; Krause, Mendelson and Lynch, 2003).

Eating disorders are often described as dysfunctional coping strategies, used to avoid and distract from other psychologically distressing feelings or events in an individual's life

(Crisp, 1980; Fairburn et al, 1998; Waller, Ohamia, Meyer and Osman, 2000; Spranger, Waller, Bryant and Waugh, 2001). It may be that eating disorders are a form of emotion-focused coping, used in response to the depression and anxiety that results from emotional abuse. Kent et al (1999) found that anxiety mediated the association between emotional abuse and eating disorders.

3.4 Core Beliefs

Young (1994) identified fifteen negative core beliefs/maladaptive schema that he stated are formed by early childhood experiences (Table 3.1). These schema impact on the way the individual views the world (Meyer and Gillings, 2004).

Hartt and Waller (2002) reported associations between childhood abuse and negative core schema in a bulimic population. In particular emotional abuse was associated with mistrust/abuse, defectiveness/shame and emotional inhibition schema. The origins of the negative schema may indicate how they mediate between early childhood experience and bulimia. It may be that emotional inhibition stemmed from an aversive consequence following the expression of emotion. Defectiveness/shame schema is likely to develop if the child is criticised and made to feel unworthy (Young, 1994).

Meyer and Gillings (2004) built on Hartt and Waller's (2002) finding that mistrust/abuse beliefs partially mediated between parental overprotection and the severity of bulimic attitudes. They hypothesised that the parental overprotection meant the child was unable to develop suitable interpersonal coping strategies: they used bulimic behaviours (as an avoidance strategy) to 'block out the pain caused by the development of the mistrust/abuse beliefs' (Meyer and Gillings, 2004).

Table 3.1: Young's (1994) maladaptive schemas (reproduced from Waller, 2002)

Abandonment (the belief that close relationships will end imminently);
*Functional dependence/incompetence (*the belief that one is not competent and cannot be independent);
*Defectiveness/shame (*the belief that one is internally flawed);
Emotional deprivation (the belief that one's emotional needs will never be met)
Emotional Inhibition (the belief that one's emotions should be inhibited to avoid adverse consequences);
Enmeshment (the lack of individual identity, due to emotional over-involvement with others);
Entitlement (the belief that one can act without consideration for others);
Failure to achieve (the belief that one is incapable of performing well);
Insufficient self-control (the belief that one cannot control one's impulses or feelings);
Mistrust/abuse (the belief that one will be taken advantage of by others);
Subjugation (the belief that one must submit to others to avoid negative consequences);
Social isolation (the belief that one is different and isolated from the world);
Self-sacrifice (the belief that one must sacrifice one's own needs to help satisfy others' needs);
Social undesirability (the belief that one is unattractive to and disliked by others);
Unrelenting standards (the belief that one should strive for unrealistic standards);
Vulnerability to harm and illness (the belief that one has no control over the threat of disasters)

Meyer and Gilling's (2004) idea of eating disorders serving as a coping strategy in relation to dealing with negative beliefs (and indirectly negative childhood experiences) has been developed by Cooper, Wells and Todd (2004). They too hypothesised that childhood abuse leads to the development of core schema that subsequently trigger core schema compensation behaviours, such as dieting and binging, as a means of coping.

3.5 Aims of current research

The reviewed literature demonstrates that emotional abuse (separate from other abuses) can have an independent effect on psychopathology; a number of possible links between emotional abuse and eating psychopathology were highlighted. However, although the literature is clear that an association exists between emotional abuse and eating

psychopathology, direct empirical evidence of why or how the association functions is less clear. The model proposed (Figure 2.1) goes some way to operationalise the association between emotional abuse and eating psychopathology. The primary aim of the current work was to investigate the relationship between emotional abuse and eating disorder development, based on the proposed model. The aim was accomplished through a series of smaller objectives.

Objective 1: Develop a multi-dimensional measure of emotional abuse (see chapter 4).

Objective 2: Investigate the effects of emotional abuse on eating psychopathology independently of sexual abuse, physical abuse and neglect.

Objective 3: Investigate the centrality of emotional abuse in the development of eating psychopathology.

Objective 4: Test a mediational model of emotional abuse and eating psychopathology as proposed in Figure 2.1.

CHAPTER 4

Development of the Parental Emotional Abuse Questionnaire (PEA-Q) in a Female Population

4.1 Introduction

In clinical settings clinicians and therapists interview patients to explore whether they have a history of emotional abuse. Therefore it is typically left to their discretion whether an event, action or behaviour is labelled as abusive. Inevitably this may lead to imprecise diagnoses and discrepancies between clinicians (Thompson and Kaplan, 1999). However with the recent operational definition that is currently used these discrepancies have reduced (ibid). In a research setting the luxury of interviewing large samples of people is rarely possible. Therefore a standardised measure of emotional abuse is necessary. However, there are few questionnaires that specifically measure emotional abuse and the measures that are available do not always incorporate the dimensions laid out on the operational definitions available.

Generally when emotional abuse is measured quantitatively it is included as a scale within a questionnaire that measures other variables, for example the Parental Bonding Instrument (PBI; Parker, Tupling and Brown, 1979) and EMBU (Egna Minnen Betraffande Ufostram: 'My Memories of Upbringing'; Perris, Jacobson, Lindtröm, Knorring and Perris, 1980).

The PBI (Parker et al, 1979) was designed to measure the bond between parent and child, rather than investigating whether the behaviour was abusive; the EMBU (Perris et

al, 1980) is concerned with the general rearing style of parents, rather than whether the rearing behaviour is emotionally abusive, and finally the Parent-to-Child Conflict Tactics Scale (CTSPC; Straus, Hamby, Finkelhor, Moore and Runyan, 1998) measures ways of dealing with conflict rather than abuse.

The few existing emotional abuse instruments have a limited scope. Briere and Runtz's (1988) psychological abuse scale only tapped verbal abuse. Engels and Moisan's (1994) Psychological Maltreatment Inventory (PMI) asked participants about the effect of the abuse rather than how often it occurred. Sanders and Becker-Lausen's (1995) Child Abuse and Trauma Scale (CATS) measured emotional abuse in terms of 'negative home environment' (e.g. 'did you feel disliked by either of your parents?'). Kent and Waller (1998) extended the CATS to include a seven item emotional abuse subscale that asked questions about the participants' experience of being terrorised and isolated by their parents. Although a significant advancement on Briere and Runtz's abuse questionnaire, the modified CATS still did not incorporate the full range of emotional abuse dimensions, such as those laid out by the APSAC (1995) and Hart and Brassard (1990).

The PMI (Engels and Moisan, 1994) is the most comprehensive measure of emotional abuse discussed so far. The PMI included items that closely related to the operationlised dimensions of emotional abuse, such as rejection, isolation, aggression, emotional neglect and indifference. However the PMI asked the participants to respond based on the 'negative effect' it had on them rather than how often the negative behaviour had occurred. As discussed in section 1.10.3, the severity and persistence of negative behaviours are important because these factors identify when behaviour becomes abusive.

The previous two questionnaires measured emotional abuse by parents as a single unit. Kent et al (1999) suggested that a questionnaire that measured emotional abuse by mothers and fathers separately may highlight whether a non-abusive parent can buffer against the effects of an abusive parent. In fact Parker et al (1979) found that mothers were perceived as 'more caring and slightly more overprotective than fathers'.

In light of the failure of the existing questionnaires to tackle the multi-dimensional nature of emotional abuse, the present study developed an emotional abuse questionnaire that incorporated items from each dimension of emotional abuse. The first version of the questionnaire measured parental behaviour, the second version of the questionnaire was in two parts that measured mother and father emotional abuse independently.

4.2 Method for the Development of the Parental Emotional Abuse Questionnaire

4.2.1 Participants

Approval was obtained from the local Ethics Committee. All of the participants were female and recruited from the general public. The majority of participants were approached by the researcher who asked them to complete the questionnaire. Some of the participants were recruited through snowballing. 249 participants took part in the current study. The participants' ages ranged between 18-73 years old ($\underline{M}$ = 35.1, SD = 12.3).

4.2.2 Questionnaire Items

52 items were compiled based on the findings in chapter 2 and the operational definitions available (shown in Table 4.1). The items were thought to explore emotional unresponsiveness, emotional unavailability, emotional inappropriateness, rejection,

isolation, terrorising, threatening and ignoring behaviour. Each item asked how often the participants' parents had acted in a stated way through the participants' childhood, up to and including the age of 16. They responded to each item on a seven-point scale that ranged from 'never' (1) to 'always' (7).

4.3 Results of the Development of the Parental Emotional Abuse Questionnaire

The data were subjected to factor analysis. Following the initial principal components analysis, the scree plot identified 3 factors with eigenvalues of 21.38, 3.62 and 2.1 respectively that accounted for 52.13% of the overall variance.

Pallant (2003) suggests that to carry out factor analysis the equivalent of 5 participants per item is generally accepted. Comery and Lee (1992) state that a sample size of 200 participants is 'fair', whilst 300 is 'good'. The present study met both of these criteria. The Kaiser-Meyer-Olkin (KMO) measure of sampling adequacy indicates whether the factor analysis of variables is acceptable (Kaiser, 1974). Kaiser stated that a KMO measure of 0.9 and above was 'marvellous', 0.8 - 0.9 was 'meritorious', 0.7 - 0.8 was 'middling', 0.6 - 0.7 was 'mediocre', 0.5 - 0.6 was 'miserable' and below 0.5 as 'unacceptable'. The present variable had a KMO of 0.94 so was comfortably suitable for factor analysis. Bartlett's test of sphericity was significant ($p<0.0001$) indicating that the sample used was from a 'multivariate normal distribution' and that it was appropriate to use a factor model (Bartlett, 1954).

To enhance the meaningfulness of the factors the factor matrix was rotated using varimax rotation. Varimax rotation was chosen because it attempted to minimize the

number of variables on each factor, producing a cleaner, more interpretable factor structure.

23 items loaded heavily on factor 1, 9 items loaded on factor 2, and 6 items on factor 3. Due to the large number of items in the analysis a minimum loading cut off point of 0.55 was used to extract the high loaders and reduce the number of cross-loaders. The overriding construct reflected in factor 1 was parental emotional coldness; the feeling that 'you were unwanted by your parents'. Factor 2 pertained to the participants' parents being overprotective, and factor 3 was defined as psychological punishment, such as being blamed 'for things you didn't do'.

Cronbach's alpha was carried out on each factor. The 'Alpha if item deleted' figures were used to establish whether it was beneficial to exclude some of the items. The items that were excluded through using Cronbach's alpha were already items that had been identified as loading above the 0.55 cut-off point but were difficult to interpret. This process allowed a much more concise questionnaire to be produced that was especially important because mother and father versions of the questionnaire would later be produced that would increase the number of items two-fold (all factor loadings are shown in Table 4.1). The 21 remaining items (Table 4.2) were subjected to further factor analysis.

Table 4.1: Initial factor structure of the Parental Emotional Abuse Questionnaire

	I	II	III
Factor 1			
Did your parents sulk or refuse to talk to you about an issue?	**.601**	.253	.285
Did your parents show a lack of interest towards you?	**.694**	.055	.226
Were you ever blamed for your parents' wrongdoing?	**.600**	.170	.463
Did your parents make you feel like you were a bad person?	**.607**	.312	.424
Did your parents seem emotionally cold to you?	**.813**	.169	.180
Were you emotionally isolated from your family?	**.718**	.221	.257
Were you emotionally rejected by your parents?	**.730**	.206	.393
Were you ever made to feel that you should 'stay out of the way'?	**.675**	.188	.345
Did you feel uncomfortable with your parents because you didn't know what to talk about?	**.735**	.262	.159
Did you feel emotionally isolated from your parents e.g. you didn't know what they expected from you or how they felt about you?	**.740**	.266	.305
Did you ever feel unwanted by your parents?	**.759**	.107	.337
Did you ever feel unloved by your parents?	**.772**	.136	.331
Were you ever made to feel that you were a burden to your parents?	**.775**	.114	.318
Factor 2			
Did your parents try to make you feel dependent on them?	.286	**.623**	.228
Did your parents try to prevent you from growing up?	.183	**.662**	.015
Did your parents try to control everything you did?	.221	**.717**	.279
Did your parents try to make you feel like you couldn't cope without them?	.323	**.658**	.222
Were your parents overprotective of you?	-.185	**.607**	.031
Factor 3			
Did your parents ever get really angry with you when you thought there was no reason to be?	.449	.281	**.550**
Were you grounded or your privileges taken away?	.142	.128	**.702**
Did your parents blame you for things you didn't do?	.406	.194	**.598**
Were you ever shouted/yelled/screamed/cursed at by your parents?	.257	-.066	**.749**
Were you ever physically isolated from your family i.e. forced to go into another room/part of the house?	.270	.176	**.643**
Did your parents ever get really angry with you?	.380	.136	**.657**

Table 4.1: Factor structure of the Parental Emotional Abuse Questionnaire continued

	I	II	III
Excluded Items			
Did your parents ever say they would send you away or kick you out of the house?	.492	.111	.529
Were your parents ever available to speak to when you had a problem?	**.699**	.185	-.211
Were you ever stopped from doing things you liked doing by you parents, even though there seemed no valid reason?	.287	.510	.271
Did your parents threaten to spank or hit you but did not actually do it?	.105	.108	.425
Were you ever ridiculed or humiliated by your parents?	.530	.239	.361
Did your parents let you do things you liked doing?	.298	-.513	-.063
Were you forced into something by your parents that you didn't want to do?	.273	.413	.392
Did you feel you parents' choices of what you were not allowed to do was unfair to you?	.191	**.563**	.400
Did your parents praise you?	**-.694**	-.245	-.098
Did your parents allow you to go out without supervision?	.097	-.335	.196
Did your parents not talk to you very much?	.508	.121	.168
Was there a tense atmosphere at home?	**.620**	.220	.361
Do you feel you had an excessively strict upbringing?	.210	**.579**	.374
Would your parents agree to let you do something then change their mind for no reason?	.334	.378	.492
How often do you feel your parents were dismissive of your problems, e.g. because they thought they weren't important enough/childish/they were busy?	**.634**	.219	.372
Were you parents academically supportive?	-.538	-.081	-.080
Did you feel you could rely on your parents for emotional support?	**-.822**	-.138	-161
Were you allowed to partake in something you enjoyed, that your parents consented to, even though they did not like it?	-.462	-.448	-.135
Do you feel your parents responded inappropriately to emotional problems you had?	**.558**	.112	.324
Did your parents try to instil a sense of personal freedom?	-.200	-.540	.068
Do you feel you parents tried to understand your views?	**-.614**	-.374	-.213
Do you fell your parents didn't listen to you?	**.570**	.353	.327
Did your parents try to socially educate you?	**-.576**	-.157	.048
Did your parents purposefully ignore you?	**.579**	.191	.356
Were you ever allowed to partake in hobbies of your choosing?	-.520	-.415	-.119
Did you have the choice of not partaking in a pastime/activity even though your parents wanted you to?	-.221	-.439	-.076
Did you have a sense of personal freedom?	.301	**-.723**	-.156
Were you ever stopped from doing something by your parents that other friends were allowed to do?	.056	**.605**	.240

The scree plot and eigenvalues (10.25, 2.28 and 1.35 respectively) of the second factor analysis both indicated a three-factor solution, which accounted for 66.33% of the variance. The KMO was 0.93 and Barlett's test of sphericity was significant ($p<0.0001$). Eleven items loaded on factor 1, and five items loaded on factor 2 and factor 3 (see Table 4.2). The content of each factor were the same as in the first factor analysis.

A high level of internal consistency was demonstrated for the final parental emotional abuse questionnaire. Chronbach's alpha for factor 1 was 0.96 while factors 2 and 3 had alpha scores of 0.82. Item-total correlation coefficients were also high for each item ($p<0.0001$).

Table 4.2: Final factor structure of the Parental Emotional Abuse Questionnaire

	I	II	III
Factor 1			
Did your parents show a lack of interest towards you?	**.719**	-.065	.197
Were you ever blamed for your parents' wrongdoing?	**.634**	.207	.207
Did your parents make you feel like you were a bad person?	**.642**	.359	.343
Did your parents seem emotionally cold to you?	**.856**	.150	.155
Were you emotionally rejected by your parents?	**.782**	.248	.336
Were you ever made to feel that you should 'stay out of the way'?	**.757**	.133	.268
Did you feel uncomfortable with your parents because you didn't know what to talk about?	**.701**	.306	.159
Did you feel emotionally isolated from your parents e.g. you didn't know what they expected from you or how they felt about you?	**.757**	.291	.280
Did you ever feel unwanted by your parents?	**.849**	.085	.248
Did you ever feel unloved by your parents?	**.841**	.131	.261
Were you ever made to feel that you were a burden to your parents?	**.846**	.109	.238
Factor 2			
Did your parents try to make you feel dependent on them?	.259	**.717**	.186
Did your parents try to prevent you from growing up?	.169	**.704**	.031
Did your parents try to control everything you did?	.217	**.757**	.257
Did your parents try to make you feel like you couldn't cope without them?	.366	**.751**	.155
Were your parents overprotective of you?	-.178	**.729**	-.020
Factor 3			
Did your parents ever get really angry with you when you thought there was no reason to be?	.635	.305	**.620**
Were you grounded or your privileges taken away?	.130	.101	**.808**
Did your parents blame you for things you didn't do?	.413	.205	**.609**
Were you ever shouted/yelled/screamed/cursed at by your parents?	.266	-.049	**.754**
Were you ever physically isolated from your family i.e. forced to go into another room/part of the house?	.320	.162	**.620**

4.4 Method for the Development of the Mother and Father Emotional Abuse Questionnaires

4.4.1 Participants

163 participants completed the mother and father emotional abuse questionnaires. The participants were recruited in the same way that they were recruited to complete the parental version of the questionnaire (see section 4.2.1). The participants' ages ranged between 16 and 77 years old ($\underline{M}$ = 34.2, SD = 12.62).

4.4.2 Questionnaire Items

The same 21 items that were produced in the final factor structure of the parental version of the questionnaire were used in the mother and father versions of the questionnaire. The participants responded to the items in the mother and father questionnaires in the same way that they responded to the parental questionnaire items.

4.4.3 Factor Analysis of the Mother Emotional Abuse Questionnaire

Three factors were requested to match the factors of the parental questionnaire. The content of the factors on the mother questionnaire were almost identical to the parental version of the questionnaire. The eigenvalues were 9.62, 2.56 and 1.53 respectively. The KMO was .90, Bartlett's test of sphericity was significant ($p<0.0001$) and the total variance accounted for was 65.29%. The cut-off loading point remained at 0.55 (see Table 4.3 for factor structure). One item that loaded above the cut-off point on the parental questionnaire loaded below the cut-off point on the mother questionnaire, so was excluded from the final factor structure (Table 4.4).

Table 4.3: Initial factor structure of the Mother Emotional Abuse Questionnaire

	I	II	III
Factor 1			
Did your mother show a lack of interest towards you?	**.736**	.169	.102
Did your mother seem emotionally cold to you?	**.872**	.170	.174
Were you ever blamed for your mother's wrongdoing?	**.631**	.098	.286
Were you ever made to feel that you should 'stay out of the way' by your mother?	**.764**	.076	.264
Did your mother make you feel like you were a bad person?	**.708**	.197	.334
Were you emotionally rejected by your mother?	**.747**	.205	.278
Did you feel uncomfortable with your mother because you didn't know what to talk about?	**.618**	.347	.113
Did you feel emotionally isolated from your mother e.g. you didn't know what she expected from you or how tshe felt about you?	**.789**	.293	.131
Did you ever feel unwanted by your mother?	**.861**	-.040	.226
Did you ever feel unloved by your mother?	**.858**	.116	.187
Were you ever made to feel that you were a burden to your mother?	**.836**	.051	.201
Factor 2			
Did your mother try to make you feel dependent on her?	.318	**.705**	.282
Did your mother try to prevent you from growing up?	.191	**.869**	-.083
Did your mother try to control everything you did?	.295	**.732**	.261
Did your mother try to make you feel like you couldn't cope without them?	.171	**.761**	.077
Were your mother overprotective of you?	-.133	**.793**	.094
Factor 3			
Did your mother ever get really angry with you when you thought there was no reason to be?	.297	.154	**.667**
Were you grounded or your privileges taken away?	-.095	.088	**.779**
Did your mother blame you for things you didn't do?	.434	.129	**.588**
Were you ever shouted/yelled/screamed/cursed at by your mother?	.330	.143	**.740**
Excluded Items			
Were you ever physically isolated from your mother i.e. forced to go into another room/part of the house?	.376	.107	.539

The eigenvalues of the final factor structure of the mother emotional abuse questionnaire were 9.29, 2.58 and 1.46 respectively. The KMO was .90, Bartlett's test of sphericity was significant ($p<0.0001$) and the total variance accounted for was 66.62%. Cronbach's alpha demonstrated a high level of internal consistency for each factor: factor 1 = .95, factor 2 = .86 and factor 3 = .77 (the final mother factor structure is shown in Table 4.4).

Table 4.4: Final factor structure of the Mother Emotional Abuse Questionnaire

	I	II	III
Factor 1			
Did your mother show a lack of interest towards you?	**.735**	.172	.092
Did your mother seem emotionally cold to you?	**.878**	.166	.145
Were you ever blamed for your mother's wrongdoing?	**.637**	.104	.279
Were you ever made to feel that you should 'stay out of the way' by your mother?	**.765**	.088	.243
Did your mother make you feel like you were a bad person?	**.723**	.198	.285
Were you emotionally rejected by your mother?	**.757**	.213	.237
Did you feel uncomfortable with your mother because you didn't know what to talk about?	**.615**	.355	.097
Did you feel emotionally isolated from your mother e.g. you didn't know what she expected from you or how she felt about you?	**.792**	.285	.120
Did you ever feel unwanted by your mother?	**.869**	-.040	.226
Did you ever feel unloved by your mother?	**.864**	-.040	.196
Were you ever made to feel that you were a burden to your mother?	**.841**	.047	.185
Factor 2			
Did your mother try to make you feel dependent on her?	.324	**.715**	.250
Did your mother try to prevent you from growing up?	.187	**.868**	-.064
Did your mother try to control everything you did?	.303	**.725**	.254
Did your mother try to make you feel like you couldn't cope without her?	.171	**.769**	.052
Were your mother overprotective of you?	-.133	**.793**	.099
Factor 3			
Did your mother ever get really angry with you when you thought there was no reason to be?	.321	.143	**.661**
Were you grounded or your privileges taken away?	.013	.094	**.787**
Did your mother blame you for things you didn't do?	.450	.128	**.595**
Were you ever shouted/yelled/screamed/cursed at by your mother?	.350	.143	**.756**

4.4.4 Factor Analysis of the Father Emotional Abuse Questionnaire

Three factors were requested to match the factors of the parental questionnaire. The KMO was .91, Bartlett's test of sphericity was significant ($p<0.0001$) and the total variance accounted for was 67.08%. The cut-off loading point remained at 0.55. The content of the factors on the father questionnaire were almost identical to the parental version of the questionnaire. The first factor related to emotional coldness (eigenvalue = 9.97). The same items loaded on factor 1 as on the parental questionnaire except that two items loaded on factor two and one item loaded on factor 3. The two items that loaded on factor 2 fitted with the content of factor 2 so were not removed. However the item that loaded on factor 3 was difficult to interpret so was excluded from the questionnaire (Table 4.5). One item cross-loaded and was therefore removed from the

questionnaire (Table 4.5). The content of factors 2 and 3 reversed on the father questionnaire. Factor 2 related to psychological punishment and factor 3 related to control (the eigenvalues were 2.82 and 1.31 respectively; the initial father factor structure is shown in Table 4.5)

Table 4.5: Initial factor structure of the Father Emotional Abuse Questionnaire

	I	II	III
Factor 1			
Did your father show a lack of interest towards you?	**.837**	.200	.142
Did your father seem emotionally cold to you?	**.849**	.219	.068
Were you emotionally rejected by your father?	**.864**	.266	.083
Did you feel uncomfortable with your father because you didn't know what to talk about?	**.755**	.222	.184
Did you feel emotionally isolated from your father e.g. you didn't know what he expected from you or how he felt about you?	**.855**	.210	.134
Did you ever feel unwanted by your father?	**.644**	.306	.070
Did you ever feel unloved by your father?	**.889**	.260	.120
Were you ever made to feel that you were a burden to your father?	**.609**	.522	.094
Factor 2			
Did your father ever get really angry with you when you thought there was no reason to be?	.339	**.747**	.280
Were you grounded or your privileges taken away?	.021	**.632**	.370
Did your father blame you for things you didn't do?	.407	**.727**	.181
Were you ever shouted/yelled/screamed/cursed at by your father?	.280	**.760**	.306
*Were you ever blamed for your father's wrongdoing?	.426	**.607**	.031
*Did your father make you feel like you were a bad person?	.318	**.567**	.128
Factor 3			
Did your father try to make you feel dependent on him?	.166	.102	**.806**
Did your father try to prevent you from growing up?	.028	.234	**.798**
Did your father try to control everything you did?	.163	.506	**.592**
Did your father try to make you feel like you couldn't cope without him?	.108	.077	**.765**
Was your father overprotective of you?	.011	.168	**.723**
Excluded Items			
Were you ever made to feel that you should 'stay out of the way' by your father?	**.557**	**.651**	.169
Were you ever physically isolated from your father i.e. forced to go into another room/part of the house?	.405	.257	**.575**

* = items that loaded on factor 1 in the parental emotional abuse questionnaire

A second factor analysis was carried out on the father emotional abuse questionnaire that excluded two items. The factors were almost identical to the previous analysis. However one item that loaded on factor 1 on the previous father factor structures now cross-loaded over factors 1 and 2, therefore it was excluded from the final factor

structure (Table 4.6). The final factor structure consisted of 18 items and accounted for 68.8% of the variance. The eigenvalues were 8.24, 2.74 and 1.22 respectively, the KMO was .89 and Bartlett's test of sphericity was significant ($p<0.0001$). Good internal reliability was demonstrated by the Cronbach's alpha scores: factor 1 = .94, factor 2 = .87, factor 3= .79.

Table 4.6: Final factor structure for Father Emotional Abuse Questionnaire

	I	II	III
Factor 1			
Did your father show a lack of interest towards you?	**.845**	.190	.124
Did your father seem emotionally cold to you?	**.857**	.207	.065
Were you emotionally rejected by your father?	**.863**	.259	.057
Did you feel uncomfortable with your father because you didn't know what to talk about?	**.770**	.236	.172
Did you feel emotionally isolated from your father e.g. you didn't know what he expected from you or how he felt about you?	**.864**	.204	.119
Did you ever feel unwanted by your father?	**.641**	.292	.066
Did you ever feel unloved by your father?	**.890**	.244	.108
Factor 2			
Did your father ever get really angry with you when you thought there was no reason to be?	.347	**.751**	.260
Did your father ever ground you or take your privileges away?	.026	**.664**	.347
Did your father blame you for things you didn't do?	.413	**.742**	.145
Were you ever shouted/yelled/screamed/cursed at by your father?	.298	**.778**	.274
Were you ever blamed for your father's wrongdoing?	.436	**.576**	.039
Did your father make you feel like you were a bad person?	.329	**.576**	.117
Factor 3			
Did your father try to make you feel dependent on him?	.167	.123	**.783**
Did your father try to prevent you from growing up?	.045	.240	**.812**
Did your father try to control everything you did?	.176	.484	**.610**
Did your father try to make you feel like you couldn't cope without him?	.115	.093	**.759**
Was your father overprotective of you?	.024	.158	**.746**

4.4.5 Upset Scale

A 7-point 'upset' scale, ranging from 'not upset' to 'very upset' was added to the mother and father questionnaires. The original items formed part 'a' of each question and was called the 'frequency' scale, and the upset scale formed part 'b'; for example a) did your mother show a lack of interest toward you? b) How upset were you by this? (Appendix 1.6) The upset scales were not subjected to factor analysis because it was possible that a high level of upset would not match a high the level of abuse. It may be the case that an individual does become very upset by their parents' negative behaviour, however it is equally possible, for example, that the individual does not pay attention to the negative behaviour and so is not affected by it.

The final mother and father emotional abuse questionnaires were collectively named the Parental Emotional Abuse Questionnaire (PEA-Q). The upset scales were additional to the frequency scales but were not core to the PEA-Q; the questionnaire could be completed without the upset scales.

4.4.6 PEA-Q Scoring

The PEA-Q consisted of 6 core subscales/dimensions: mother coldness, control and psychological punishment, and father coldness, control and psychological punishment. The 6 additional upset scales included in the questionnaire related to each frequency subscale.

The subscales were scored by adding together the scores of each item on the subscale. The minimum and maximum scores are shown in Table 4.7.

The subscales were divided into three parts based on visual inspection of the frequencies and referral to the original item scores: non-abusive, negative parental behaviour and emotional abusive behaviour (Table 4.7). The participants who scored within the non-abusive range of scores were people who had responded with very low scores on all of the items on the subscale. The negative parental behaviour label was used for the next range of scores because the majority of item scores were low but included some high scores. In a clinical setting the presence of a consistent negative behaviour (illustrated by a high score) may have raised the need for that specific behaviour to be monitored. The final group of scores represented high score responses to the majority of items, which was indicative of the parents using negative behaviour persistently. The definition from the Home Office, Department of Health, Department of Education and Science and Welsh Office (1989) stated that the actions should be "persistent and severe" to be classed as emotionally abusive. The top range of scores on the PEA-Q satisfied these criteria.

Norms of the data were set up (Table 4.7). The majority of the population did not report any abuse experiences. No more than 9% of the population reported emotionally abusive experiences.

Table 4.7: PEA-Q scores divided by level of abuse reported, norms for each group and the potential range of scores that a participant could score

	No Abuse	Negative Parental Behaviour	Emotionally Abusive Behaviour	Potential Range of Scores
Frequency of Emotional Abuse				
Mother Coldness				
Range of Scores	11-23	24-39	40+	11-77
% of Population	82%	12%	5%	
Mother Control				
Range of Scores	5-16	17-21	22+	5-35
% of Population	86%	11%	3%	
Mother Psychological Punishment				
Range of Scores	4-9	10-17	18+	4-28
% of Population	48%	47%	5%	
Father Coldness				
Range of Scores	7-16	17-29	30+	7-49
% of Population	71%	20%	9%	
Father Control				
Range of Scores	5-10	11-16	17+	5-35
% of Population	74%	20%	6%	
Father Psychological Punishment				
Range of Scores	6-12	13-25	26+	6-42
% of Population	69%	27%	4%	

4.5 Discussion

4.5.1 Dimensions of Emotional Abuse and the PEA-Q

To date measurements of emotional abuse have been made by using questionnaires that consider parent-child interaction from a non-abusive perspective, for example the PBI (Parker et al, 1979) and EMBU (Perris et al, 1980). The PEA-Q was developed to fill the need for a reliable measurement of parental emotional abuse. However it does share similarities with the factor structures of the PBI and EMBU. Parental care, measured by the PBI, emotional warmth in the EMBU and emotional coldness in the PEA-Q (Factor 1) have similar features. Furthermore parental control (Factor 2) in the PEA-Q is similar to the overprotective factor of the EMBU and PBI.

The APSAC's definition of emotional abuse stated that the frequency of adverse behaviour is important when assessing whether the behaviour is abusive. An advantage of the PEA-Q was that it incorporated the frequency aspect of the APSAC's definition, whereas the PMI asked about the extent of negative effect the abuse had on the participant rather than how often the behaviour had occurred.

The third dimension in the present study, psychological punishment, was not found in either the PBI or EMBU. The psychological punishment dimension included items such as 'did your parents ever get really angry with you when you thought there was no reason to be?' Briere and Runtz's (1988) psychological and physical maltreatment scale includes seven items dealing with psychological maltreatment: how often the child's mother/father 'yelled', 'insulted', 'criticised', 'humiliated/ridiculed' and/or 'embarrassed' the child and made them feel 'guilty' or like a 'bad person'. However, it does not ask about other dimensions of emotional abuse (such as emotional coldness) that are necessary to construct a complete picture of an emotionally abusive relationship.

4.5.2 Mother and Father Emotional Abuse

Kent et al (1999) suggested that a questionnaire that measured mothers and fathers separately may be useful. In the current study the participants' description of their mothers and fathers behaviour differed slightly.

The mother factor structure was closer to the parental version of the questionnaire than the father factor structure. The participants seemed to be answering the parental questionnaire more with their mother's behaviour in mind; she was most probably the primary caregiver. This suggested that the mother and father questionnaires were

necessary so that the behaviour of each parent could be explored, rather than only the behaviour of the dominant parent.

Emotional coldness accounted for equal amounts of variance in both mother and father questionnaires. However control accounted for more variance than psychological punishment in the mother questionnaire, whereas psychological punishment accounted for more of the variance than the control factor in the father questionnaire. The difference in variance may be explained because the mother is generally the primary caregiver. Simply she has more interaction with the child and thus more opportunity to say what the child can and cannot do. The common saying; "you just wait until your father gets home!" highlights that the father rather than the mother is often seen as the disciplinarian. The father's role as punisher is perhaps encouraged by the mother's threat of the father. However, further research needs to be conducted. The difference in factor structures of mother and father in the current study supported the need to investigate the relationship between the child and their mothers and fathers separately.

4.5.3 Inclusion of the Upset Scale on the PEA-Q

The upset scale included in the PEA-Q is not included in any other parental bonding measure. Inclusion of this scale seems important because the extent of a child's distress may result in a vulnerability to later psychopathologies as illustrated by Thompson, Cattarin, Fowler and Fisher (1995). They studied perceptions of teasing in relation to eating disturbance, body image and self-esteem in college women. They found that the frequency of teasing predicted variance in body image anxiety and some eating disorder scales. The 'effect' of the teasing (found by asking 'how upset were you?' for each item) significantly contributed to the variance accounted for by the frequency of teasing.

4.5.4 The PEA-Q's Potential Use in the Treatment of Psychopathology

Thompson and Kaplan (1999) illustrated that children who were diagnosed with psychological problems such as disruptive behaviour disorders, anxiety, depressive, adjustment and pervasive developmental disorders were reported to have suffered at least one dimension of emotional abuse. The PEA-Q may prove valuable in the initial stages of treatment of such disorders because it offers a convenient quantitative measure of a diversity of parental behaviour. It may be used to establish whether there is a problem with the parents' interaction with the child and the extent of the problem if one exists. It may also be used to focus attention on the treatment of one area of the parents' behaviour, for example, one dimension of emotional abuse.

4.5.5 The Relationship between the PEA-Q and Previous Themes of Chapter 2

The dimensions of emotional abuse that were presented in the PEA-Q reflected the negative parental behaviours listed in the first stage of the proposed model in the previous chapter. The first dimension of the PEA-Q, emotional coldness, seemed to incorporate the sub-themes of rejection and isolation that were presented in the first stage of the model. Unexpectedly the unloved/unwanted sub-theme of the 'child's emotional response to their parents' behaviour' stage of the model was also present in the PEA-Q. The emotional abuse literature tends not to describe behaviour as being emotionally cold. However it seems that this label is a useful umbrella term for some of the behaviours listed in the operational definition (e.g. APSAC, 1995).

The psychological punishment dimension on the PEA-Q reflected the cruelty sub-theme of the first stage of the model. However, the control dimension of the PEA-Q was not described by any of the participants in the qualitative study even though it has been

related to eating psychopathology in the past (Williams and Ricciardelli, 2003; Fouts and Vaughan, 2002; Horesh et al, 2000). Like emotional coldness, control is rarely referred to as being abusive. A secure parent/child attachment would mean that the parent would instinctively try to protect their child. However, a secure attachment also means that the child is given the freedom to explore away from the home, which is necessary to produce a psychologically balanced adult (Bowlby, 1973). Overprotectiveness and enforced dependency prohibits the child's natural search for independence (ibid). Therefore the control dimension of the PEA-Q measures what potentially may be an important factor in the development of adult psychopathology.

4.5.6 Limitations

The main problem with the development of the PEA-Q was that had a retrospective design. Therefore whether the participant's responses were based on their perceptions of their experiences or actual experiences was unknown. However the latter limitation may not be as important as it is first perceived because if the individual feels that they have had adverse experiences that may still encourage psychopathology. To test whether the PEA-Q offered a valid report of the participant's childhood relationship with their parents it would be necessary to carry out a longitudinal study. Merely giving the questionnaire to children at one time period would be equally as problematic if not more problematic than the retrospective study carried out. The researcher would only be able to analyse a snapshot of the child's life that would not take into account the changing relationships and interactions between the child and parent as the child matured.

It was difficult to quantify abuse, i.e. what score was equivalent to abusive behaviour. Further research needs to be carried out to investigate whether an abuse cut-off point could be implemented.

The questionnaire was developed on a female population. Therefore it is not generalisable to a male population. More research needs to be carried out to develop the questionnaire in a male population.

4.5.7 *Further Analysis*

In conclusion the PEA-Q is the first questionnaire that has looked at emotional abuse in a systematic manner. Three factors, each measuring a different dimension of emotional abuse were identified. However, validation of the PEA-Q was necessary before it could be used to test the model of eating disorder development that was proposed in chapter 2. The validation is reported in the following chapter.

Chapter 5

Initial validation of the PEA-Q

5.1 Introduction

The first hypothesis of the current study was that there would be a positive correlation between emotional abuse experience and the upset caused by emotional abuse (UCEA; the first and second hypotheses were tested in a 'normal' population)

Emotional abuse is closely related to other types of abuse (Higgins and McCabe, 2000). The second hypothesis of the current study was that the PEA-Q would correlate with neglect and physical abuse (that was carried out by the parents).

As discussed in section 1.10.10, links have been found between emotional abuse and unhealthy eating attitudes (Rorty et al, 1994; Kent et al, 1999; Witkiewitz and Dodge-Reyome, 2000). Therefore the third hypothesis was that there would be a positive correlation between emotional abuse and eating psychopathology. The fourth hypothesis predicted that people with an eating disorder would have higher PEA-Q scores than people without an eating disorder, which in turn meant that they would have reported higher levels of emotional abuse. The final hypothesis was that the eating disorder group would have higher upset scores than the non-eating disordered group.

The data used in the validation of the PEA-Q was part of a larger study (see chapter 6).

5.2 Method

5.2.1 Participants

5.2.1.1 Eating Disorder Group Recruitment

The Eating Disorders Association (EDA) had a database of volunteers who had or had had an eating disorder and were willing to be involved in research. The researcher sent the questionnaires to the EDA who then sent them on to the people on their database that met the requirements of the study. 119 females and 2 males who were recruited through the EDA database returned the questionnaires. A further 5 responses were returned from women in the general public who had an eating disorder. The male responses were excluded from the final analysis.

The eating disordered participants reported a range of eating disorders; AN, BN, BED, an eating disorder not otherwise specified, a combination of the above, or they had recovered from their eating disorder. The sample sizes of those who had reported an eating disorder other than AN and BN and that had recovered were not big enough to be reliably analysed.

5.2.1.2 Matched controls (Tables 5.1 and 5.2)

The majority of control participants recruited were approached by the researcher who asked them to complete a booklet of questionnaires. Some of the participants were recruited through snowballing. All of the participants were female and recruited from the general public. 168 questionnaire booklets were returned, 76 of which matched the eating disordered (anorexic and bulimic) participants on age and educational background (Table 5.1 and 5.2).

Table 5.1: Means, standard deviations and ranges of age for anorexics, bulimics and their matched controls.

	Mean	Standard Deviation	Range
Anorexics	34	9.92	19 - 61
Anorexic Controls	34.4	10.72	19 - 63
Bulimics	28.7	8.5	16 - 59
Bulimic Controls	28.1	9.3	16 -59

Table 5.2: Educational background frequency data for anorexics, bulimics and their controls.

	No Qualifications	GCSE	A-level	Degree	Post-Graduate
Anorexics	1	9	19	13	3
Anorexic Controls	1	9	19	13	3
Bulimics	*	9	15	5	1
Bulimic Controls	1	9	15	5	1

* One participant did not complete the education section of the questionnaire. However she was matched with someone with the equivalent level of education based on her occupation

5.2.1.3 Socio –Economic Status

The participants fell into one of nine categories. The first five categories were based on the standard socio-economic groups (Market Research Society, 2003): High professional, lower professional/managerial, clerical, skilled manual, unskilled manual. The final four categories were student, unemployed due to illness, unemployed and housewife/full time mother. Usually the final four groups are collapsed into one group, however, for illustrative purposes each group was listed separately.

The eating disorder and control groups had similar numbers of participants in low professional/managerial occupations, skilled and unskilled manual occupations and an equal number of students. None of the participants in the control groups were unemployed due to illness which contrasted to the eating disorder groups, particularly the anorexic group (Table 5.3). Of the participants who were unemployed due to illness many of them cited their eating disorder as the reason for their illness. Socio-economic status was considered for use as a matching variable; however, it was a misleading measure. It was clear that many of the eating disordered participants were prevented from working in potentially higher status professions due to their illness.

Table 5.3: Frequency data for socio-economic status for anorexics, bulimics and their matched controls.

	Anorexics	Anorexic Controls	Bulimics	Bulimic Controls
High Professional	1	2	1	0
Low Professional / Managerial	9	10	4	4
Clerical	1	18	2	10
Skilled Manual	2	1	2	1
Unskilled Manual	4	4	6	7
Student	8	8	8	8
Unemployed due to Illness	13	0	3	0
Unemployed	2	0	1	0
Housewife / Full time Mother	4	1	3	0

5.2.2 Materials

Cover note (appendix 1.1)

The Eating Disorders Association (EDA) included their own covering note with the researcher's questionnaire booklets. The note reminded the participants that they were taking part in the study voluntarily and that their responses were anonymous and confidential.

The cover note written by the researcher reiterated the EDA's cover note. It explained who the researcher was, what the questionnaires were about and explained that although their answers were confidential and anonymous, if they did not want to write their signature on the consent form they could write a cross to indicate they had read and understood it. The questionnaire booklet given to the controls was similar to the one given to the eating disorder group except that it explained that their responses were needed for comparison with the eating disorder group. The cover note for both groups explained that the questionnaire should be returned in the pre-paid envelope that was provided.

Consent form (appendix 1.2)

The consent form explained what questionnaires were included in the questionnaire booklet and briefly explained how the participants would be expected to respond to the questions (such as circling a number or writing an answer). It told the participant approximately how long it would take them to complete the booklet and gave the email address of the researcher. It asked the participants to sign the form to indicate that they understood that they were taking part in the study voluntarily and that all their answers were confidential.

Information Sheet (appendix 1.3)

The information sheet included general helpline numbers and websites such as the Samaritans and Respond, specific help information for the abused such as the NSPCC and Reachout, and information specifically for eating disorders, such as the EDA.

Demographic information (16 items; see appendix 1.4)

Demographic information about the participants was gained through a set of questions about age, gender, education, occupation, family history, and eating disorders. Participants responded either by marking a box that was appropriate to them or if asked, by writing a brief answer.

The Parent-Child Conflict Tactics Scale (7 items; CTSPC; see appendix 1.5)

The CTSPC (Straus et al, 1998) was a modification of the Conflict Tactics Scale (CTS; Straus, 1979, 1990a: Straus, Hamby, Boney-McCoy and Sugarman, 1996) that originally measured abuse within adult relationships. Items were used from the 'severe assault' (physical maltreatment) and 'very severe assault' (severe physical maltreatment) scales. The present study altered the original scale because the CTSPC rated parents' behaviour towards their children, asking them how often in the last week the behaviour occurred. The new scale asked the participants to rate the frequency of the listed situations on a 7-point scale, up to and including 16 years old. The CTSPC's neglect scale (5 items) was also used. The original scale was altered to a 7-point scale to match the physical abuse scale being used. The final physical abuse and neglect scores were calculated similarly by adding each item score together. The CTSPC is a widely accepted and widely used measure of abuse.

Emotional abuse (appendix 1.6 and 1.7, also see chapter 4)

Emotional abuse was measured using the PEA-Q.

The Eating Disorders Inventory (EDI; appendix 1.8)

The EDI (Garner et al, 1983) is an essential tool in the clinical diagnosis of eating disorders. It was used to investigate the different psychological characteristics of eating disorders. It demonstrated good all round validity and reliability and can distinguish unhealthy eating and body attitudes in non-clinical populations (Garner et al, 1983).

Three of the EDI scales were used: Drive for Thinness (DFT), Bulimia (B) and Body Dissatisfaction (BD). All of the scales operated on a six-point scale, ranging from always agree to never agree. The data were recoded according to the authors' guidelines (Garner et al, 1983).

The DFT scale (7 items) measured the desire to lose weight and be thin. The bulimia scale (7 items) scale measured the likelihood of the individual uncontrollably overeating. The BD scale (9 items) measured dissatisfaction with different parts of the body and was strongly correlated with body image disturbance (Garner et al, 1983).

5.2.3 Procedure

After signing the consent form and completing the questionnaire booklet the participants returned them both using the pre-paid envelope provided.

5.3 Results

The distributions of all the control group variables (except for BD) were skewed. Therefore Spearman rho correlations were carried out. The data in the eating disorder group were normally distributed (except for the physical abuse data).

5.3.1 Emotional abuse and the Upset Caused by Emotional Abuse

Significant correlations were present between all of the emotional abuse dimensions and their corresponding upset scales (Table 5.4). Emotional abuse also correlated strongly with neglect, physical abuse and eating psychopathology (except that parental[1] coldness did not correlate with bulimia; see Tables 5.5 and 5.6).

Table 5.4: Relationships between emotional abuse and UCEA in the matched control group

	MC	FC	MCT	FCT	MP	FP
Mother Coldness Upset	**.95****	.58**	.44**	.60**	.55**	.48**
Father Coldness Upset	.59**	**.97****	.22	.40**	.31**	.45**
Mother Control Upset	.56**	.33**	**.95****	.53**	.55**	.39**
Father Control Upset	.64**	.42**	.50**	**.94****	.29*	.70**
Mother Psychological Punishment Upset	.53**	35**	.59**	.30*	**.89****	.30*
Father Psychological Punishment Upset	.51**	.46**	.31**	.71**	.29*	**.93****

MC = Mother Coldness FC = Father Coldness MCT = Mother Control
FCT = Father Control MP = Mother Psychological Punishment
FP = Father Psychological Punishment
** = $p<0.01$

[1] 'Parental' refers to both the mother and father scales collectively; for example, parental coldness refers to mother and father coldness.

Table 5.5: Relationships between emotional abuse, neglect, physical abuse and sexual abuse in the matched control group

	Neglect	Physical Abuse
Mother Coldness Frequency	.62**	.38**
Father Coldness Frequency	.63**	.44**
Mother Control Frequency	.29**	.22**
Father Control Frequency	.41**	.41**
Mother Psychological Punishment Frequency	.41**	.36**
Father Psychological Punishment Frequency	.36**	.44**
Neglect	———	.63**
Physical Abuse	———	———

** = $p<0.01$

Table 5.6: Relationships between abuse and eating psychopathology in the matched control group

	Drive for Thinness	Bulimia	Body Dissatisfaction
Mother Coldness Frequency	.16*	.13	.32**
Father Coldness Frequency	.27*	.18	.23**
Mother Control Frequency	.36**	.35**	.42**
Father Control Frequency	.27**	.24**	.20*
Mother Psychological Punishment Frequency	.26*	.30*	.29**
Father Psychological Punishment Frequency	.33**	.30*	.33**

* = $p<0.05$ ** = $p<0.01$

5.3.2 *Demographic Information; Combining Anorexics and Bulimics to Form a Single Eating Disorder Group*

The anorexics and bulimics were compared (using t-tests) on each measure of eating psychopathology, abuse[2] and the UCEA scale (the distribution of physical abuse was skewed so a Mann-Whitney test was used to test the difference between anorexics and bulimics on this variable). There were no differences between the groups in the level of abuse experienced or level of UCEA. The participants did not differ in the level of DFT they reported. However bulimics reported more bulimia symptoms, which was expected, and were significantly more dissatisfied with their bodies (Table 5.7). There was no evidence to suggest that the two groups were fundamentally different to each other, therefore they were collapsed into a single eating disorder group.

5.3.3 *Comparison of the Eating Disorder and Matched Controls on Levels of Abuse, the Upset Caused by Emotional Abuse, Perfectionism and Eating Psychopathology*

The physical abuse data were skewed in the eating disorder group. In the control group the distributions of the DFT, bulimia, abuse and UCEA data were skewed. Therefore Mann –Whitney U tests were carried out to compare the groups on these variables. A t-test was used to analyse the BD data because they were normally distributed in both groups.

Overall the eating disorder group reported significantly higher levels of abuse, UCEA and eating psychopathology than the control group (Table 5.8).

[2] 'Abuse' refers to neglect, physical abuse, sexual abuse and each dimension of emotional abuse collectively.

Table 5.7: Means, standard deviations and t-values for abuse, UCEA and eating psychopathology for anorexics and bulimics

	Mean	SD	t-value
EDI			
Drive for Thinness			
AN	10.81	6.59	
BN	12.47	6.99	-1.03
Bulimia			
AN	5.86	6.10	
BN	11	6.65	-3.38**
Body Dissatisfaction			
AN	16.30	7.32	
BN	19.87	6.41	-2.15*
Emotional Abuse			
Mother Coldness			
AN	39.73	18.14	-.31
BN	41.01	19.22	
Father Coldness			
AN	29.87	13.53	
BN	29.90	14.55	-.01
Mother Control			
AN	16.66	14.79	
BN	9.17	7.02	.93
Father Control			
AN	14.71	7.65	
BN	12.21	6.29	1.47
Mother Psychological Punishment			
AN	14.70	6.36	
BN	15.31	6.23	-.40
Father Psychological Punishment			
AN	21.36	8.86	
BN	21.55	10.63	-.09
Reaction to Emotional Abuse			
Mother Coldness Upset			
AN	43.07	19.50	
BN	45.24	19.38	-.47
Father Coldness Upset			
AN	28.76	14.63	
BN	33.00	17.15	-1.12
Mother Control Upset			
AN	16.28	9.23	
BN	14.89	7.40	.67
Father Control Upset			
AN	13.66	7.39	
BN	12.31	6.20	.81
Mother Psychological Punishment Upset			
AN	18.30	6.58	
BN	18.14	6.77	-.10
Father Psychological Punishment Upset			
AN	23.35	10.58	
BN	24.83	11.12	-.56
Neglect			
AN	11.64	5.10	
BN	11.35	5.41	.23
Physical Abuse	*Median*	*Range*	*Z - score*
AN	10	7-46	
BN	9	7-29	-.37

* = $p<0.01$ ** = $p<0.05$

Table 5.8: Medians, ranges and z-scores for abuse, UCEA and eating psychopathology for the eating disorder group and their matched controls. Means, standard deviations and t-values for body dissatisfaction scores

	Median	Range	Z-Score
EDI			
Drive for Thinness			
ED	12 (11.49)	1-21	
MC	4 (3.27)	0-21	-7.61**
Bulimia			
ED	6.5 (7.93)	0-21	
MC	1 (1.56)	0-21	-6.75**
Neglect			
ED	8 (11.52)	5-23	
MC	10 (7.89)	5-23	-4.87**
Physical Abuse			
ED	9.5 (11.86)	7-46	
MC	8 (8.75)	7-46	-3.84**
Emotional Abuse			
Mother Coldness			
ED	39 (40.27)	11-77	
MC	21 (17.50)	11-66	-7.77**
Father Coldness			
ED	26.5 (29.87)	8-56	
MC	9.5 (15.61)	8-52	-6.31**
Mother Control			
ED	14 (15.91)	5-35	
MC	11 (9.90)	5-32	-4.86**
Father Control			
ED	12.5 (13.73)	5-34	
MC	7 (8.68)	5-28	-5.45**
Mother Psychological Punishment			
ED	15 (14.95)	4-28	
MC	10 (10.55)	4-23	-4.41**
Father Psychological Punishment			
ED	17 (21.43)	7-49	
MC	9 (12.96)	7-43	-5.22**
Upset Caused by Emotional Abuse			
Mother Coldness Upset			
ED	46.5 (43.94)	11-77	
MC	23.5 (18.65)	11-64	-7.59**
Father Coldness Upset			
ED	25 (30.49)	8-56	
MC	9.5 (15.58)	8-52	-5.95**
Mother Control Upset			
ED	14 (15.73)	5-35	
MC	11 (9.48)	5-32	-4.77**
Father Control Upset			
ED	13 (13.12)	5-33	
MC	6 (8.26)	5-31	-5.99**
Mother Psychological Punishment Upset			
ED	19 (18.24)	4-28	
MC	12 (11.93)	4-27	-5.60**
Father Psychological Punishment Upset			
ED	21 (23.96)	7-49	
MC	10 (13.92)	7-44	-5.52**
Body Dissatisfaction	*Mean*	*SD*	*t-value*
ED	17.77	7.14	
MC	12.44	9.06	.3.98**

ED = Eating Disorder Group MC = Matched Control Group
** = $p<0.01$

5.3.4 *PEA-Q Norms for the Eating Disorder Group*

PEA-Q norms were produced for the eating disorder and matched control groups (Table 5.9). There was a large percentage difference between the two groups depending on whether they had been emotionally abused. Overall an equal percentage of participants experienced negative parental behaviour, except for mother control where the eating disorder group had a much larger percentage. Finally there was a stark contrast in the group percentages in the emotionally abused category. The lowest percentage in the eating disorder group was 26% and the highest percentage in the matched control group was 11%.

Table 5.9: PEA-Q norms for the eating disorder group compared to the matched control group

	No Abuse	Negative Parental Behaviour	Emotionally Abusive Behaviour	Range Of Scores
Frequency of Emotional Abuse				
Mother Coldness				
% of ED Population	23	29	48	11-77
% of MC Population	85	11	4	11-66
Mother Control				
% of ED Population	58	16	26	5-35
% of MC Population	89	4	7	5-32
Mother Psychological Punishment				
% of ED Population	21	46	33	4-28
% of MC Population	45	50	5	4-23
Father Coldness				
% of ED Population	22	27	51	8-56
% of MC Population	66	23	11	8-52
Father Control				
% of ED Population	38	30	32	5-34
% of MC Population	71	22	7	5-28
Father Psychological Punishment				
% of ED Population	18	50	32	7-49
% of MC Population	61	34	5	7-43

ED = Eating Disorder Group MC = Matched Controls Group

5.3.5 *Summary of Comparison Data*

- The UCEA correlated with the frequency of emotional abuse.

- The frequency of abuse scale on the PEA-Q correlated with parental neglect and parental physical abuse.

- The eating disorder group reported significantly higher levels of emotional abuse than the control group.

- Within the control and eating disorder groups, the abuse and UCEA scores were similar. Therefore the higher UCEA scores in the eating disorder group were expected.

5.4 Discussion

The first hypothesis that there would be a positive correlation between emotional abuse and UCEA was accepted. UCEA was significantly correlated with the frequency of emotional abuse. However, the correlation coefficients were extremely high (.89 - .97) suggesting that the frequency and upset scales may have been measuring the same construct. Unfortunately it was hard to distinguish whether the two scales measured the same construct or were just very strongly correlated because it was likely that upset would be closely linked to abusive behaviour.

Thompson et al (1995) included an upset scale in their study of the affects of parental teasing on children's body image and eating disturbance. They found that upset had a unique (although small) significant predictive relationship with body image and eating disturbance. Therefore the upset scales in the present study should not be dismissed.

The first evidence of validation for the PEA-Q was provided by the acceptance of the second hypothesis; emotional abuse would correlate with neglect and physical abuse. Past literature suggests that emotional abuse is very strongly associated with physical abuse and neglect (Higgins and McCabe, 2000). But whether emotional abuse can exist independently of other types of abuse was not established in the present study, but was investigated in the following chapter.

Based on studies by Rorty et al (1994), Kent et al (1999) and Witkeiwitz and Dodge-Reyome (2000), emotional abuse was hypothesised to be positively correlated with unhealthy eating attitudes. The hypothesis was accepted. Every dimension of the PEA-Q significantly correlated with DFT and BD in the matched controls group. The importance of investigating emotional abuse as a multi-dimensional construct was highlighted by the relationship between emotional abuse and bulimia symptoms. Parental control and psychological punishment significantly correlated with bulimic symptoms but parental coldness did not.

Rorty et al (1994) studied bulimic patients. Higher rates of emotional and physical abuse in the bulimic group were found compared to the control group. The present eating disorder group reported significantly higher rates of emotional (scores on the PEA-Q) and physical abuse than the control group, which supported the third and fourth hypotheses.

On closer inspection the medians of the eating disorder group rested in the negative parental behaviour category rather than the emotional abuse category. This may suggest that rather than being abusive, parents of eating disordered people treated their children

more harshly than non-eating disordered people. However the percentage of eating disorder participants who had experienced emotional abuse was much larger than the percentage of control participants who had experienced emotional abuse (Table 5.9). Consequentially there was strong evidence was provided that people who had been emotionally abused by their parents were more likely to have an eating disorder.

It followed that because the eating disorder group had experienced more emotional abuse they would also have higher upset scores than the control group. This hypothesis was supported.

5.4.1 Conclusion

In conclusion the initial validation of the PEA-Q was successful. The findings corresponded to the past literature that suggested that emotional abuse was closely related to other types of abuse (Higgins and McCabe, 2000) and more specifically to eating psychopathology (Rorty et al, 1994; Kent et al, 1999; Witkiewitz and Dodge-Reyome, 2000). Furthermore the norms of the matched control group almost identically matched the norms for the normal population in the previous chapter (Table 4.7). The similar norms highlight the reliability of the PEA-Q.

5.4.2 Limitations

The current study was a retrospective study so the participants' responses may not have been reliable due to the time that had passed since the events. There was no other evidence to support the participants' responses. Furthermore if the participants had been abused it may have been very distressing for them and 'may [have] cause[ed] selective memory to operate over time, leading these individuals to "remember" such incidents to

a greater degree than "non-distressed" subjects (producing inaccurate frequency ratings as adults)' (Thompson et al, 1995).

5.4.3 Further Analysis

Chapter 2 concluded by suggesting a need for a new measurement of emotional abuse; chapter 4 answered this need. The current chapter validated the PEA-Q by replicating relationships that have been described in the previous literature.

Chapter 6 used the PEA-Q to test the model of eating disorder development proposed in chapter 2. The hypotheses for the following investigation are stated at the end of section 3.1.

Chapter 6

Analysis of the Control and Eating Disorder Groups

6.1 Introduction

The following chapter reports an initial validation of the proposed model of eating disorder development presented in chapter 2 (see figure 2.1). The model suggested that negative parental behaviour (that took the form of emotional abuse, see section 2.4.2) began a process that led to an eating disorder. The negative parental behaviour promoted the child's feelings of being unloved and/or unwanted. In order to feel loved and wanted, and/or to neutralise the negative behaviour towards them, the child was 'good' to please and receive approval from their parents. By constantly being 'good' the child developed unhealthy levels of negative perfectionism. It was proposed that by this point in the process the child had experienced few of the benefits of a secure attachment and was ultimately left without 'normal' coping skills. When the participant experienced a traumatic event they employed dysfunctional coping strategies to deal with it, such as their eating disorder.

The literature reviewed in chapter 1 supported the link between each of the themes in the model and eating psychopathology. Thus it seemed reasonable to quantitatively test the model. As well as the relationship between eating psychopathology and emotional abuse the relationships between eating psychopathology and other types of abuse (neglect, physical abuse and sexual abuse) were tested. Therefore if emotional abuse was related to eating psychopathology (as predicted), it would be clear whether the relationship existed independently of the other forms of abuse.

There are two parts to the current chapter. The first part was carried out on a non-eating disorder group (N-ED). It examined the relationships between emotional abuse, neglect, physical abuse and eating psychopathology (as established in chapter 4) and two new variables; sexual abuse and perfectionism. The second part of the chapter examined the same relationships as in the first part of the chapter but with the eating disorder (ED) group already described (section 4.2.1). If eating psychopathology was due to abuse, UCEA and perfectionism then the relationships between these variables in the normal group should be similar to the relationships between the variables in the ED group. If the same variables were not responsible for high eating psychopathology scores in the N-ED group and the ED group, it would be reasonable to suggest that the groups were fundamentally different in some way.

- H_1: The N-ED and ED group would display similar relationships between neglect, physical abuse, sexual abuse, emotional abuse, UCEA, perfectionism and eating psychopathology.

- H_2: Emotional abuse would be independently related to eating psychopathology. Its relationship with eating psychopathology would be the only predictive relationship of all the abuse variables.

- H_3: The UCEA would predict eating psychopathology.

- H_4: Negative perfectionism would mediate the relationship between emotional abuse, the UCEA and eating psychopathology.

6.2 Non-Eating Disorder Group Analysis

6.2.1 Method

6.2.1.1 Participants

Out of 168 participants 163 participants took part in the current study (5 were excluded because they were currently diagnosed with an eating disorder). The participants were drawn from the sample described in section 4.2.1.2. The participants' ages ranged between 16 and 77 years old ($\underline{M}$ = 34.2, SD = 12.62).

6.2.2.2 Materials

The materials used in the present study were the same as those used in chapter 4. The additional questionnaires used measured the experience of personal trauma, sexual abuse experiences and perfectionism.

***Personal Trauma** (1 item; see appendix 1.3)*

The trauma question was included in the demographic information questionnaire described in section 5.2.2. It asked participants whether they had ever experienced a personally traumatic event and asked to expand on their answer qualitatively.

Sexual abuse (4 items; see appendix 1.9)

The sexual abuse questions were modified versions of the sexual abuse questions on the SPAQ (Sexual and Physical Abuse Questionnaire; Kooiman, Ouwehand and ter Kuile, 2002). Advice was taken from a clinical psychologist who worked with eating disordered patients. She advised that the questions should be modified because they were very likely to upset the eating disordered participants, in turn it would make them

less likely to respond. This questionnaire is used in clinical settings as a screening instrument for sexual and physical abuse. The participants were asked to indicate whether they had encountered any of the situations stated, their age when it occurred, the frequency with which it occurred and the identity of the perpetrator (family, friend, acquaintance or stranger). If the participant had been abused more than once and on different occasions, the first age of the sexual abuse was recorded.

The Positive-Negative Perfectionism Scale *(40 items; P-NP; appendix 1.10)*

The P-NP (Terry-Short et al, 1995) was rated on a reversed 5-point scale and categorised two ways; positive perfectionism and negative perfectionism. The two final scores were calculated similarly; by adding each item together. Terry-Short et al (1995) suggested a cut off point for unhealthy perfectionism as a score of 69+.

6.2.2.3 Procedure

See section 5.2.3.

6.3 Results

Experience of Trauma in the Eating Disorder and Non-Eating Disorder Groups

89% of eating disordered participants had experienced a personal trauma, which was similar to the non-eating disorder group, 55% of which had experienced a trauma. Only 8% of the eating disorder group had not experienced a trauma, whereas 28% of the non-eating disorder group reported never experiencing a personal trauma (17% of the non-eating disorder group did not respond to the question). Due to the way the data were collected (as a yes/no response, followed by a qualitative response) the trauma

differences between the groups could not be investigated further and therefore were not included in the following analysis (for a discussion of the problems see section 6.7.7).

6.3.1 Demographic Information

The descriptive statistics for abuse, perfectionism and eating psychopathology are shown in Table 6.2. The distributions of the DFT scale, bulimia scale, and abuse scales were skewed; therefore the medians and ranges were reported. The sexual abuse data were ordinal and nominal (the frequencies for sexual abuse are shown in Table 6.1). The BD scale and perfectionism scales were normally distributed so the means and standard deviations were reported. The medians and means show that in general there was little evidence of any eating psychopathology, abuse or unhealthy perfectionism within the N-ED group.

Table 6.1: Frequencies of the participants in the N-ED group; presented in groups based on type of sexual abuse experiences, abuser and age of first sexual abuse

	No. of Participants
Never	106
Touch	31
Sex	20
Family	23
Friend	27
Acquaintance	0
Stranger	0
-12 years	15
+13 years	31

Table 6.2: Ranges, medians, means and standard deviations (where applicable) for the N-ED group data

	N	Range	Median
EDI			
Drive for Thinness	158	0-18	2 (3.41)
Bulimia	161	0-21	0 (1.50)
Physical Abuse	163	7-37	7 (8.78)
Neglect	160	5.25	6 (7.46)
Emotional Abuse			
Mother Coldness Frequency	159	11-72	14 (18.05)
Father Coldness Frequency	156	7-45	9.5 (14.42)
Mother Control Frequency	160	5-32	8 (10.01)
Father Control Frequency	155	5-28	7 (8.51)
Mother Psychological Punishment Frequency	160	4-26	10 (10.34)
Father Psychological Frequency	153	6-39	9 (11.71)
Upset Caused by Emotional Abuse			
Mother Coldness Upset	159	11-71	14 (18.44)
Father Coldness Upset	155	7-45	9 (13.49)
Mother Control Upset	157	5-35	7 (9.32)
Father Control Upset	153	5-31	6 (7.99)
Mother Psychological Punishment Upset	161	4-27	12 (11.96)
Father Psychological Punishment Upset	153	6-38	10 (12.71)
		Mean	*SD*
Body Dissatisfaction	157	11.97	8.65
Perfectionism			
Positive Perfectionism	153	67.07	9.90
Negative Perfectionism	154	55.32	15.19

A high score was indicative of: worse eating psychopathology, more abuse, more upset and being more perfectionistic

6.3.2 Associations between the Different Types of Abuse, Perfectionism and Eating Psychopathology

Sexual abuse was coded as a dichotomous (yes/no) variable. Pearson's point-biserial correlations were used to measure the relationship between sexual abuse and perfectionism. All the other correlations that were carried out involved skewed

distributions; therefore Spearman Rho correlations were used. The general findings were that emotional abuse was significantly correlated with neglect and physical abuse. Sexual abuse was associated with emotional abuse to a lesser extent. It was only significantly correlated with parental coldness and mother control (Table 6.3).

Table 6.3: Relationships between emotional abuse, neglect, physical abuse and sexual abuse in the N-ED group

	Neglect	Physical Abuse	Sexual Abuse
Mother Coldness Frequency	.62**	.38**	.22**
Father Coldness Frequency	.63**	.39**	.22**
Mother Control Frequency	.29**	.22**	.17*
Father Control Frequency	.33**	.34**	.12
Mother Psychological Punishment Frequency	.45**	.41**	.06
Father Psychological Punishment Frequency	.42**	.42**	.17
Neglect	——	.63**	.19*
Physical Abuse	——	——	.17*
Sexual Abuse	——	——	——

* = $p<0.05$ ** = $p<0.01$

All of the abuse scales (except sexual abuse) significantly correlated with negative perfectionism. None of the abuse scales significantly correlated with positive perfectionism (Table 6.4).

Five of the emotional abuse scales significantly correlated with DFT and BD, and four significantly correlated with bulimia (Table 6.5). Physical abuse significantly correlated

with each EDI scale but neglect and sexual abuse did not correlate with any of the scales (Table 6.5).

Table 6.4: Relationships between abuse and perfectionism in the N-ED group

	Negative Perfectionism	Positive Perfectionism
Mother Coldness Frequency	.34**	-.05
Father Coldness Frequency	.30**	-.02
Mother Control Frequency	.34**	.00
Father Control Frequency	.25**	.09
Mother Psychological Punishment Frequency	.41**	.09
Father Psychological Punishment Frequency	.23**	.09
Neglect	.25**	-.10
Physical Abuse	.31**	.04
Sexual Abuse	.09	-.14

** = $p<0.01$

Table 6.5: Relationships between abuse and eating psychopathology in the N-ED group

	Drive for Thinness	Bulimia	Body Dissatisfaction
Mother Coldness Frequency	.16*	.13	.16*
Father Coldness Frequency	.16*	.17*	.23**
Mother Control Frequency	.13	.14	.20
Father Control Frequency	.27**	.24**	.20*
Mother Psychological Punishment Frequency	.24**	.30**	.25**
Father Psychological Punishment Frequency	.17*	.22**	.16**
Neglect	.15	.07	.09
Physical Abuse	.21**	.23**	.16*
Sexual Abuse	.12	.12	.13

* = $p<0.05$ ** = $p<0.01$

6.3.3 *Associations between Perfectionism and Eating Psychopathology*

Negative perfectionism significantly correlated with eating psychopathology. Positive perfectionism did not correlate with any of the EDI subscales (Table 6.6).

Table 6.6: Relationships between perfectionism and eating psychopathology in the N-ED group

	Drive for Thinness	Bulimia	Body Dissatisfaction
Negative Perfectionism	.47**	.46**	.49**
Positive Perfectionism	.12	.15	-.02

** = p<0.01

6.3.4 *Associations between the Upset caused by Emotional Abuse, Abuse, Perfectionism and Eating Psychopathology*

Generally the UCEA was significantly associated with neglect, physical abuse and emotional abuse. However only upset caused by parental coldness and upset caused by father psychological punishment was significantly associated with sexual abuse (Table 6.7 and 6.8).

Table 6.7: Relationships between UCEA, neglect, physical abuse and sexual abuse in the N-ED group

	Neglect	Physical Abuse	Sexual Abuse
Mother Coldness Upset	.63**	.33**	.20*
Father Coldness Upset	.59**	.33**	.18*
Mother Control Upset	.35**	.34**	.12
Father Control Upset	.35**	.34**	.12
Mother Psychological Punishment Upset	.42**	.32**	.05
Father Psychological Punishment Upset	.40**	.41**	.18*

* = p<0.05 ** = p<0.01

Table 6.8: Relationships between UCEA and emotional abuse in the N-ED group

	MC	FC	MCT	FCT	MP	FP
Mother Coldness Upset	.96**	.49**	.51**	.39**	.51**	.38**
Father Coldness Upset	51**	.95**	.35**	.34**	.31**	.49**
Mother Control Upset	.63**	.39**	.92**	.37**	.51**	.30**
Father Control Upset	.47**	.37**	.44**	.91**	.29**	.48**
Mother Psychological Punishment Upset	.50**	.28**	.44**	.23**	.87**	.25**
Father Psychological Punishment Upset	.43**	.50**	.24**	.47**	.35**	1.00**

MC = Mother Coldness FC = Father Coldness MCT = Mother Control
FCT = Father Control MP = Mother Psychological Punishment
FP = Father Psychological Punishment
** = $p<0.01$

Negative perfectionism was significantly correlated with all of the upset scales. Positive perfectionism did not significantly correlate with any of the upset scales (Table 6.9).

Table 6.9: Relationships between UCEA and perfectionism in the N-ED group

	Negative Perfectionism	Positive Perfectionism
Mother Coldness Upset	.30**	-.07
Father Coldness Upset	.32**	.02
Mother Control Upset	.32**	-.01
Father Control Upset	.18*	.11
Mother Psychological Punishment Upset	.33**	.05
Father Psychological Punishment Upset	.23*	.13

* = $p<0.05$ ** = $p<0.01$

Eating psychopathology correlated with the upset caused by parental psychological punishment and father coldness (except DFT which did not correlate with the upset caused by father psychological punishment). DFT and bulimia further correlated with the upset caused by father control (Table 6.10).

Table 6.10: Relationships between UCEA and eating psychopathology in the N-ED group

	Drive for Thinness	Bulimia	Body Dissatisfaction
Mother Coldness Upset	.14	.10	.15
Father Coldness Upset	.18*	.17*	.23**
Mother Control Upset	.14	.09	.13
Father Control Upset	.17*	.16*	.15
Mother Psychological Punishment Upset	.18*	.24**	.23**
Father Psychological Punishment Upset	.15	.21**	.25**

* = $p<0.05$ ** = $p<0.01$

6.3.5 Regression Analysis

The skewed data were transformed so that they could be subjected to regression analysis. The DFT and bulimia scales were transformed using logarithms, whilst the abuse data were transformed using the inverse method. The transformation methods were chosen based on the shape of the distribution (Pallant, 2003). The normally distributed scales were entered into the regressions in their original form. Forced entry regressions were used due to the sample sizes involved in the analysis (Tabachnick and Fidell, 1996).

(Pearson's r correlations were carried out using the transformed data which produced the same results as the correlations using the original data (presented in sections 6.3 - 6.10). For consistency only the original Spearman rho correlations were reported).

The mediated relationship that was previously predicted between emotional abuse and eating psychopathology was tested using hierarchical regressions (Baron and Kenny, 1986). The regression analyses were carried out in two stages. Firstly associations needed to be established between the independent variables (abuse and UCEA), the

dependent variables (EDI subscales) and the mediators (negative and positive perfectionism). Multicollinearity meant that the UCEA variables had to be entered into regression equations separately to the emotional abuse variables. Therefore the abuse scales were entered into one standard regression to predict eating psychopathology and the UCEA variables were entered into another. The mediators were then entered into a standard regression to predict eating psychopathology. The significant predicting independent variables (from the abuse and UCEA variables) were then entered into standard regressions to predict perfectionism.

The independent variables and the mediating variables that predicted eating psychopathology were then entered simultaneously into a hierarchical regression to predict eating psychopathology (each EDI scale). 'A perfect mediational model is supported if the relationship between the independent variables and the dependent variable is no longer significant. Imperfect mediation is indicated if the relationship remains but is weakened' (Kent et al, 1999).

6.3.5.1 Drive for Thinness

None of the abuse variables or UCEA predicted DFT. The mediators were entered simultaneously into a standard regression. The model accounted for 16% of the variance of DFT. Only negative perfectionism significantly contributed to the variance. Positive perfectionism did not predict DFT (Table 6.11).

6.3.5.2 Bulimia

Bulimia was not predicted by any of the abuse or UCEA variables. A significant predictive model was produced accounting for 15% of the variance but neither negative

nor positive perfectionism made a significant contribution to the overall variance. However negative perfectionism narrowly missed significance (Table 6.11).

Table 6.11: Significant models of drive for thinness and bulimia in the N-ED group

	Adjusted R squared	Beta	t-value	F-value
DV = Drive For Thinness				
Negative Perfectionism		.38	3.90**	
Positive Perfectionism	.16	.07	.69	10.29**
DV = Bulimia				
Negative Perfectionism		.27	1.98	
Positive Perfectionism	.15	.21	1.53	6.07*

* = $p<0.05$ **$p<0.001$

6.3.5.3 Body Dissatisfaction

A significant model that predicted BD was produced by all of the abuse variables. However, only mother psychological punishment and neglect significantly contributed to the model. Due to the number of variables and number of analyses carried out a chance finding might have occurred. Therefore the two variables were entered into a regression separately to the other abuse variables. Only mother psychological punishment predicted BD, accounting for 6%. Therefore it was concluded that the relationship between mother psychological punishment and BD was stable but the neglect relationship with BD was an artefact of the analysis. Neglect was not included in the subsequent analyses.

The mediators were entered simultaneously into a regression. Both negative and positive perfectionism significantly contributed to the model that accounted for 20% of the variance of BD. Mother psychological punishment predicted negative perfectionism but not positive perfectionism so only mother psychological punishment and negative

perfectionism were re-entered into a hierarchical regression. Mother psychological punishment no longer significantly predicted BD. Therefore it was concluded that negative perfectionism mediated the mother psychological punishment/BD relationship (Table 6.12). When positive perfectionism alone was entered into a standard regression it did not predict BD.

The upset caused by mother psychological punishment was the only upset scale that significantly predicted BD, accounting for 6% of the variance (Table 6.13). The upset caused by mother psychological punishment also predicted negative perfectionism but not positive perfectionism. When upset caused by mother psychological punishment was entered simultaneously with negative perfectionism into a hierarchical regression, the relationship between the upset caused by mother psychological punishment and BD remained. Therefore a direct predictive relationship existed between the upset caused by mother psychological punishment and BD (Table 6.13; Figure 6.1).

Table 6.12: **1**: Significant abuse predictors of body dissatisfaction in the N-ED group

2: Significant model of mediators predicting body dissatisfaction

3: Regression between the significant independent variable and significant mediator

4: Hierarchical regression of significant predictors to predict body dissatisfaction

	Adjusted R squared	Beta	t-value	F-value
1. DV = Body Dissatisfaction				
Mother Psychological Punishment	.06	-.26	-3.35**	11.23**
2. DV = Body Dissatisfaction				
Negative Perfectionism		.48	6.00**	
Positive Perfectionism	.20	-.17	-2.14	18.07**
3. DV = Negative Perfectionism				
Mother Psychological Punishment	.11	-.34	-4.40**	19.32**
4. DV = Body Dissatisfaction				
Negative Perfectionism (Block 1)	.19	.39	-4.87**	
Mother Psychological Punishment (Block 2)	.20	-.15	-.1.82	19.24**

**p<0.001

Table 6.13: **1:** Significant UCEA predictors of body dissatisfaction in the N-ED group

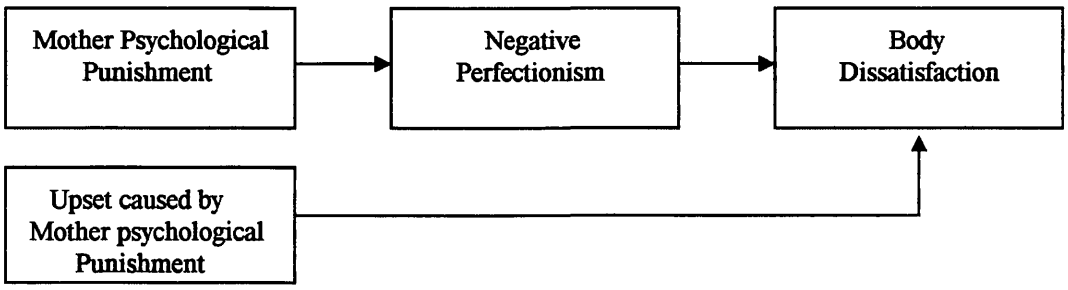
2: Regression between the significant UCEA variable and significant mediator

3: Hierarchical regression of significant UCEA variables and significant mediators to predict body dissatisfaction

	Adjusted R squared	Beta	t-value	F-value
1. DV = Body Dissatisfaction				
Upset caused by Mother Psychological Punishment	.06	-.26	-3.38**	11.45**
2. DV = Negative Perfectionism				
Upset caused by Mother Psychological Punishment	.07	-.28	-3.60**	12.96**
3. DV = Body Dissatisfaction				
Negative Perfectionism (block 1)	.19	.39	4.90**	
Upset Caused by Mother Psychological Punishment (block 2)	.20	-.17	-2.15*	19.51**

* = $p<0.05$ **$p<0.001$

Figure 6.1: Model of the abuse and perfectionism relationship with body dissatisfaction in the N-ED group



6.3.6 Summary of Non-Eating Disorder Group Data

6.3.6.1 Abuse

- Each type of abuse was inter-correlated with each other.

- Abuse was strongly correlated with negative perfectionism but was not correlated with positive perfectionism.

- Emotional abuse and physical abuse correlated most strongly with DFT and BD followed by bulimia. Neglect and sexual abuse were not related to eating psychopathology.

6.3.6.2 Upset Caused by Emotional Abuse

- As expected UCEA correlated most strongly with emotional abuse. It was also correlated with neglect and physical abuse, followed by sexual abuse.

- UCEA correlated with negative perfectionism but not positive perfectionism.

- UCEA correlated most strongly with bulimia followed by BD and DFT.

6.3.6.3 Regression Models

- Only negative perfectionism predicted DFT.

- Bulimia was not predicted by abuse, UCEA or perfectionism.

- BD was directly predicted by the upset caused by mother psychological punishment.

But negative perfectionism mediated the predictive relationship between mother psychological punishment and BD.

6.4 Eating Disorder Group Analysis

6.4.1 Method

6.4.1.1 Participants

The analysis was carried out on the same sample that was described in section 4.2.1.1. The sample consisted of 76 eating disordered (45 anorexics and 31 bulimics). There were no differences between the anorexics and bulimics that suggested they should be treated as separate groups (see section 4.3.2) so they were treated as a single ED group.

6.4.1.2 Materials and Procedure

See section 5.2.2 and 5.2.3.

6.5 Results

6.5.1 Sexual Abuse and Perfectionism Demographics for the Eating Disorder Group

The means and standard deviations for abuse, UCEA and EDI in the ED group are shown in Table 5.8. Negative perfectionism and positive perfectionism were both normally distributed in the ED and matched controls groups, therefore t-tests were used to test whether perfectionism differed between the two groups. Negative perfectionism was significantly higher in the ED group compared to the matched controls, but positive perfectionism did not differ between the ED and matched control groups (Table 6.14). The demographics for sexual abuse in the ED group are shown in the table below (Table 6.15). The table shows that the ED group had had more sexual abuse experiences than the N-ED group (see Table 6.1 for sexual abuse demographics of the N-ED group).

Table 6.14: Means, standard deviations and t-values for negative and positive perfectionism for the ED group and their matched controls.

	Mean	Standard Deviation	t-value
Negative Perfectionism			
ED	87.05	12.92	
MC	55.23	15.66	13.44**
Positive Perfectionism			
ED	68.51	10.27	
MC	67.54	9.34	.60

ED = eating disorder group MC = control group
** = $p<0.05$

Table 6.15: Frequencies of the participants in the ED group; presented in groups based on type of sexual abuse experiences and age of first sexual abuse

	No. of Participants
Never	25
Touch	21
Sex	28
-12 years	27
+13 years	42

The abuser was not listed because there were too many combinations reported i.e. touched by friend/stranger and forced intercourse by family/acquaintance.

6.5.2 *Associations between the Different Types of Abuse, Perfectionism and Eating Psychopathology*

Sexual abuse was coded as a dichotomous (yes/no) variable. Pearson's point-biserial correlations were used to measure the relationship between sexual abuse and abuse (except physical abuse), perfectionism and eating psychopathology. The associations between physical abuse and all of the other scales were tested using Spearman's rho correlations because the physical abuse scores were skewed. However the associations between neglect, emotional abuse, perfectionism and eating psychopathology were tested using Pearson's r correlations. Neglect, physical abuse and emotional abuse were inter-correlated. In general sexual abuse did not correlate with physical abuse, neglect or

emotional abuse (except for mother coldness and mother psychological punishment; Table 6.16).

Table 6.16: Inter-correlations of each type of abuse in the ED group

	Neglect	Physical Abuse	Sexual Abuse
Mother Coldness Frequency	.62**	.46**	.24*
Father Coldness Frequency	.66**	.46**	.12
Mother Control Frequency	.22*	.25*	.02
Father Control Frequency	.38**	.33**	.02
Mother Psychological Punishment Frequency	.58**	.68**	.34**
Father Psychological Punishment Frequency	.57**	.57**	.05
Neglect	——	.59**	.23
Physical Abuse	——	——	.09
Sexual Abuse	——	——	——

** = $p<0.01$ * = $p<0.05$

Parental coldness, parental control and neglect were significantly correlated with negative perfectionism. None of the abuse scales correlated with positive perfectionism (Table 6.17).

None of the abuse variables correlated with DFT. Parental psychological punishment, neglect and physical abuse correlated with bulimia. None of the abuse variables correlated with BD (Table 6.18).

Table 6.17: Relationships between abuse and perfectionism in the ED group

	Negative Perfectionism	Positive Perfectionism
Mother Coldness Frequency	.37**	-.07
Father Coldness Frequency	.31**	.01
Mother Control Frequency	.26*	-.16
Father Control Frequency	.26*	.16
Mother Psychological Punishment Frequency	.15	-.15
Father Psychological Punishment Frequency	.18	-.04
Neglect	.38**	-.02
Physical Abuse	.16	-.01
Sexual Abuse	.17	-.07

* = $p<0.05$ ** = $p<0.01$

Table 6.18: Relationships between abuse, perfectionism and eating psychopathology in the ED group

	Drive for Thinness	Bulimia	Body Dissatisfaction
Mother Coldness Frequency	.07	.17	.12
Father Coldness Frequency	.11	.10	.10
Mother Control Frequency	-.01	.09	-.01
Father Control Frequency	-.12	.13	-.06
Mother Psychological Punishment Frequency	.05	.30*	.06
Father Psychological Punishment Frequency	-.05	.31**	.05
Neglect	.06	.27*	.04
Physical Abuse	.03	.25*	.02
Sexual Abuse	.05	.08	.22

* = $p<0.05$ ** = $p<0.01$

6.5.3 *Associations between Perfectionism and Eating Psychopathology*

Negative perfectionism significantly correlated with BD. Positive perfectionism did not correlate with any of the EDI scales (Table 6.19).

Table 6.19: Relationships between perfectionism and eating psychopathology in the ED group

	Drive for Thinness	Bulimia	Body Dissatisfaction
Negative Perfectionism	.20	.23	.35**
Positive Perfectionism	-.04	.09	-.07

** = p<0.01

6.5.4 *Associations between the Upset Caused by Emotional Abuse, Abuse, Perfectionism, and Eating Psychopathology*

Generally the UCEA was significantly associated with neglect, physical abuse and emotional abuse (Table 6.20 and 6.21). Sexual abuse did not correlate with UCEA (except for the upset caused by mother psychological punishment; Table 6.20).

Table 6.20: Relationships between UCEA, neglect, physical abuse and sexual abuse in the eating disorder group

	Neglect	Physical Abuse	Sexual Abuse
Mother Coldness Upset	.59**	.40**	.21
Father Coldness Upset	.60**	.33**	.10
Mother Control Upset	.29*	.21	.06
Father Control Upset	.45**	.28*	.06
Mother Psychological Punishment Upset	.47**	.54**	.25*
Father Psychological Punishment Upset	.52**	.44**	.03

* = p<0.05 ** = p<0.01

Table 6.21: Relationships between UCEA and emotional abuse in the ED group

	MC	FC	MCT	FCT	MP	FP
Mother Coldness Upset	.92**	.45**	.31**	.23	.58**	.35**
Father Coldness Upset	.38**	.86**	.19*	.38*	.20	.56**
Mother Control Upset	.40**	.21	.87**	.36**	.37**	.14
Father Control Upset	.24	.54**	.34**	.83**	.14	.57**
Mother Psychological Punishment Upset	.55**	.25**	.37**	.31**	.78**	.32**
Father Psychological Punishment Upset	.24	.62**	.13	.53**	.18	.86**

MC = Mother Coldness FC = Father Coldness MCT = Mother Control
FCT = Father Control MP = Mother Psychological Punishment
FP = Father Psychological Punishment
* = $p<0.05$ ** = $p<0.01$

Overall UCEA was significantly correlated with negative perfectionism (except for the upset caused by mother psychological punishment) but was not associated with positive perfectionism (except for the upset caused by mother control; Table 6.22). UCEA was not associated with eating psychopathology (Table 6.23).

Table 6.22: Relationships between UCEA and perfectionism in the ED group

	Negative Perfectionism	Positive Perfectionism
Mother Coldness Upset	.41**	-.05
Father Coldness Upset	.38**	.08
Mother Control Upset	.28*	-.25*
Father Control Upset	.32**	.06
Mother Psychological Punishment Upset	.13	-.16
Father Psychological Punishment Upset	.25*	.05

* = $p<0.05$ ** = $p<0.01$

Table 6.23: Relationships between UCEA and eating psychopathology in the ED group

	Drive for Thinness	Bulimia	Body Dissatisfaction
Mother Coldness Upset	.04	.15	.07
Father Coldness Upset	.13	.10	.18
Mother Control Upset	.01	.02	-.02
Father Control Upset	-.04	.13	-.01
Mother Psychological Punishment Upset	.06	.11	.002
Father Psychological Punishment Upset	-.08	.18	-.01

* = $p<0.05$ ** = $p<0.01$

6.5.5 Regression analysis

As previously stated, all of the variables except physical abuse were normally distributed. For the purpose of the regression analysis the physical abuse data were transformed using logarithms (Pallant, 2003) whilst all of the other variables were entered into the regressions in their original form.

(Pearson's r correlations were carried out using the transformed data for physical abuse. They produced the same results as the correlations using the original data (presented in sections 6.16 – 6.20). For consistency only the original Spearman rho correlations were reported).

The same method of regression analysis was used for the eating disorder data as for the control data in section 6.3.4. To avoid the problem of multicollinearity the UCEA variables were entered into separate regression equations to the emotional abuse variables.

6.5.5.1 Drive for Thinness

DFT was not predicted by abuse, UCEA or perfectionism.

6.5.4.2 Bulimia

Bulimia was not predicted by abuse, UCEA or perfectionism.

6.5.5.3 Body Dissatisfaction

BD was not predicted by abuse or UCEA. However negative and positive perfectionism significantly predicted 19% of the variance of BD (Table 6.24).

Table 6.24: Significant model of mediators that predict body dissatisfaction in the ED group

	Adjusted R squared	Beta	t-value	F-value
DV = Body Dissatisfaction				
Negative Perfectionism		.50	4.18**	
Positive Perfectionism	.19	-.29	-2.41*	8.9**

* = p<0.05 ** = p<0.01

6.6 Summary of Eating Disorder Group Data

6.6.1 Abuse

- Emotional abuse, neglect and physical abuse were closely related to each other. Sexual abuse was not closely related to any other type of abuse.

- Parental coldness, control and neglect were the only types of abuse that were associated with negative perfectionism. Positive perfectionism was not related to abuse.

- Overall abuse had a very weak relationship with eating psychopathology. Bulimia was the only dimension of eating psychopathology that correlated with abuse (parental punishment, neglect and physical abuse).

6.6.2 Upset caused by Emotional Abuse

- UCEA was associated most strongly with emotional abuse (as expected), neglect, and then physical abuse. It was not related to sexual abuse (except for the upset caused by mother psychological upset).

- UCEA was related to negative perfectionism but not to positive perfectionism (except for the upset caused by mother control).

- UCEA was not correlated with eating psychopathology.

6.6.3 Regression Models

- DFT and bulimia were not predicted by abuse, UCEA or perfectionism.

- BD was not predicted by abuse or UCEA but was predicted by both types of perfectionism.

6.7 *Discussion*

6.7.1 Sexual Abuse and Eating Psychopathology

There was no relationship between sexual abuse and eating psychopathology in the eating disorder and non-eating disorder group (Table 6.5 and 6.18) which strongly supported the view that sexual abuse was not related to eating psychopathology (Pope and Hudson, 1992; Waller and Ruddock, 1995) and was not predictive (Kent et al, 1999). Therefore the hypothesis that the relationship between sexual abuse and eating psychopathology would be the same between the eating disorder and non-eating disorder group was supported. There may be a number of reasons why sexual abuse did not relate to eating psychopathology in the current study. It may be that sexual abuse is a minor risk factor of eating disorders that is picked up by some studies and not by others. However it may also be that the data collected about the sexually abusive experiences of the participants was of poor quality; for example, the participants were asked three questions about the type of sexually abusive experience they had had; had the participants been touched against their will, been forced to touch someone else against their will, or been forced into intercourse against their will. The three questions were coded into two categories, touched and forced sexual intercourse (Table 6.1). Therefore there was a restriction on the level of analysis that could be carried out.

6.7.2 Physical Abuse and Eating Psychopathology

The relationships between bulimia and physical abuse were similar in the eating disorder and non-eating disorder group (Tables 6.5 and 6.18). DFT and BD correlated with physical abuse in the non-eating disorder group, but not in the eating disorder group (Tables 6.5 and 6.18). Therefore the hypothesis that similar relationships would exist between the groups was only partially supported. Although the suggestion has been

made that physical abuse is a risk factor in bulimia (Stuart et al, 1990; Rorty et al, 1995) it did not predict bulimic symptoms in the eating disorder group. It may have been that physical abuse shared a correlation with eating psychopathology through its correlation with other factors (Welch and Fairburn, 1996), such as its relationship with emotional abuse (Kent et al, 1999).

6.7.3 Neglect and Eating Psychopathology

The present study indicated that neglect was associated with bulimic symptoms in the eating disorder group but was not associated with any eating psychopathology in the non-eating disorder group (Tables 6.5 and 6.18). Despite the associations neglect was not a predictive factor of eating psychopathology in the eating disorder or non-eating disorder groups (Kent et al, 1999; Witkiewitz and Dodge-Reyome, 2000).

The bulimia/neglect association in the eating disorder group seemed to fit with the stereotypic bulimic family profile of a hostile home environment reported by so many other studies (Stuart et al, 1990; Rorty et al, 1995; Witkiewitz and Dodge-Reyome, 2000). The hypothesis that the relationship between neglect and eating psychopathology would be the same between the eating disorder and non-eating disorder group was only partially supported. It seemed that neglect shared a unique relationship with pathological bulimic symptoms (Table 6.18).

6.7.4 Emotional Abuse and Eating Psychopathology

In the non-eating disorder group associations were found between emotional abuse and each EDI scale (Table 6.5) which was contrary to Witkiewitz and Dodge-Reyome (2000). The different results may have been due to the way the questionnaires were

scored in the two studies. Witkiewitz and Dodge-Reyome had scored the EDI items based on the six-point scale that the participants' used whereas the present study recoded the scores according to the authors' scoring system (see section 5.2.2). However Kent et al's (1999) finding that emotional abuse was related to eating psychopathology in non-eating disordered people was supported, except that emotional abuse correlated with bulimic symptoms in the present study (Table 6.5) but not in Kent et al's study. The only relationship that was apparent in the eating disorder group was between parental psychological punishment and bulimic symptoms (Table 6.18), which was consistent with previous literature (Stuart et al, 1990; Rorty et al, 1995).

The fact that DFT (the central characteristic of AN) in the eating disorder group was not related to emotional abuse (Table 6.18) was supported by Palmer, Oppenheimer and Marshall (1988), Calam, Waller, Slade and Newton (1990) and Castro, Toro and Cruz (2000) who found that families of anorexics did not differ from families of non-eating disordered people. However, a self report that family functioning is normal is not necessarily reflective of the truth. North, Gowers and Bryam (1995) objectively observed families and found significantly greater dysfunction in bulimic families. It may be that eating disordered people do not like to speak badly of their parents. They may feel guilty about speaking badly or feel that it is their personal faults that cause their parents to act negatively towards them, which is consistent with Rorty et al (1995). Rorty et al (1995) suggested that children who were abused over time 'may come to internalize a sense that they are bad, worthless, and blameworthy, and therefore deserving of punishment they receive'. If this were the case then the eating disordered participants in the present study should not have perceived their parents' behaviour as abusive or uncalled for, and this would explain the lack of correlations between

emotional abuse and eating psychopathology in the eating disorder group. However in the previous study the eating disordered participants reported higher levels of each dimension of emotional abuse than the control participants (Table 5.8). Thus the theory discussed did not seem to be relevant when explaining the lack of associations between emotional abuse and eating psychopathology.

Although the emotional abuse / eating psychopathology relationship differed between the eating disorder and non-eating disorder groups, in general emotional abuse did not predict eating psychopathology in either group (see sections 6.3.5.1 – 6.3.5.3 and 6.5.4.1 – 6.5.4.3). The only exception was that mother psychological punishment predicted BD in the non-eating disorder group (section 6.3.5.3, Table 6.12, Figure 6.1), which extended Kent et al's (1999) findings by identifying the specific dimension of emotional abuse that was important and the specific eating psychopathology dimension that was affected; Kent et al (1999) used a single emotional abuse and EDI score.

The hypothesis that emotional abuse would be similarly related to eating psychopathology in the eating disorder and non-eating disorder group was rejected. The only dimension of emotional abuse that was associated with eating psychopathology (bulimic symptoms) in the eating disorder group was parental psychological punishment (Table 6.18). Associations were found between all the eating psychopathology dimensions and parental coldness, father control and parental psychological punishment in the non-eating disorder group (Table 6.5).

The hypothesis that emotional abuse would be independently related to eating psychopathology was also rejected. There were no cases in the eating disorder group

where the participants had only experienced emotional abuse. Equally there were no cases where the participants had only experienced physical abuse, sexual abuse or neglect. In the non-eating disorder group only a very small minority of people were identified that had only experienced emotional abuse. Therefore it was concluded that emotional abuse was, in the majority of cases, inextricable from other types of abuse. These findings support the observations of Thompson and Kaplan (1999). They found that emotional abuse was often missed in diagnosis because of a more evident, more easily defined type of abuse. When the previous two studies were considered, the suggestion arose that emotional abuse may underpin other types of parental abuse. Kent et al (1999) demonstrated the centrality of emotional abuse when they reported that physical abuse and neglect correlated with eating psychopathology only through their correlations with emotional abuse.

6.7.4.1 Predictive Relationships between Emotional Abuse and Eating Psychopathology in the Non-Eating Disorder Group

The suggestion by Kent et al (1999) that emotional abuse was the central type of abuse in the development of unhealthy eating attitudes was supported as the only predictive type of abuse was an emotional abuse dimension. However the variance that was accounted for was very small (6%; Table 6.12).

The relationship between mother psychological punishment and BD was mediated by negative perfectionism (Table 5612, Figure 6.1). The negative perfectionism relationship with BD built on Witkiewitz and Dodge-Reyome's (2000) findings that perfectionism (measured as a uni-dimensional construct) was strongly associated with each dimension of emotional abuse that they measured.

The relationship between mother psychological punishment and negative perfectionism may be explained by the participant striving for perfection to avoid punishment from their mother, and/or as an attempt to change their mother's negative behaviour towards them. Perfectionism affects the way a person views their entire world. It may be possible that eventually BD became a manifestation of their perfectionism; that the way they looked did not match their high standards of how they thought they should look.

Alternatively it may be that negative perfectionism led to low self-esteem (which was not measured) which then led to BD. However past research (Hewitt et al, 1995; Joiner et al, 1997; Vohs et al, 1999) suggests that perfectionism remains a mediator even when self-esteem is measured. The participant feels dissatisfied with their body shape and subsequently develops low self-esteem. Their perfectionistic trait manifests itself in their BD which in turn motivates their drive for thinness and in turn increases their social acceptance and self-esteem. However the current study illustrated that perfectionism predicted BD, suggesting that the latter theory is probably not applicable.

6.7.4.2 Predictive Relationships between Emotional Abuse and Eating Psychopathology in the Eating Disorder Group

The lack of a predictive relationship between emotional abuse and eating psychopathology in the eating disorder group (Table 6.18) was supported by research from Hartt and Waller (2002), although their results should be considered with caution because of the heterogeneous group they studied. However, the study carried out in chapter 6, did find that eating disordered people were more likely to have suffered more emotional abuse in general (higher scores on each dimension; Table 6.8) than the non-eating disorder group. Correlations were also present between bulimic symptoms and

parental psychological punishment in the present study (Table 6.18), indicating that emotional abuse did seem to be a risk factor.

The current study acknowledged that eating disordered people display varying symptoms, just as emotional abuse has different dimensions. The use of an overall emotional abuse and EDI score may have meant that the variance of one symptom may have affected the expression of another. In Kent et al's (1999) study DFT and BD correlated with emotional abuse but not bulimia. They concluded that general unhealthy eating attitudes (which combined the DFT, BD and bulimia scores) were predicted by emotional abuse. However, the correlations suggested that bulimic symptoms were not predisposed by emotional abuse. It is acknowledged that independent variables can predict dependent variables even when no correlation is present, but there is a strong possibility that Kent et al's (1999) findings were misleading because they included the bulimia subscale in the analysis. It seemed reasonable to assume that each symptom of eating psychopathology may be affected in different ways (i.e. sexual abuse, impulsivity and BPD are linked to BN but not AN, whereas perfectionism is predominantly linked to AN rather than BN). Independent analysis of each EDI dimension allowed for a more sensitive analysis.

It may be that eating disorders have a genetic basis (Bulik et al, 2000; Steiger, 2004) that develops when an inappropriate environment it provided. It may be that emotional abuse provides an unstable environment for the individual that allows their genetic vulnerability to be expressed. It may be that this genetic vulnerability takes the form of dysfunctional coping strategies; coping strategies that the individual feels they need to stabilise their world. Alternatively emotional abuse may manifest itself as an insecure attachment

(Patterson, 1986; Crittenden and Ainsworth, 1989) that subsequently prevents the child developing efficient coping strategies for life stressors.

The present work was unable to establish a clear theoretical reason why emotional abuse was more prominent in the eating disorder group (Table 5.8) but did not directly relate to eating psychopathology (Table 5.6). Only one reason was put forward for the results; all of the eating disordered participants already had eating disorder symptoms. Therefore a ceiling effect may have been present that prevented any relationships from being illustrated.

6.7.5 UCEA and Eating Psychopathology

The upset caused by mother psychological punishment was the only predictive UCEA variable (section 6.3.5.3; Table 6.13; Figure 6.1). It predicted BD in the non-eating disorder group, but unlike the frequency of mother psychological punishment, it imperfectly mediated the relationship with BD. Eating psychopathology was not predicted by UCEA in the eating disorder group (section 6.3.5.3; Table 6.13; Figure 6.1).

A possible explanation of the direct relationship between the upset caused by mother psychological punishment and BD may be that the upset encouraged the participant to develop generally negative cognitive schemas that were transposed onto their body image. The participants may have felt that the actual punishment from their parents was an overt behaviour that could be overtly counteracted by changing their own behaviour. The upset was an involuntary reaction, not a behaviour that could be counteracted with other behaviour.

It has previously been noted that the frequency of emotional abuse and UCEA may have been measuring the same construct. However, the frequency of mother psychological punishment and the upset caused by mother psychological punishment related to BD differently (section 6.3.5.3; Tables 6.12 and 6.13; Figure 6.1). It seemed that the two variables accounted for unique variance (section 6.3.5.3; Tables 6.12 and 6.13; Figure 6.1) suggesting that in general the frequency of emotional abuse and UCEA are just very closely related but do not measure the same construct. Thompson et al (1995) showed that emotional affect brought about by parents teasing their child (measured using an upset scale) predicted unique variance of body image disturbance. Although in the present study the upset was measured in relation to psychological punishment rather than teasing, it replicated Thompson et al's (1995) upset/BD relationship. The amount of variance accounted for by the upset caused by mother psychological punishment (Table 6.13) and by the upset caused by teasing (in Thompson et al's (1995) study) was very small. Consequently it may be that although upset may be a reliable risk factor of BD, it may be a minor rather than major risk factor. Emotional reactions to emotional abuse, other than upset, could be more important in eating psychopathology, for example, depression and anxiety have been found to mediate the emotional abuse / eating psychopathology relationship and accounted for much more variance (Kent et al, 1999).

The hypothesis that UCEA would have the same relationship with eating psychopathology in the eating disorder and non-eating disorder group was rejected. None of the upset scales correlated with eating psychopathology in the ED group (Table 5.21). A few scales correlated in the non-eating disorder group (Table 6.10). Neither DFT nor bulimic symptoms were predicted by UCEA in either group. That upset predicted BD in a non-eating disorder population replicated Thompson et al's (1995)

study. Even though the origins of the upset differed (in the present study the origin of the upset was psychological punishment, but in Thompson et al's (1995) study the origin of the upset was teasing) it could be argued that they were connected; a parent who is psychologically punishing to an unhealthy degree is likely to be overly negative in other ways, for example, making fun of their child / teasing them inappropriately.

6.7.6 Perfectionism and Eating Psychopathology

The link between emotional abuse and negative perfectionism was a novel finding. However the relationship was expected, not only because of the initial proposed model (Figure 2.1) but because parental behaviour / attitudes have been indicated as an integral part of their child's perfectionistic behaviour (Hamchek, 1978; Barrow and Moore, 1983; Shaffran and Mansell, 2001).

Perfectionism is considered to be very closely linked to eating psychopathology, particularly AN (Garner, Olmstead, Polivy and Garfinkel, 1984; Bastiani et al, 1995; Hewitt et al, 1995; Joiner et al, 1997; Lilenfield et al, 1998; Vohs et al, 1999; Bulik, Tozzi, Anderson, Mazzeo, Aggen and Sullivan, 2003) which was replicated in the non-eating disorder group; negative perfectionism predicted DFT and BD (section 6.3.5.1 and 6.3.5.3; Tables 6.11 and 6.12). Although the eating disorder group had significantly higher perfectionism scores than the matched controls group (section 6.5; Table 6.14) perfectionism was not correlated with (Table 6.19) and did not predict DFT in the eating disorder group.

A genetic basis of perfectionism has received attention in recent literature (Lilenfield et al 1998; Halmi, Sunday, Strober, Kaplan, Woodside, Fichter, Treasure, Berreltini and

Kaye, 2000) and a genetic basis of AN has also been studied (Steiger, 2004). It may be that both perfectionism and AN have a genetic basis which means that they may develop simultaneously, but independently of each other, and therefore do not predict each other. However, if it was true that perfection and AN developed simultaneously an association between the two would still be expected however no association was present between them in the current study (Table 6.19). Furthermore there is a body of evidence to suggest that perfectionism occurs before AN (Bruch, 1973; Casper, 1983; Strober, 1991; Bastini et al, 1995). It may be that although perfectionism is a characteristic of AN, it does not share a linear relationship with the severity of AN symptoms.

The predictive relationship between negative perfectionism and BD in the non-eating disorder group was replicated in the eating disorder group (Tables 6.13 and 6.24). Again both negative and positive perfectionism predicted BD; positive perfectionism to a much lesser extent (Table 6.24). There was no reason to suggest that the relationship between perfectionism and BD functioned differently to the same relationship in the non-eating disorder group, except that the origin of the perfectionism was not abuse.

Despite a recent finding that perfectionism was related to BN (Bulik et al, 2003), its predictive capacity is documented as much smaller than for AN (Garner et al, 1984; Polivy and Herman, 2002). The current study was in line with these findings as perfectionism did not predict bulimic symptoms.

The hypothesis that perfectionism would relate to eating psychopathology similarly in both the eating disorder and non-eating disorder group was rejected. Negative perfectionism predicted DFT and mediated the mother psychological punishment / BD

relationship in the non-eating disorder group (Tables 6.11 and 6.13). But perfectionism only predicted BD in the eating disorder group (Table 6.24) and the origins of the perfectionism differed to the non-eating disorder group.

6.7.7 Trauma

It was difficult to decipher the trauma data. The participants had responded to a yes/no question and then explained what the trauma involved. The participants were not asked to supply the age when the trauma occurred, and some of the participants had in effect duplicated their responses; for example, they reported that they had been raped in response to the trauma question, but also reported that they had been forced into sexual intercourse against their will in response to the sexual abuse questions. Therefore it was impossible to analyse the data other than assessing the frequency that trauma was reported (section 6.3)

However no literature was found that suggested that eating disordered people report significantly more traumatic life experiences than non-eating disordered people. It may be that eating disordered people do not experience more trauma than non-eating disordered people, but they have a worse response to it.

6.7.8 Limitations

Potentially the most detrimental limitation was that the eating disorder group was self-selected. The participants had all voluntarily agreed to be involved in the EDA research database which meant there was a very strong possibility that they had been part of other research previous to the current study. Consequently their responses may have been affected by the other research they were involved in. A further weakness of using the

EDA database was that there was no way of verifying that the participants truly had an eating disorder or were correctly reporting which eating disorder they had. Furthermore all of the participants had received some kind of therapy which may have altered the way they felt about their childhood and how they reported past events. However, not all the questionnaires that were distributed to the general public were returned: the non-eating disorder group may equally have been self-selected.

As discussed in section 6.1.2, the participants' responses may have been affected by selective memory. Abuse experiences will have been very distressing for the participants; they may have repressed the memory or altered it in an attempt to cope.

An obvious design limitation was the use of self-report, retrospective questionnaires. There was no evidence (e.g. from parents or siblings) to prove that the participants were giving truthful or accurate accounts of their past. However, even if other people's (e.g. parents or siblings) accounts of past event were obtained, there is no guarantee that they would be accurate.

The sample size of the eating disorder group restricted the analysis. Analysis of subgroups was not always possible, for example it was not feasible to split the participants who had been sexually abused into more specific categories. However it may have been that the sample size was a reflection of the nature of events; for example, there were no eating disordered people who had only experienced one type of abuse, which in itself was interesting and gave insight into the nature of abuse.

The limitations presented should not overshadow the actual findings. Although new findings have been reported some of the results complimented past research, such as the physical abuse / bulimia link and the inter-correlations between the different types of abuse. As likely as it was that the participants' responses may have been biased there was an equal likelihood that they responded more honestly than other eating disorder populations; for example, it may be that eating disorder inpatients are more susceptible to interviewer bias.

The current analysis could not establish whether the participants were responding based on the reality or their perception of their past. Had participants who had recovered from an eating disorder been involved in the study it may have been possible to separate perception from reality. Recovered eating disordered people did complete the questionnaire booklets but there were too few to carry out any reliable analysis. However two recovered anorexics who were interviewed in a previous study (chapter 2) reported emotionally abusive experiences, suggesting that the reality rather than the perception may have been reported in the current study.

Finally, the upset caused by physical abuse, sexual abuse and neglect was not considered. On reflection these other variables should have been included.

6.7.9 Further Research

It is important to elucidate whether people with an eating disorder are accurate in their report of childhood or whether their eating disorder alters their view. As discussed earlier a direct comparison of recovered and non-recovered eating disordered people is necessary.

Although binge eaters completed the questionnaire booklet, the sample size was not substantial enough to include them in the analysis. Chapter 2 indicated that binge eaters do experience emotional abuse but that it may be manifested differently compared to anorexics and bulimics. Grilo and Masheb (2001) also found that emotional abuse (and no other type of abuse) correlated with BD, and in their 2002 study, they found that emotional abuse was related to binge eating disorder through personality disorders. It would be interesting to investigate whether, in terms of abuse, binge eaters differ to anorexics and bulimics. Finally, drawing on a previous point, different emotional reactions to emotional abuse should be considered such as guilt, shame, depression and anxiety (Kent et al, 1999) as well as the emotional reaction to abuse other than emotional abuse.

Chapter 7

General Discussion

7.1 Introduction

A number of issues that related to the development of eating disorders were discussed in the literature review. But the initial investigation of the current thesis drew specific attention to the emotional abuse literature. The eating disordered people who were interviewed described emotionally abusive experiences by their parents that matched the operationalised definitions of emotional abuse set out by the APSAC (1995; for further examples see Hart and Brassard, 1990; Hart et al, 1987; Garabino et al, 1986; Glaser, 1995; McGee and Wolfe, 1991; Thompson and Kaplan, 1996). Emotional abuse seemed to begin a process that, in some, led to the development of an eating disorder.

By investigating a series of objectives (section 4.5) the relationship between emotional abuse and eating psychopathology was measured in both an eating and non-eating disorder group. Emotional abuse was related to eating psychopathology independently of other forms of abuse. However its association was indirect, supporting other research that implicates emotional abuse as being part of more complex mechanisms (Kent et al, 1999; Krause, 2003). The proposed model (Figure 2.1) provided a theoretical framework to investigate the emotional abuse / eating psychopathology relationship. But based on the subsequent findings of the current research and other existing empirical evidence, the model was found to be in need of revision (Figure 7.1).

7.2 Objective 1: Emotional Abuse as a Multi-dimensional Construct

There was no suitable emotional abuse measure available that measured the emotionally abusive behaviours described in the original model (Figure 2.1). Therefore a new emotional abuse questionnaire was developed that factor analysis indicated should include emotional coldness, control and psychological punishment. The new questionnaire was labelled the PEA-Q. The PEA-Q measured mother and father emotional abuse separately (section 3.4).

The initial validation of the PEA-Q was demonstrated when emotional abuse was found to be strongly correlated with parental physical abuse and neglect. Secondly as the literature suggested, the eating disordered group reported more emotional abuse than the non-eating disordered group (Kent et al, 1999).

Feeling unloved and unwanted was considered a display of parental coldness, which was measured by the coldness sub-scales on the PEA-Q. Therefore the initial model (Figure 2.1) required revision to combine the first two stages: 'negative parental behaviour' and 'child's emotional response to their parents' behaviour'. The new combined stage was labelled 'parental emotional abuse' in the revised version on the proposed model (Figure 7.1).

The structure of emotional abuse varied only slightly between the mother and father questionnaires. A couple of items loaded on different factors on each questionnaire (Tables 4.4 and 4.5). With regard to eating psychopathology the role of mother and father emotional abuse in the development of eating disorders was indistinguishable in the eating disorder group. A body of literature suggested that mothers are the influential

parent in eating disorder development (Smith et al, 1995; MacBrayer et al, 2001). However, some recent literature suggests that fathers can play an important role (Bonenberger and Klosinski, 1988; Iniewicz, Jozefik, Namyslowska and Ulasinska, 2002). The likelihood is that both parents have an influential role. Children form attachments with both parents, and problems with either are sure to have consequences. The participants in the current research responded to the emotional abuse items similarly for both parents. The uncertainty of the independent effects of the mother/child and father/child relationship in eating disorder development may indicate a need for further research. Based on the suggestion by Kent et al (1999) that a good relationship with one parent may buffer against the effects of an abusive relationship with the other parent, the revised model in Figure 7.1 included a new stage. The new stage highlighted that a buffering parental relationship may act as a moderating factor in the development of eating psychopathology (discussed further in section 7.5).

7.3 Objective 2 and 3: Independence and Centrality of Emotional Abuse

The literature suggested that physical abuse, sexual abuse and neglect may all play a role in eating disorder development, but these types of abuse were not described as precursors to the participants' eating disorders in the initial study (in one case sexual abuse was described and although it triggered a relapse of AN, it occurred after the initial onset of the eating disorder; chapter 2). It was concluded that in the majority of cases emotional abuse does not occur independently of other forms of abuse. However its independent effect in the presence of other types of abuse had been established previously by Kent et al (1999) and Witkiewitz and Dodge-Reyome (2000), and was supported by the current work. The participants that were interviewed in chapter 2 described emotional abuse experiences but not physical abuse or neglect, and where

sexual abuse was described it was independent of emotional abuse. However, emotional abuse was the only type of abuse to predict eating disorder symptoms (Table 6.12) and therefore offers support for Kent et al's (1999) findings that emotional abuse may be central to the development of eating psychopathology.

7.4 Objective 4: The Relationship between Emotional Abuse and Eating Disorder Development: Investigation of the Proposed Mediational Model (Figure 2.1)

The nature of the link between emotional abuse and eating disorders that was suggested in the proposed model (Figure 2.1) was also different to that previously suggested (Witkiewitz and Dodge-Reyome, 2000; Kent et al, 1999). Witkiewitz and Dodge-Reyome (2000) found a direct relationship between a specific dimension of emotional abuse, mother neglect, and eating psychopathology, but had not tested whether the relationship was mediated by an intermediate factor. Kent et al (1999) found that anxiety and dissociation mediated the relationship between emotional abuse (which was treated as a uni-dimensional construct) and eating psychopathology (also treated as a uni-dimensional construct). There was no evidence to confirm Kent et al's findings in the initial study; instead perfectionism was the clear mediator (see sections 2.3.3.2 and 2.4.2 and Table 6.12). In the originally proposed model (Figure 2.1) perfectionism was referred to as a uni-dimensional construct. However, in the subsequent analysis positive and negative perfectionism were differentiated. It was negative perfectionism specifically that mediated the relationship between emotional abuse and eating psychopathology (section 6.3.6.3). Therefore specific reference was made to negative perfectionism when the model was revised (Figure 7.1, section 7.5).

7.4.1 The Relationship between Emotional Abuse and Eating Disorder Development: Discussion of the Proposed Model (Figure 2.1) in the Eating Disorder Group

People who had experienced higher levels of emotional abuse were more likely to have an eating disorder (Table 5.8). There was a high prevalence of emotional abuse in the eating disorder group (significantly higher than the non-eating disorder group; Table 5.8) supporting of the first stage of the originally proposed model; 'negative parental behaviour' (Figure 2.1). This was translated into the 'parental emotional abuse' stage in the revised model (Figure 7.1). Emotional abuse did not correlate with eating disorder symptoms (Table 6.18); however, because the hypothesis was that emotional abuse was linked to having an eating disorder, rather than the severity of the eating disorder symptoms, this was not viewed as evidence contrary to the hypothesis. Furthermore the criteria necessary for being diagnosed with an eating disorder includes displaying eating disorder symptoms such as the ones measured; DFT, BD and bulimia. Therefore the variance being measured in the eating disorder group was much smaller than in a non-eating disorder group which included people with and without symptoms.

Perfectionism measured the 'good girl syndrome' sub-theme within the 'child's behavioural response to parents' stage. Negative perfectionism related to emotional abuse (Table 6.17). It was deduced that the emotional abuse was a precursor of perfectionism because it occurred in childhood, whereas the perfectionism measure referred to the participants' behaviour in the present. However, it was acknowledged that the perfectionistic traits may have been present since early childhood.

The original model (Figure 2.1) proposed that the participants were perfectionistic to avoid, and if possible rectify, their parents' negative behaviour towards them. Thus the participants' behaviour was negatively driven (Shatford and Evans, 1986; Troop et al, 1994; Wlihelm et al, 2002; Krause et al, 2003), which was supported by the relationship between emotional abuse and negative perfectionism (Table 6.17). The use of avoidance techniques are reminiscent of the coping strategy literature, specifically dysfunctional coping (Nolen-Hoeksema, 1987). Emotion-focused coping provides avoidance and distraction from the individual's experiences. In relation to the current work, it may be that perfectionism operationalised emotion-focused coping by offering a way for the individual to avoid emotionally abusive experiences and avoid thinking about the experiences they had already had.

Emotion-focused coping may also explain the predictive relationship between negative (and to a smaller extent positive) perfectionism and BD, as it is a common assumption that emotion-focused coping is related to eating psychopathology (Shatford and Evans, 1986; Troop et al, 1994).

7.4.2 The Relationship between Emotional Abuse and Eating Psychopathology: Discussion of the Proposed Model (Figure 2.1) in the Non-Eating Disorder Group

Correlations were found between emotional abuse and negative perfectionism (Table 6.4): emotional abuse and unhealthy eating attitudes (symptoms of eating psychopathology; Table 6.5): and between negative perfectionism and unhealthy eating attitudes (Table 5.6). Mother psychological punishment was the only emotional abuse dimension that predicted a dimension of unhealthy eating attitudes, BD, but the relationship was mediated by negative perfectionism (Table 6.12). The upset caused by

mother psychological punishment directly predicted BD (Table 6.13). However, it was likely that the UCEA was measuring the same construct as the PEA-Q scores due to their strong correlations.

The proposed model of the relationship between emotional abuse and eating psychopathology (Figure 2.1) in a non-eating disordered group was cautiously accepted. The model was perhaps too simplistic because there were many dimensions of emotional abuse that needed to be considered; for example the relationships between mothers and fathers and between each parent and their child, as mentioned previously (section 7.2). The results of this study further highlighted the need to revise the original model shown in Figure 2.1. The revision is discussed in section 7.5.

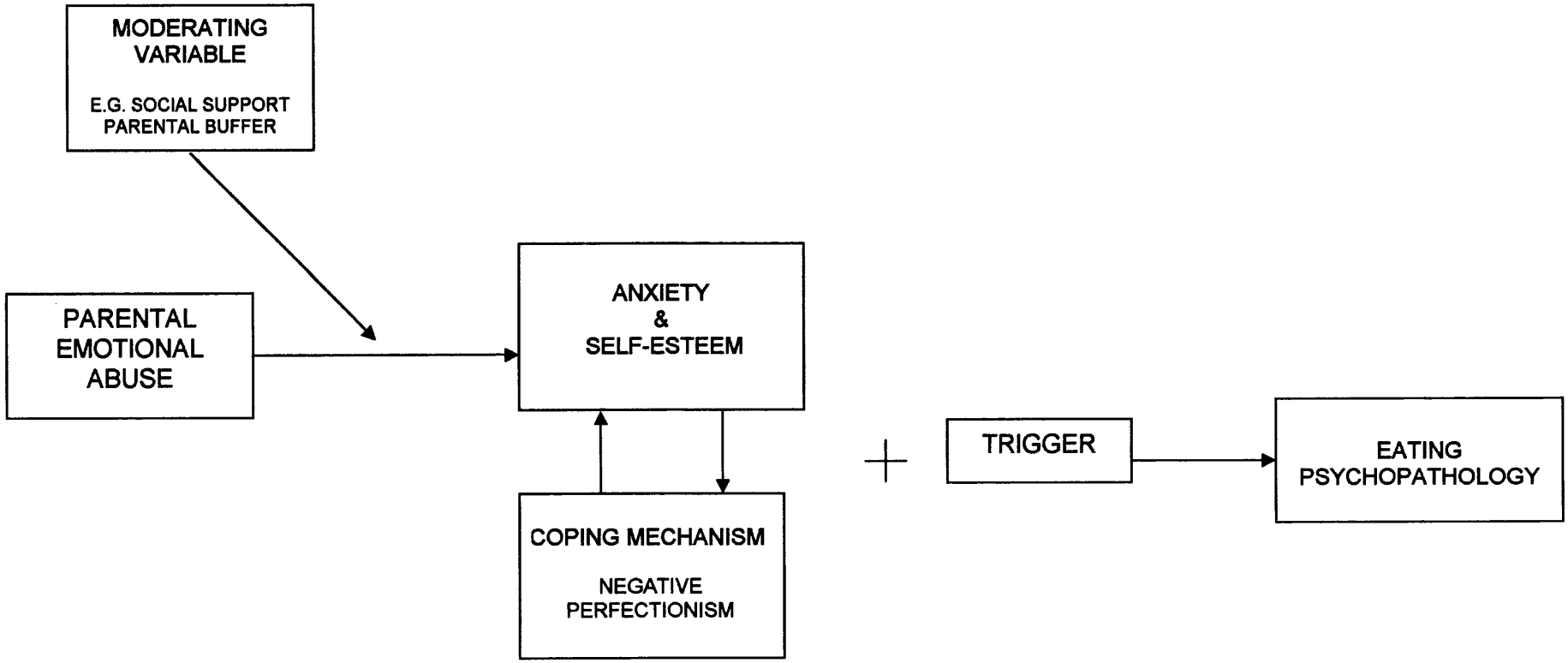
7.4.3 Research Limitations

The rebellion sub-theme was not measured. At the time the questionnaire booklet was compiled there did not seem to be a suitable way of testing it. There was a strong possibility that any questions that were asked about rebellion would be leading and therefore the data would be biased and the results unreliable. To measure whether rebellion is a general factor, in future it would be sensible to interview the participants in person and avoid asking direct questions about rebellion and biasing the participants' responses.

Unfortunately the trigger stage of the proposed model (Figure 2.1) was difficult to measure (sections 6.3 and 6.7.7) in the current work. Both the eating disordered and non-eating disordered participants had experienced traumas. But as explained in the previous chapter (sections 6.3 and 6.7.7) there was difficulty in deciphering the finer

details of when the traumas occurred and whether they were separate events from other types of abuse (such as sexual abuse).

Figure 7.1: A theoretical model of the development of eating disorders from an emotional abuse perspective.



7.5 Revision of the Proposed Model

As discussed in section 7.2, the first two stages of the model proposed in Figure 2.1 were collapsed into one stage which was more appropriately named 'parental emotional abuse' (Figure 7.1).

The rebellion sub-theme within the third stage of the original model (child's behavioural response to her parent's behaviour) was not measured (section 7.4.3), and was therefore not included when the model was revised. The 'good girl syndrome' sub-theme, also within the third stage of the original model, was supported because perfectionism was related to emotional abuse (in both the eating disorder and non-eating disorder groups). It also predicted some dimensions of eating psychopathology in both groups, although it only acted as a mediator between emotional abuse and BD in the non-eating disorder group. In the original model (Figure 2.1) the dimensions of perfectionism were not distinguished. The subsequent analysis found that negative (rather than positive) perfectionism was the influential mediating factor between emotional abuse and eating psychopathology. Therefore in the model revision explicit reference was made to negative perfectionism (Figure 7.1).

It was suggested that negative perfectionism acted as a mediator because of its connections with dysfunctional coping strategies (section 7.4.1). Therefore the 'child's behavioural response to her parent's behaviour' stage was more succinctly labelled 'coping mechanism'.

The relationship between emotional abuse and perfectionism was small indicating a possibility that other factors were playing a part in the relationship between the two.

Consideration of the past literature on anxiety and low self-esteem highlighted other possible explanations for the association between emotional abuse and negative perfectionism (Kent and Waller, 1999).

Anxiety has been associated with the experience of emotional abuse (Arrindell et al, 1983; Arrindell et al, 1989; Bruch and Heinburg, 1994; Bandelow et al, 2004). The relationship between anxiety and perfectionism has also been well documented (Mor et al, 1995; Kent and Waller, 2000; Davies, Claridge and Fox, 2000). It may be that anxiety acts as a mediator between emotional abuse and eating psychopathology (Kent et al, 1999). This possible relationship is further consolidated as emotion-focused strategies are often used in response to anxiety (Spertus et al, 2003) and perfectionism is often considered an emotion-focused coping strategy. Therefore it seems reasonable that anxiety may form a connection between emotional abuse and perfectionism. Revision of the original model (Figure 2.1) suggested that anxiety may be important in the process that leads to the development of eating psychopathology (Figure 7.1.).

Another possibility that may account for the unexplained variance is the mutual association that emotional abuse and perfectionism share with low self-esteem (Kent et al, 2000). Emotional abuse is thought to be associated with low self-esteem because the child internalises the abuse as their own fault (Hartt and Waller, 2002). Shafran and Mansell (2001) explained that low self-esteem is 'inevitable for the perfectionist because even the mildest of negative feedback could be seen as a failure'. Therefore it appears that a cycle is formed; for example, the child develops low self-esteem because he/she feels rejected by his/her parents. However because the child internalises the abuse he/she believes that they were rejected because they are a failure. Therefore the child

attempts to take control of the situation and counteract their failure by being perfect (Hartt et al, 1998). When their parents' behaviour is not modified the child feels more of a failure and his/her self-esteem decreases further. Thus he/she raises his/her standards (Shafran and Mansell, 2001) and the cycle repeats itself. Revision of the original model (Figure 2.1) may include low self-esteem as another influential factor in the development of eating psychopathology (Figure 7.1.).

The weak association between emotional abuse and eating psychopathology may be due to the child's internalisation of the abuse. The internalisation may have promoted a shift in focus from child/parent discord to problems within the child, such as low self-esteem, anxiety and perfectionism. This theory is supported by Beck (1967, 1976) and Young (1994) who stated that early childhood experience can lead to the formation of dysfunctional assumptions about oneself that lead to later psychological distress.

The trigger stage of the original model (Figure 2.1) characterised by the presence of a personal trauma was not quantitatively explored (see section 6.7.7). Exactly why a trauma should trigger an existing vulnerability to an eating disorder was not established. However, as discussed in section 6.7.7, it may be the individual's response to their trauma that is important rather than the presence of the trauma *per se*.

Perfectionism may have been sufficient to deal with daily problems and sub-clinical psychopathology. But an increase in distress, brought about by a personal trauma would demand the counterattack of a more 'advanced' coping strategy. The trauma will have increased feelings of anxiety, low self-esteem and the inability to cope; perhaps initiating a shift toward eating psychopathology.

There is a strong body of literature linking coping strategies to eating disorders (Andrews et al, 2002; Ghaderi, 2003), therefore it seems plausible that perfectionism is used as a coping strategy. Ruggiero, Levi, Ciuna and Sassordi (2003) studied non-eating disordered adolescents and found a general association between perfectionism and BD. But they found that a specific very stressful event (in their study collecting exam results) stimulated the relationship between perfectionism and DFT. They explained the role of stress in terms of control. The stressful event meant the participants felt that the situation was completely out of their control. Therefore their DFT may have been an attempt to recover some control.

The influence of the trigger stage discussed above parallels the 'critical event' stage of Beck's (1967, 1976) cognitive model. He proposed that critical incidents occur in an individual's life that 'mesh with the person's own beliefs' and could therefore trigger psychopathology. When applied to the current research a trauma may trigger eating psychopathology because the perfectionist needs a sense of control to protect their sense of self-worth (Shafran and Mansell, 2002) and reduce anxiety. A trauma would reaffirm that the perfectionist has no control and is hence a failure; in turn perpetuating their anxiety and low self-esteem. Due to the evidence that trauma is important both directly (Beck, 1967, 1976; Ruggiero et al, 2003) and indirectly (Andrews et al, 2002; Shafran and Mansell, 2002; Ghaderi, 2003) to eating psychopathology, it was proposed that the trigger stage would remain in the revised model (Figure 7.1).

The question remains why there were both eating disordered and non-eating disordered participants who suffered equal levels of emotional abuse and/or traumatic events, but only some developed an eating disorder. An insecure attachment pattern was discussed

in the previous chapter. However, this would mean that both eating disordered and non-eating disordered participants would have an insecure attachment with their parents and should therefore both have an equal chance of developing an eating disorder. Further research needs to investigate what makes some people develop an eating disorder and others not develop an eating disorder, when they have all experienced the same events. If anxiety and low self-esteem are consequences of emotional abuse and potentially lead to negative perfectionism, the suggestion is that not all people who have been emotionally abused develop anxiety and/or self-esteem issues. This theory was supported as the non-eating disorder group had significantly lower levels of negative perfectionism than the eating disorder group (section 6.6, Table 6.14). Therefore it seems likely that there may have been other factors present that moderated the association between emotional abuse and anxiety/self-esteem (Figure 7.1).

Kent et al (1999) suggested that the age of emotional abuse onset may moderate the association between emotional abuse and anxiety; however, they found that this was not the case. Kent and Waller (2000) hypothesised that the perpetrator may act as a moderator; perhaps there is a differential effect of mother and father abuse (section 7.2).

Alternatively it may be that the child's level of social support moderates the effect of the abuse (see section 7.5). In general, eating disordered people are known to be socially withdrawn and have few friends (Smith, 1984; Larson and Johnson, 1985; Mottram, 1985). It may be that they do not have a supportive peer group (before their eating disorder developed) and thus have less opportunity to off-load their problems or discuss them with others. There is also a strong suggestion in the literature that social support has a connection with the development, treatment and recovery of eating disorders

(McClintock and Evans, 2001; Ghaderi, 2003; Woods, 2004). In contrast it may be that people who develop eating psychopathology are members of friendship groups that place value on perfect body image (Paxton, Schutz, Wertheim and Muir, 1999). It is likely that exposure to these values will feed feelings of low-self worth and anxiety about oneself (Jarry, 1998).

Another possibility may be that some people have a genetic vulnerability to general psychopathology and/or eating disorders and emotional abuse provides a fertile environment for their vulnerability to be expressed. Those without a genetic vulnerability may respond to emotional abuse through unhealthy eating attitudes, but without the genetic vulnerability these attitudes may never become pathological. In revision of the model proposed in Figure 2.1, a moderating variable between the 'parental emotional abuse' stage and 'anxiety/self-esteem' stage (Figure 7.1) was considered.

7.6 Future Research

Emotional eating is a common phenomenon (Lacey, 1986; Waller and Osman, 1998). It may have been that emotional abuse related to adult unhealthy eating because the participants learnt to respond to their parents' negative behaviour with feelings that allowed compensation through food, for example, comfort eating. Waller and Osman (1998) showed that emotional eating was linked to higher weight but not restrictive eating attitudes. It would be interesting for further research to investigate whether there is a link between emotional eating and emotional abuse.

The literature generally links emotional abuse to anti-social disorders and aggressive behaviour (Thompson and Kaplan, 1999). So the finding in the current work that emotional abuse related to perfectionism was novel. Future research should investigate why some people develop anti-social behaviour as a result of emotionally abusive experiences, and why some people develop perfectionistic behaviour.

7.7 Treatment Implications

Parental emotional abuse should be borne in mind in therapeutic interventions. However, the emphasis would need to be assessed in each individual case. If the patient was a child and/or lived with their parents (in the absence of physical abuse or sexual abuse, otherwise the child would be removed from the home) it may be important to address emotional abuse issues. It may be best to offer intervention at the core of the problem; the parents. Parental counselling would focus on helping the parents understand the inappropriateness of their behaviour towards their child; it would help them to understand the long term psychological effects that their behaviour has on their child; and give advice on re-structuring their behaviour towards their child. Communication between family members may also be focused on in a therapeutic environment. By communicating more effectively, both the child and the parents would be able to convey their feelings more effectively. The child would learn to challenge their parents' behaviour without fear of reproach, which may stop the child's possible misinterpretation of their parents' behaviour.

If the patient was an adult and/or did not live with their parents, emotional abuse may be an issue that requires much less attention. One approach may be to treat the patient's perfectionistic traits and self-esteem problems, which may help them to

view their relationship with their parents differently or at least give them the skills to cope with it more effectively.

7.8 Conclusion

Emotional abuse proved to be a multidimensional construct. Each dimension functioned differently and it was rarely the case that emotional abuse existed independently of other types of abuse, a finding that concurred with Hartt and Waller's (2002) findings that 'nearly all participants reported some experience of emotional abuse or neglect, and all participants reported experiencing some physical abuse/punishment'. The current research also suggested that emotional abuse may underpin all types of abuse. Despite the small relationships between emotional abuse and eating psychopathology, emotional abuse was the only type of abuse that predicted unhealthy eating attitudes in the non-eating disorder group. The findings supported previous work that emotional abuse was central to all types of abuse associated with unhealthy eating attitudes (Kent et al, 1999).

In summary the model proposed in Figure 2.1 needed to be revised. It provided a plausible theoretical framework to work from, but in when considering the outcome of the present work and existing theory, the model was too simplistic and did not explain the pattern of results for both the eating and non-eating disorder groups. Therefore a revised, more general model of eating psychopathology was proposed (section 7.5; Figure 7.1).

The revised model highlighted a possible new pathway from emotional abuse to eating psychopathology, but it also supported elements of existing theories (Kent et al, 1999; Kent and Waller, 2000; Ghaderi, 2003; Krause et al, 2003). Furthermore, it integrated

theory from other areas of research such as the role of stressful life events, the development of general psychopathology and coping strategies and considered them as precursors of eating psychopathology. Further research is needed to investigate the revised model.

In retrospect:

They f**k you up, your mum and dad
They may not mean to, but they do.
They fill you with the faults they had
And add some extra, just for you.
But they were f**ked up in their turn
By fools in old-style hats and coats,
Who half the time were soppy-stern
And half at one another's throats
Man hands on misery to man.
It deepens like a coastal shelf.
Get out as early as you can,
And don't have any kids yourself.

(Philip Larkin)

References

Abrams, L.S., Cook-Stormer, C.C. (2002). Sociocultural variations in the body image perceptions of urban adolescent females. *Journal of Youth and Adolescence, 31,* 443-450.

Ainsworth, M.D. S., Blehar, M.C., Waters, E., Wall, S. (1978). *Patterns of attachment: a psychological study of the strange-situation.* New Jersey: Lawrence Erlbaum Associates.

Altabe, M. (1998). Ethnicity and body image: Quantitative and qualitative analysis. *International Journal of Eating Disorders, 23,* 153-159.

American Psychiatric Association. (1994). *Diagnostic and statistical manual of mental disorders* (4th ed.). Washington, DC: Author.

APSAC (1995). Psychosocial evaluation of suspected psychological maltreatment in children and adolescents. *Practice Guidelines.* American Professional Society on the Abuse of Children.

Andrews, L., Troop, N., Joseph, S., Hiskey, S., Coyne, I. (2002). Attempted versus successful avoidance: associations with distress, symptoms, and strategies for mental control. *Personality and Individual Differences, 33,* 827-907.

Arrindell, W.A., Emmelkamp, P.M., Monsma, A., Brilman, E. (1983). The role of perceived parental rearing practices in the aetiology of phobic disorders: a controlled study. *British Journal of Psychiatry, 143,* 183-187.

Arrindell, W.A., Kwee, M.G., Methorst, G.J., van der Ende, J., Pol, E., Moritz, B.J. (1989). Perceived parental rearing practices of agoraphobic and socially phobic in patients. *British Journal of Psychiatry, 155,* 526-535.

Atta, H., Youseff, R. (1998). Mothers' behaviour and perceptions. *Child Abuse and Neglect, 4,* 502-512.

Bandelow, B., Torrente, A.C., Wedekind, D., Broockes, A., Hajak, G., Rüther, E. (2004). Early traumatic life events, parental rearing styles, family history of mental disorders, and birth risk factors in patients with social anxiety disorder. *European Archives of Psychiatry and Clinical Neuroscience, 254,* 397-405.

Baron, R., M., Kenny, D., A. (1986). The moderator-mediator variable distinction in social psychology research: Conceptual, strategic, and statistical considerations. *Journal of Personality and Social Psychology, 15,* 1173-1182.

Barrow, J.C., Moore, C.A. (1983). Group interventions with perfectionistic thinking. *Personnel and Guidance Journal, 61,* 612-615.

Bartlett, M.S. (1954). A note on the multiplying factors for various chi-square approximations. *Journal of the Royal Statistical Society, 16 (Series B),* 296-298.

Bastiani, A.M., Radhika, R., Weltzin, T., Kaye, W.H. (1995). Perfectionism and anorexia nervosa. *International Journal of Eating Disorders, 17,* 147-152.

Beck, A.T. (1967). *Cognitive therapy and the emotional disorders.* New York: Harper and Row.

Beck, A.T. (1976). *Depression: clinical, experimental, and theoretical aspects.* New York: International Universities Presses.

Becker, A. Burwell, R.W., Herzog, D.B., Hamburg, P., Gilman, S.E. (2002). Eating behaviours and attitudes following prolonged exposure to television among ethnic Fijian adolescent girls. *British Journal of Psychiatry, 180,* 509-514.

Black Becker, C., DeViva, J.C., Zayfert, C. (2003). Eating disorder symptoms among female anxiety disorder patients in clinical practice: The importance of anxiety comorbidity assessment. *Anxiety Disorders, 464,* 1-20.

Bonenberger, R., Klosinski. G. (1988). Parent personality, family status and family dynamics in anorexia nervosa patients with special reference to father-daughter relations (a retrospective study. *Zeitschrift fur Kinder und Jugendpsychiatrie, 16,* 186-195

Bowlby, J. (1973). *Attachment and loss: Vol 2. Separation: Anxiety and anger.* New York: Basic Books, and London: Hogarth.

Bowlby, J. (1988). *A secure base: Clinical applications of attachment theory.* London: Routledge.

Briere, J., Runtz, M. (1988). Multivariate correlates of childhood psychological and physical maltreatment among university women. *Child Abuse and Neglect, 12,* 331-341.

Briere, J., Runtz, M. (1990). Differential adult symptomology associated with three types of child abuse histories. *Child Abuse and Neglect, 14,* 357-364.

Browne, A., Finkelhor, D. (1986). Initial and long-term effects: a review of the research. In D. Finkelhor (Ed.). *A sourcebook on child sexual abuse* (pp. 143-179). Newbury Park, CA:Sage.

Bruch, H. (1973). *Eating disorders: Obesity, anorexia nervosa and the person within.* New York: Basic Books.

Bruch, M.A., Heimburg, R.G. (1989). Social phobia and perceptions of parental and personal characteristics between generalised and nongeneralised social phobics. *Journal of Anxiety Disorders, 8,* 155-168.

Bryam, V., Wagner, H.L., Waller, G. (1995). Sexual abuse and body image distortion. *Child Abuse and Neglect, 19,* 507-510.

Bulik, C.M., Sullivan, P.F., Wade, T.D., Kendler. (2000). Twin studies of eating disorders: A review. *International Journal of Eating Disorders, 27,* 1-20.

Builik, C.M., Tozzi, F., Anderson, C., Mazzeo, S.E., Aggen, S., Sullivan, P.F. (2003). The relation between eating disorders and components of perfectionism. *American Journal of Psychiatry, 160,* 366-368.

Burns, D.D. (1980a). *Feeling good: the new mood theory.* New York: New American Library.

Calam, R., Waller, G., Slade, P., Newton, P. (1990). Eating disorders and perceived family relationships with parents. *International Journal of Eating Disorders, 9,* 479-485.

Casper, R.C. (1983). Some provisional ideas concerning the psychologic structure in anorexia nervosa and bulimia. In P.L. Darby, P.E. Garfinkel, D.M. Garner, D.V. Coscnia. *Anorexia Nervosa: Recent Developments in Research* (Eds.), pp. 387-92. New York: Liss.

Cassidy, E., Allsopp, M., Williams, T. (1999). Obsessive compulsive symptoms at initial presentation of adolescent eating disorders. *European Child and Adolescent Psychiatry, 8,* 193-199.

Castro, J., Toro, J., Cruz, M. (2002). Quality of rearing practices as predictor of short-term outcome in adolescent anorexia nervosa. *Psychological Medicine, 30,* 61-67.

Chamberlain. K. (1999). Using grounded theory in health psychology: Practices, premises and potential. In M. Murray and K. Chamberlain (1999). *Qualitative research in health psychology.* London: Sage.

Chassler, L. (1997). Understanding anorexia nervosa and bulimia nervosa from an attachment perspective. *Clinical Social Work Journal, 25,* 407-485.

Claussen, A., Crittenden, P. (1991). Physical and psychological maltreatment: relations among types of maltreatment. *Child Abuse and Neglect, 15,* 5-18.

Coffey, P., Leitenberg, K., Henning, K., Turner, T., Bennett, R.T. (1996). Mediators of the long-term impact of child sexual abuse: perceived stigma, betrayal, powerlessness, and self-blame. *Child Abuse and Neglect, 20,* 447-455.

Comery, A.L., Lee, H.B. (1992). *A first course in factor analysis* (2nd Eds.). Hillsdale, NJ: Lawrence Erlbaum Associates, Publishers.

Cooper, M.J., Wells, A., Todd, G. (2004). A cognitive model of bulima nervosa. *British Journal of Clinical Psychology, 43,* 1-16.

Coyne, J.C, Racioppo, M.W. (2000). Never the twain shall meet? Closing the gap between coping research and clinical intervention research. *American Psychologist, 55,* 655-664.

Crago, M., Shisslak, C., Estes, L. (1995). Eating disturbances among American minority groups: a review. *International Journal of Eating Disorders, 19,* 239-248.

Crisp, A.H. (1980). *Anorexia Nervosa: Let me be.* Academic Press Ltd.

Crittenden, P.M., Ainsworth, M.D.S. (1989). Child maltreatment and attachment theory. In D. Cichetti and V. Carlson *Child Maltreatment: Theory and Research on the Causes and Consequences of Child Abuse and Neglect* (eds). New York: Cambridge University Press.

Cusumano, D.L., Thompson, K.J. (2000). Media influence and body image in 8-11-year-old boys and girls: a preliminary report on the multidimensional media influence scale. *International Journal of Eating Disorders, 29,* 37-44.

Davies, C., Claridge, G., Fox., J. (1999). Not just a pretty face: physical attractiveness and perfectionism in the risk for eating disorders. *International Journal of Eating Disorders, 27,* 67-73.

Department of Health, National Assembly for Wales, Department of Health, Social Services and Public Safety, Northern Ireland, 2000. *Table 7.22, Children and young people on child protection registers: by age and category.* Viewed on 18/09/02, on www.statistics.gov.uk/statbase/Expodata/spreadsheets/D4600.xls

Devaud, C., Michaud, P.A., Narring, F. (1995). Anorexia and bulimia: increasing disorders? A review of the literature on the epidemiology of eating disorders. *Revue D Epidemiologie et de Sante Publique, 43,* 347-360.

Eating Disorders Association (2000). The need for action in 2000 and beyond. http://www.edauk.com/sub_hiddencost.htm

Egeland, B., Sroufe, L.A., Erikson, M. (1983). The developmental consequences of different patterns of maltreatment. *Child Abuse and Neglect, 7,* 459-469.

Engels, M., Moisan, D. (1994). The psychological Maltreatment Inventory: Development of a measure of psychological maltreatment in childhood for use in adult clinical settings. *Psychological Reports, 74,* 595-604.

Everill, J., Waller, G. (1995). Disclosure of sexual abuse and psychopathological adjustment in female undergraduates. *Child Abuse and Neglect, 19,* 93-100.

Fahy, T.A. (1991). Obsessive-compulsive symptoms in eating disorders. *Behaviour Research and Therapy, 29,* 113-116.

Fairburn, C.G., Cooper, Z., Doll, H.A., Welch, L. (1999). Risk factors for anorexia nervosa: three integrated case-control comparisons. *Archives of General Psychiatry, 56,* 468-476.

Fairburn, C.G., Marcus, M.D., Wilson, G.T. (1993). Cognitive-behavioural therapy for binge eating and bulimia nervosa: a comprehensive treatment manual. In C.G. Fairburn and G.T. Wilson (Eds.). *Binge Eating: Nature, Assessment and Treatment* (361-404). New York: Guildford Press.

Fairburn, C.G., Shafran, R., Cooper, Z. (1998). A cognitive behavioural theory of anorexia nervosa. *Behaviour Research and Therapy, 37,* 1-13.

Fairburn, C.G., Welch, S.L., Doll, H.A., Davies, B.A., O'Connor, M.E. (1997). Risk factors for bulimia nervosa. *Archives of General Psychiatry, 54,* 509-517.

Finkelhor, D. (1979). *Sexually victimised children.* New York. Macmillian.

Finkelhor, D., Browne, A. (1985). The traumatic impact of child sexual abuse: a conceptualization. *American Journal of Orthopsychiatry, 55,* 530-541

Fouts, G., Vaughan, K. (2002). Locus of control, television viewing and eating disorder symptomology in young females. *Journal of Adolescence, 25,* 307-311.

Friedberg, N.L., Lyddon, W.J. (1996). Self-other working models of eating disorders. *Journal of Cognitive Psychotherapy: An International Quarterly, 10,* 193-203.

Frost, R.O., Marten, P., Lahart, C.M., Rosenblate, R. (1990). The dimensions of perfectionism. *Cognitive Therapy and Research, 14,* 449-468.

Garabino, J., Guttman, E., Seeley, J. (1986). *The psychologically battered child: Strategies for identification, assessment and identification.* San Francisco: Jossey-Bass.

Garner, D.M., Olmstead, M.P., Polivy, J. (1983). Development and validation of a multidimensional eating disorder inventory for anorexia nervosa and bulimia. *International Journal of Eating Disorders, 2,* 15-34.

Garner, D.M., Olmstead, M.P., Polivy, J., Garfinkel, P.E. (1984). Comparison between weight preoccupied women and anorexia nervosa. *Psychosomatic Medicine, 46,* 255-266.

Ghaderi, A. (2003). Structural modelling analysis of prospective risk factors for eating disorder. *Eating Behaviours, 3,* 387-396.

Glaser, D. (1995). Emotionally abusive experiences. In P. Reder and C. Lucey (Eds.), *Assessment of parenting: Psychiatric and psychological contributions* (pp 73-86) London, UK:Routledge.

Glaser, B.G. (1978). *Theoretical sensitivity: Advances of methodology in grounded theory.* Mill Valley. CA: Sage.

Goldner, E.M., Srikameswaran, S., Schroeder, M.L. (1999). Dimensional assessment of personality pathology in patients with eating disorders. *Psychiatric Research, 22,* 151-159.

Gracia, E. (1995). Visible but unreported: case for the "not serious enough" cases of child maltreatment. *Child Abuse and Neglect, 19,* 1083-1093.

Grilo, C.M., Masheb, R.M. (2001). Childhood psychological, physical, and sexual maltreatment in outpatients with binge eating disorder: frequency and associations with gender, obesity, and eating related psychopathology. *Obesity Research, 9,* 320-325.

Grilo, C.M., Masheb, R.M. (2002). Childhood maltreatment and personality disorders in adult patients with binge eating disorder. *Acta Psychiatrica Scandinavica, 106,* 183-188.

Gupta, M.A., Gupta, A.K., Schork, N.J., Watteel, G.N. (1995). Perceived touch deprivation and body image: some observations among eating disordered and non-clinical subjects. *Journal of Psychosomatic Research, 39,* 459-464.

Halmi, K.A., Sunday, S.R., Strober, M., Kaplan, A., Woodside, D.B., Fichter, M., Treasure, J., Berrettini, W.H., Kaye, W.H. (2000). Perfectionism in anorexia nervosa: Variation by clinical subtype obsessionality, and pathological eating behaviour. *American Journal of Psychiatry, 157,* 1799-1805.

Hamachek, D.E. (1978). Psychodynamics of normal and neurotic perfectionism. *Psychology: A Journal of Human Behavior, 15,* 27-33

Hanson, R., Resnick, H., Saunders, B., Kilpatrick, D., Best, C. (1999). Factors related to the reporting of childhood rape. *Child Abuse and Neglect, 23,* 559-569.

Hart, S.N., Brassard M.R. (1990). Psychological maltreatment of children. In R.T. Ammerman and M. Hersen (Eds.). *Treatment of family violence: a sourcebook* (pp77-112). New York: John Wiley and Sons.

Hart, S.N., Germain, R.B., Brassard, M.R. (1987). The challenge: to better understand and combat psychological maltreatment of children and youth. In M.R. Brassard, R.B.

Germain and S.N. Hart (Eds.), *Psychological maltreatment of children and youth* (pp 3-24). New York: Pergamon Press.

Hartt, J., Waller, G. (2002). Child abuse, dissociation, and core beliefs in bulimic disorders. *Child Abuse and Neglect, 26,* 923-928.

Heinberg, L., Thompson, J.K., Stormer, S. (1994). Development and validation of the sociaocultural attitudes towards the appearance questionnaire. *International Journal of Eating Disorders, 17,* 81-89.

Henriques, G., Calhoun, L., Cann, A. (1996). Ethnic differences in women's body dissatisfaction: an experimental investigation. *Journal of Social Psychology, 136,* 689-698.

Hepworth. J. (1994). Qualitative analysis and eating disorders: Discourse analytic research on anorexia nervosa. *International Journal of Eating Disorders, 15,* 179-185.

Herzog, D.B., Keller, M.B., Sacks, N.R., Yeh, C.J., Lavori, P.W. (1992). Psychiatric co-morbidity in treatment-seeking anorexics and bulimics. *Journal of the American Academy of Child and Adolescent Psychiatry, 31,* 810-818.

Hewitt, P.L., Flett, G.L. (1993). Dimensions of perfectionism, daily stress and depression: a test of the specific vulnerability hypothesis. *Journal of Abnormal Psychology, 102,* 58-65.

Hewitt, P.L., Flett, G.L., Ediger, E. (1994). Perfectionism and depression: longitudinal assessment of a specific vulnerability hypothesis. *Journal of Abnormal Psychology, 105,* 276-280.

Hewitt, P.L., Flett, G.L., Ediger, E. (1995). Perfectionism traits and perfectionistic self-presentation in eating disorder attitudes, characteristics, and symptoms. *International Journal of Eating Disorders, 18,* 317-326.

Higgins, D.J., McCabe, M.P. (2000). Relationships between different types of maltreatment during childhood and adjustment in adulthood. *Child Maltreatment, 5,* 261-272.

Home Office, Department of Health, Department of Education and Science and Welsh Office (1991). *Working together under the children act 1989.* London: HSMO.

Horesh, N., Zalsman, G., Apter, A. (2000). Internalized anger self-control, and mastery experience in inpatient anorexic adolescents. *Journal of Psychosomatic Research, 49,* 247-253.

Ingram, R.E. (1984). Toward and information processing analysis of depression. *Cognitive Therapy Research, 8,* 443-478.

Iniewicz, G., Jozelik, B., Namyslowska, I., Ulasinska, R. (2002). Assessment of family relations by the patients from anorexia nervosa – part II. *Psychiatri Pol, 36,* 65-81.

Joiner, T.E., Heatherton, T.F., Rudd, M.D., Schmidt, N.B. (1997). Perfectionism, perceived weight status, and bulimic symptoms: two studies testing a diathesis-stress model. *Journal of Abnormal Psychology, 106,* 145-153.

Jarry., J.L. (1998). The meaning of body image for women with eating disorders. *Canadian Journal of Psychiatry, 43,* 367-74.

Kaiser, H. (1974). An index of factorial simplicity. *Psychometrika, 39,* 31-36.

Kaye, W.H., Weitzin, T.E., Hsu, L.K.G., Bulik, C., McConaha, C., Sokiewicz, T. (1992). Patients with anorexia nervosa have elevated scores on the Yale Brown Obsessive Compulsive Scale. *International Journal of Eating Disorders, 12,* 57-62.

Kent, A., Waller, G. (1998). The impact of childhood emotional abuse: an extension of the child abuse and trauma scale. *Child Abuse and Neglect, 22,* 393-399.

Kent, A., Waller, G., Dagnan, D. (1999). A greater role of emotional than physical or sexual abuse in predicting disordered eating attitude: the role of mediating variables. *International Journal of Eating Disorders, 25,* 159-167.

Kernberg, O.F. (1985). *Borderline conditions and pathological narcissism.* Northvale, NJ: Jason Aronson.

Kooiman, C.G., Ouewhand, A.W., ter Kuile, M.M. (2002). The sexual and physical abuse questionnaire (SPAQ). A screening instrument for adults to assess past and current experiences of abuse. *Child Abuse and Neglect, 26,* 939-953.

Krause, E.D., Mendelson, T., Lynch, T.R. (2003). Childhood emotional invalidation and adult psychological distress: the mediating role of emotional inhibition. *Child Abuse and Neglect, 27,* 199-213.

Lacey, J.H. (1986). Pathogensis. In L.J. Downey and J.C. Malkin (Eds.), *Current approaches: Bulimia nervosa* (pp.17-27). Southampton: Duphar.

Larson, R., Johnson, C. (1985). Bulimia: Disturbed patterns of solitude. *Addictive Behaviour, 10,* 281-290.

Latzer, Y., Hochdorf, Z., Bacher, E., Canetti, L. (2002). Attachment style and family functioning as discriminating factors in eating disorders. *Contemporary Family Therapy, 24,* 581-599.

Lavin, M.A., Cash, T.F. (2001). Effects of exposure to information about appearance stereotyping and discrimination on women's body images. *International Journal of Eating Disorders, 29,* 51-58.

Lilenfield, L.R., Kaye, W.H., Greeno, C.G., Merkingras, K.R., Plotnicov, K., Pollice, C., Rao, R., Streober, M., Bulik, C.M., Nagy, L. (1998). A controlled family study of anorexia nervosa and bulimia nervosa: psychiatric disorders in first degree relatives and effects of proband comorbidity. *Archive of General Psychiatry, 55,* 603-610.

Logue, A.W. (1998). *The psychology of eating and drinking: an introduction (2nd eds.).* W.H. Freeman and Co. New York.

MacBrayer, E.K., Smith, G.T., McCarthy, D.E., Demos, S., Simmons, J. (2001). The role of family of origin food-related experiences in bulimic symptomology. *International Journal of Eating Disorders, 30,* 149-160.

Mancini, C., van Ameringen, M., MacMillian, H. (1995. Relationship of childhood sexual and physical abuse to anxiety disorders. *Journal of Nervous Mental Disorders, 183,* 309-314.

Market Research Society. (2003). *Job classification guide.*

Matsunga, H., Kiriike, N., Iwasaki, Y., Miyata, A., Matsui, T. (2000). Multi-impulsivity among bulimic patients in Japan. *International Journal of Eating Disorders, 27,* 348-352.

Mazzeo, S.E., Espelage, D.L. (2002). Association between childhood physical and emotional abuse and disordered eating behaviors in female undergraduates. *Journal of Counselling Psychology, 49,* 86-100.

McClintock, J.M., Evans, I.M. (2001). The underlying psychopathology of eating disorders and social phobia: a structural equation analysis. *Eating Behaviour, 2*, 247-261.

McElroy, S.L., Phillips, K.A., Keck, P.E. (1994). Obsessive compulsive spectrum disorder. *Journal of Clinical Psychiatry, 55*, 33-51.

McGee, R., Wolfe, D. (1991). Psychological maltreatment: toward an operational definition. *Development and Psychopathology, 3*, 3-18.

Meyer, C., Gillings, K. (2004). Parental bonding and bulimic psychopathology: the mediating role of mistrust/abuse beliefs. *International Journal of Eating Disorders, 35, 229-233.*

Moeller, T., Bachmann, G. (1993). The combined effects of physical, sexual, and emotional abuse during childhood: long-term health consequences for women. *Child Abuse and Neglect, 17*, 623-640.

Morande, G., Celada, J., Casas, J.J. (1999). Prevalence of eating disorders in a Spanish school-age population. *Journal of Adolescent Health, 24*, 212-219.

Mottram, M.A. (1985). Personal constructs in anorexia. *Journal of Psychiatric Research, 19*, 291-295.

Mukai, T. (in press). Body image and the westernization of Japanese women. In S.A. O'Neale and C. Thompkinson (Eds.), *Keeper of the Flame: Power, Myth and Cultural Consciouness in Ethinic Female Identity.* Detroit, MI: Wayne State University Press.

Mukai, T., Kambara, A., Sasaki, Y. (1998). Body dissatisfaction, need for approval, and eating disturbances among Japanese and American college women. *Sex Roles, 39,* 751-763.

Mullen, P., Martin, J., Anderson, S., Romans., Herbison, G. (1996). The long-term impact of the physical, emotional, and sexual abuse of children: a community sample. *Child Abuse and Neglect, 20,* 7-21.

National Child Abuse Statistics. Compiled June 2002 by Childhelp USA. Viewed on 18/09/02, on www.childhelpusa.org/child/statistics. In Portwood, S.G. (1999). Coming to terms with a consensual definition of child maltreatment. *Child Maltreatment, 4,* 56-68.

Neumark-Steiner, D., Story, M., Hannan, P.J., Beuhring, T., Resnick, D. (2000). Disordered eating among adolescents and associations with sexual/physical abuse and other familial/psychosocial factors. *International Journal of Eating Disorders, 28,* 249-258.

Nolen-Hoeksema, S. (1987). Sex differences in unipolar depression: evidence and theory. *Psychological Bulletin, 101,* 259-282.

North, C., Gowers. S., Bryam, V. (1995). Family functioning in adolescent anorexia nervosa. *British Journal of Psychiatry, 167,* 673-678.

O'Brien, K.M., Vincent, N.K. (2003). Psychiatric comorbidity in anorexia and bulimia nervosa: nature, prevalence, and causal relationships. *Clinical Psychology Review, 23,* 57-74.

O'Hagan, K. (1995). Emotional and psychological abuse: problems of definition. *Child Abuse and Neglect, 19,* 449-461.

Pallant, J. (2003). *SPSS survival manual: A step by step guide to data analysis using SPSS for windows (versions 10 and 11).* Open University Press.

Palmer, R.L., Oppenheimer, R., Marshall, P.D. (1988). Eating disordered patients remember their parents: A study using the parental bonding instrument. *International Journal of Eating Disorders, 7,* 589-599.

Parker, G., Tupling, H., Brown, L.B. (1979). A parental bonding instrument. *British Journal of Medical Psychology, 52,* 1-10.

Parker, S., Nichter, M., Vuckovic, N., Sims, C., Ritenbaugh, C. (1994). Body image and weight concerns among African-American and White adolescent females: differences that make a difference. *Human Organization, 54,* 103-114.

Parkes, C., M, Stevenson-Hinde, J. (Eds). *The place of attachment in human behavior* (1982). London: Tavistock Publications.

Patterson, G.R. (1986). Performance models of anti-social boys. *American Psychologist, 41,* 432-444.

Paxton, S.J., Schutz, H.K., Wertheim, E.H., Muir, S.L. (2000). Friendship clique and peer influences on body image concerns, dietary restraint, extreme weight-loss behaviors, and binge eating in adolescent girls. *Journal of Abnormal Psychology* ,108, 255-66.

Perkins, D.F., Luster, T. (1999). The relationship between sexual abuse and purging: Findings from community-wide surveys of female adolescents. *Child Abuse and Neglect, 23,* 371-382.

Perris, C., Jacobson, L., Lindtröm, H., von Knorring, L., Perris, H. (1980). Development of a new inventory for assessing memories of parental rearing behaviour. *Acta Psychiattrica Scandinavica, 61,* 265-274.

Polivy, J., Herman, C.P. (2002). Causes of eating disorders. *Annual Review of Psychology, 53,* 187-213.

Pope, K.G., Hudson, J.L. (1992). Is childhood sexual abuse a risk factor in bulimia nervosa? *American Journal of Psychiatry, 149,* 455-463.

Portwood, S.G. (1999). Coming to terms with a consensual definition of child maltreatment. *Child Maltreatment, 4,* 56-68.

Quadflieg, N., Fichter, M.M. (2003). The course and outcome of bulimia nervosa. *European Child and Adolescent Psychiarty, 12 (Suppl. 1),* 99-109.

Raffi, A.R., Rondini, M., Grandi, S., Fava, G.A. (2000). Life events and prodromal symptoms in bulimia nervosa. *Psychological Medicine, 30,* 727-31.

Rodgers, C.S., Lang, A.J., Laffaye, C., Satz, L.E., Dresselhaus, T.R., Stein, M.B. (2004). The impact of individual forms of childhood maltreatment on health behavior. *Child Abuse and Neglect, 28,* 575-586.

Root, M.P.P., Fallon, P. (1988). The incidence of victimisation in a bulimic sample. *Journal of Interpersonal Violence, 3,* 161-173.

Rorty, M., Yager, J., Rossotto, E. (1994). Childhood sexual, physical, and psychological abuse in bulimia nervosa. *American Journal of Psychiatry, 151,* 1122-1126.

Rorty, M., Yager, J., Rossotto, E. (1995). Aspects of childhood physical punishment and family environment correlates in bulimia nervosa. *Child Abuse and Neglect, 19,* 659-667.

Rosen, L. N., Martin, L. (1996). Impact of childhood abuse history on psychological symptoms among male and female soldiers in the U.S. army. *Child Abuse and Neglect, 20,* 1149-1160.

Rubenstien, C.S., Pigott, T.A., Altemus, M., L'Heureux, F., Gray, J.J., Murphy, D.L. (1993). High rates of co-morbid OCD in patients with bulimia nervosa. *Eating Disorders: The Journal of Treatment and Prevention, 1,* 147-155.

Ruggiero, G.M., Levi, D., Ciuna, A., Sassaroli, S. (2003). Stress situation reveals an association between perfectionism and drive for thinness. *International Journal of Eating Disorders, 34,* 220-226.

Salzman, J.P. (1997). Ambivalent attachment in female adolescents: Association with affective instability and eating disorders. *International Journal of Eating Disorders, 21,* 251-259.

Sanders, B., Becker-Lausen., E. (1995). The maltreatment of psychological maltreatment: early data on the child abuse and trauma scale. *Child Abuse and Neglect, 19,* 315-323.

Schaaf, K.K., McCanne, T.R. (1994). Childhood abuse, body image disturbance, and eating disorders. *Child Abuse and Neglect, 18,* 607-615.

Scher, C.D., Stein, M.B. (2003). Developmental antecedents of anxiety sensitivity. *Anxiety Disorders, 17,* 253-269.

Schmidt, N.B., Telch, M.J. (1990). Prevalence of personality disorders among bulimics, nonbulimic binge eaters, and normal controls. *Journal of Psychopathology and Behavioral Assessment, 12,* 169-185.

Schumacher, J., Smith Slep, A., Heyman, R. (2001). Risk factors for male-to-female partner psychological abuse. *Aggression and Violent Behaviour, 6,* 255-268.

Serpell. L., Treasure. J., Teasdale. J., Sullivan. V. (1999). Anorexia nervosa: Friend or foe? *International Journal of Eating Disorders, 25,* 177-186.

Shafran, R., Mansell, W. (2001) Perfectionism and psychopathology: a review of research and treatment. *Clinical Psychology Review, 21,* 879-906.

Shatford, L.A., Evans, D.R. (1986). Bulimia as a manifestation of the stress process: A LISREL causal modelling analysis. *International Journal of Eating Disorders, 5,* 451-473.

Slade, P.D. (1982). Towards a functional analysis of anorexia nervosa and bulimia nervosa. *British Journal of Clinical Psychology, 21,* 167-179.

Slade, P.D., Owens, R.G. (1998). A dual process model of perfectionism based on reinforcement theory. *Behavioral Modification, 22,* 372-390.

Smith, J.A., (1996). Beyond the divide between cognition and discourse: using interpretative phenomenological analysis in health psychology. *Psychology and Health, 11,* 261-271.

Smith, J.A., Flowers, P., Osborn, M. (1997). Interpretative phenomenological analysis and health psychology. In: L. Yardley (Ed.). *Material Discourses and Health of Health and Illness.* London:Routledge.

Smith, J.A., Harré, R., Van Langenhove, L. (1995). Ideography and the case study. In: J.A. Smith, R. Harré and L. Van Langenhove (Eds.) *Rethinking Psychology.* London:Sage.

Smith, L.M., Mullis, R.L., Hall, W.E. (1995). Identity strivings with in the mother-daughter relationship. *Psychological Reports, 76,* 495-503.

Smith, M.S. (1984). Anorexia nervosa and bulimia. *Journal of Family Practice, 18,* 757.

Solyom, L., Freeman, R.J., Miles, J.E. (1982). A comparative psychometric study of anorexia nervosa and obsessive neurosis. *Canadian Journal of Psychiatry, 27,* 282-286.

Speranza, M., Corcos, M., Godart, N., Loas, G., Guilbaud, O., Jeammet, P., Flament, M. (2001). Obsessive compulsive disorders in eating disorders. *Eating Behaviours, 2,* 193-207.

Spertus, I.L., Yehuda, R., Wong, C.M., Halligan, S., Seremetis, S.V. (2003). Childhood emotional abuse and neglect as predictors of psychological and physical symptoms in women presenting to a primary care practice. *Child Abuse and Neglect, 27,* 1247-1258.

Spranger, S.C., Waller, G., Bryant-Waugh, R. (2001). Schema avoidance in bulimic and non-eating disordered women. *International Journal of Eating Disorders, 29,* 302-306.

Srinvasagam, N.M., Kaye, W.H., Plotnicov, K.H., Greeno, C., Weltzin, T.E., and Rao, R. (1995). Persitent perfectionism, symmetry, and exactness after long-term recovery from anorexia nervosa. *American Journal of Psychiatry, 152,* 1630-1634.

Steiger, H. (2004). Eating disorders and the serotonin connection: state, trait and developmental effects. *Journal of Psychiatry and Neuroscience, 29,* 20-29.

Straus, M.A. (1979). Measuring intrafamily conflict and violence: The Conflict Tactics Scales. *Journal of Marriage and the Family, 41,* 75-88.

Straus, M.A. (1990). The Conflict Tactics Scales and its critics: An evaluation and data on validity and reliability. In M.A. Straus and R.J.Gelles (Eds.), *Physical violence in American families: Risk factors and adaptations to violence in 8,145 families* (pp 49-73). New Brunswick, NJ: Transaction Publishers.

Straus, M.A., Hamby, S.L., Boney-McCoy, S., Sugarman, D.B. (1996). The revised Conflict Tactics Scales (CTS): Development and preliminary psychometric data. *Journal of Family Issues, 17,* 223-238.

Straus, M.A., Hamby, S.L., Finkelhor, D., Moore, D.W., Runyan, D. (1998). Identification of child maltreatment with parent-child conflict tactics scales: Development and psychometric data for a national sample of American parents. *Child Abuse and Neglect, 22,* 249-270.

Strober, M. (1991). Disorders of the self in anorexia nervosa: an organismic-developmental paradigm. In C.L. Johnson. *Psychodynamic Treatment of Anorexia Nervosa and Bulimia* (Eds.), pp.354-373. New York: Guildford.

Stuart, G. W., Laraia, M.T. , Ballenger, J.C., Lydaird, R.B. (1990). Early family experiences of women with bulimia and depression. *Archives of Psychiatric Nursing, 4,* 43-52.

Swedo, S.E., Rapoport, J.L., Leonard, H., Lenane, M., Cheslow, D. (1989). Obsessive-compulsive disorder in children and adolescents. *Archives of General Psychiatry, 46,* 335-341.

Tabacknick, B.G., and Fidell, L.S. (1996). *Using multivariable statistics* (3rd Ed.). New York: HarperCollins.

Terry-Short, L.A., Owens, G.R., Slade P.D., Dewey, M.E. (1995). Positive and Negative Perfectionism. *Personality and Individual Differences, 18,* 663-668.

Thompson, J.K., Cattarin, J., Fowler, B., Fisher, E. (1995). The perception of teasing scale (POTS): A revision and extension of the physical appearance related teasing scale (PARTS). *Journal of Personality Assessment, 65,* 146-157.

Thompson, A.E., Kaplan, C.A (1996). Childhood Emotional Abuse. *British Journal of Psychiatry, 168,* 143-148.

Thompson, A.E., Kaplan, C.A. (1999). Emotionally abused children presenting to child psychiatry clinics. *Child Abuse and Neglect, 23,* 191-196.

Thompson, B. (1996). Multiracial feminist theorizing about eating problems: refusing to rank oppressions. *Eating Disorders, 4,* 104-113.

Thornton, C., Russel, J. (1997). Obsessive compulsive comorbidity in the dieting disorders. *International Journal of Eating Disorders, 21,* 83-87.

Tiggemann, M., Pickering, A.S. (1996). Role of television in adolescent women's weight concerns of fourth-grade children. *International Journal of Eating Disorders, 20,* 199-203.

Treasure, J., Uher, R., Campbell, I. (2003). The brain and eating disorders. *European Neuropsychopharmacology, 13, S121.*

Troop, N.A., Holbrey, A., Trowler, R., Treasure, J.L. (1994). Ways of coping in women with eating disorders. *Journal of Nervous Mental Disorders, 182,* 535-540.

Turnbull, S., Ward, A., Treasure, J., Jick, H., Derby, L., (1996). The demand for eating disorder care: an epidemiological study using the general practice research database, *British Journal of Psychiatry, 169,* 705-712.

U.S. Department of Health and Human Services (1981). Study findings: national study of the incidence and severity of child abuse and neglect. DHSS Publication No. (OHDS) 81-30325. Washington, DC: U.S. Government Printing Office. In E. Virginia Code, 1997, Section 16.1-228[1]. In Portwood, S.G. (1999). Coming to terms with a consensual definition of child maltreatment. *Child Maltreatment, 4,* 56-68.

Vitousek, K., Manke, F. (1994). Personality variables and disorders in anorexia nervosa and bulimia nervosa. *Journal of Abnormal Psychology, 103,* 137-147.

Vohs, K.D., Bardone, A.M., Joiner, T.E. Jr., Abramson, L.V., Heatherton, T.F. (1999). Perfectionism, perceived weight status, and self-esteem interact to predict bulimic symptoms: a model of bulimic symptom development. *Journal of Abnormal Psychology, 108,* 695-700.

Wakeling, A. (1985). Neurobiological aspects of feeding disorders. *Journal of Psychiatric Research, 19,* 191-201.

Waller, G. (2003). Schema-level cognitions in patients with binge eating disorder: a case control study. *International Journal of Eating Disorders, 33,* 458-464.

Waller, G. (1991). Sexual abuse as a factor in eating disorders. *British Journal of Psychiatry, 159,* 664-771.

Waller, G. (1998). Perceived control in eating disorders: Relationship with reported sexual abuse. *International Journal of Eating Disorders, 23,* 213-216.

Waller, G., Calam, R., Slade, P. (1988). Bulimia simplex. Unpublished Manuscript, University of Liverpool.

Waller, G., Calam, R., Slade, P. (1989). Eating disorders and family interaction. *British Journal of Clinical Psychology, 28,* 285-286.

Waller, G., Ruddock, A. (1993). Experiences of disclosure of child abuse and psychopathology. *Child Abuse and Neglect, 2,* 185-195.

Waller, G., Ruddock, A. (1995). Information-processing correlates of reported sexual abuse in eating-disordered and comparison women. *Child Abuse and Neglect, 19,* 745-759.

Waller, G., Ohanian, V., Meyer, C., Osman, S. (2000). Cognitive content among bulimic women: the role of core beliefs. *International Journal of Eating Disorders, 28,* 235-241.

Waller, G., Osman, S. (1998). Emotional eating and eating psychopathology among non-eating disordered women. *International Journal of Eating Disorders, 23,* 419-424.

Ward, A., Ramsay, R., Treasure, J. (2000). Attachment research in eating disorders. *British Journal of Medical Psychology, 73,* 35-51.

Weiner, K.E., Thompson, J. (1997). Overt and covert sexual abuse: relationship to body image and eating disturbance. *International Journal of Eating Disorders, 22,* 273-284.

Welch, S.L., Fairburn, C.G. (1996). Childhood sexual and physical abuse as risk factors for the development of bulimia nervosa: A community-based case control study. *Child Abuse and Neglect, 7* 633-642.

Wilhelm, K., Roy, K., Mitchell, P., Brownhill, S., Parker, G. (2002). Gender differences in depression risk and coping factors in a clinical sample. *Acta Psychiatrica Scandinavica, 106,* 45-53.

Williams, R.J., Ricciardelli, L.A. (2003). Negative perceptions about self-control and identification with gender-role stereotypes related to binge eating, problem drinking, and co-morbidity among adolescents. *Journal of Adolescent Health, 32,* 66-72.

Witkiewitz, K., Dodge-Reyome, N. (2000). Recollections of childhood psychological maltreatment and self-reported eating disordered behaviors in undergraduate college females. *Journal of Emotional Abuse, 2,* 15-29.

Woods, M. (2004). Untreated recovery from eating disorders. *Adolescence, 39,* 361-371.

Young, J. E. (1994). Cognitive therapy for personality disorders: a schema –focused approach (2nd Eds.). Sarasota: Professional Resource Press.

Young, J.E., Abelson, J.L., Curtis, G.C., Nesse, R.M. (1997). Childhood adversity and vulnerability to mood and anxiety disorders. *Depression and Anxiety, 5,* 66-72.

Appendices

Appendix 1.1 Cover Note

Dear Participant,

I would be grateful if you could spare a few minutes to help me with my research project. The research considers the origin of eating disorders but to do this I need to compare responses of those with eating disorders with people in the wider population to see if their responses differ in any way.

There are instructions throughout the booklet on how to complete the questions. Some of the questions are very personal in nature, if you are uncomfortable answering them please skip over them, you do not have to respond to every question. I would also like to take this opportunity again to assure you that there will be no way of identifying your responses. Although you are asked to sign the consent form at the beginning of the questionnaire booklet, when I receive it, the consent form will be removed and kept separately. **If you still feel uncomfortable signing the consent form, please make a cross instead of writing your signature so I know you have read and understood the instructions.**

It is important you have an idea of the questions so you feel comfortable and understand that you are free not to take part. Some questions are very personal; asking about sexual abuse, please skip these if you are uncomfortable. Other questions ask about how your parents (or primary caregivers) raised you, followed by questions relating to how you deal with situations, how you think and how you feel about your body.

Thank you in advance for helping me with my research, it asks major questions about the nature of eating disorders and aims to improve treatment techniques. Your responses are essential to the project.

Please return your completed booklet in the pre-paid envelope provided.

Thank you again

Annette Leponis

Appendix 1.2 Consent Form

My name is Annette Leponis; I am in my third year of a psychology PhD at the University of Wales, Swansea. My research is based on eating disorders and factors that may be associated with them.

The following booklet is made up of a series of questionnaires based on childhood experiences, parent-child interaction and parental upbringing style, eating disorders and personality characteristics. Some of the questions may be uncomfortable to respond to, if so please do not feel you must fill them in, just go on to the next question you are comfortable with answering.

Instructions on how to complete the questionnaire are given throughout; the questions that may cause discomfort are marked in advance. In some cases you will be asked to write an answer based on your personal experience, but in the majority of cases you will be asked to circle/ring the answer that is most appropriate to your personal experience. The booklet will take approximately 30 minutes to complete. There is an information page at the end listing helplines and information websites, please feel free to take this page away with you. If you would like to know the final results of the study you can contact me through email at a.f.leponis@swansea.ac.uk .

Completion of the booklet is voluntary, so if you begin but do not wish to continue, you do not have to, and you do not need to give any explanation, please just return the booklet.

All responses are completely anonymous and strictly confidential, although you will need to sign this page before you complete the questionnaires, the consent forms will be kept separately from the questionnaires, so identification will be impossible.

Thank you again for your co-operation,
Annette Leponis

Participant Declaration (please sign below if you agree to continue):
I understand the above statements, I am completing the questions in this booklet voluntarily; I understand that all of my responses are anonymous and confidential. I understand that if I feel uncomfortable when responding to any of the questions I can miss them out. I understand that I can speak to my therapist/counsellor/clinician, who gave me the questionnaire if there are any issues raised that I wish to discuss.

Participant Signature: .....

Appendix 1.3 Information Sheet

Helpful Information

If you feel you have experienced any sort of abuse i.e. emotional/physical/sexual or neglect and you would like more information about it or need/would like to speak to someone confidentially about it, then the information below may be useful.

Information sources

www.safechild.org

www.familyviolence.org

www.childresearch.net

Helplines and Websites

NSPCC 0808 800 5000 (freephone)

0808 100 2524 (freephone, welsh speaking)

Open: 11am-6:30pm (weekdays)

www.nspcc.org.uk

Careline 020 85141177 Open: 10am-4pm, 7pm-10pm (weekdays)

http://www.freezone.co.uk/t17survivors/page9.htm

Samaritans 0845 790 90 90 (24hrs)

Respond 0845 6061503 (local rate) Open: 1:30pm-5pm

www.respond.org.uk

Kidscape 020 7730 3300 Open: 10am-4pm (weekdays)

Bristol Crisis Centre for Women 0117 925 1119 (national service) Open: 9pm-12:30am (Fri/Sat evenings)

Eating Disorder Helplines and Information

EDA (Eating Disorders Association)

Adult helpline (over 18 years old) 0845 634 1414 (national service) Open 8:30am-8:30pm (weekdays).

Youthline (up to and including 18 years old) 0845 634 7650 (national service) Open 4pm-6pm (weekdays)

www.edauk.com

Helplines specifically for adults who suffered child abuse

Reachout 020 8905 4501 (24hrs)

Childwatch 01482 325 552 Open: 9am-4pm (weekdays)

www.childwatch.org.uk

Appendix 1.4 Demographic Information

Personal

1) Gender: Male ☐ Age: .....
Female ☐

2) What academic qualifications do you have (please just give number and level, e.g. 5 GCSE's, 1 A-Level)?

.....

.....

.....

3) Occupation:

.....

.....

Family

3) Marital Status:

Single ☐ Have you ever been divorced? Yes ☐
In current relationship ☐ No ☐
Co-habiting with partner ☐
Married ☐
Separated ☐
Widowed ☐

4) Do you have children? Yes ☐
No ☐

If so, what are their ages (please state if they are fostered or adopted)? .....

.....

5) Who brought you up?

Biological parents	☐	from what age? .....
Mother only	☐	from what age? .....
Father only	☐	from what age? .....
Mother and stepfather	☐	from what age? .....
Father and stepmother	☐	from what age? .....
Biological grandparents	☐	from what age? .....

Other: ....

6) Has your mother died? Yes ☐ if so, how old were you?.....
No ☐

7) Has your father died? Yes ☐ if so, how old were you?.....
No ☐

8) Are you parents:

Living together	☐
Married	☐
Separated	☐
Divorced	☐ if so, how old were you?.....

9) Do you have any siblings?

Brothers:	Yes	☐ how old are they? .....
	No	☐
Sisters:	Yes	☐ how old are they? .....
	No	☐

Eating Disorder

10a) Are you currently diagnosed with an eating disorder?

Yes	☐
No	☐

10b) If so, what is it?

Anorexia Nervosa	☐
Bulimia Nervosa	☐
Binge Eating Disorder	☐

Other.....

10c) When were you diagnosed? .....

11a) Do you have a history of eating disorders (before your current diagnosis)?

Yes ☐

No ☐

11b) Please explain your history of previous eating disorders, giving dates as best you can and say whether these eating disorders were diagnosed or treated.

.....

.....

12) If you have an eating disorder, do you consider yourself to be:

In the recovery process ☐

Maintaining your current status ☐

Recovered ☐

None of the above, but thinking about recovery in the future ☐

13) How old were you when the present eating disorder began? .....

13) How long have you had an eating disorder (if you have recovered, how long did it last)?

.....

14) Have you had any treatment for your eating disorder?

Yes ☐

What type? .....

.....

.....

No ☐

Why?.....

.....

.....

15) What do you think provoked your eating disorder?

.....

.....

.....

.....

.....

.....

16) Events affect people differently, what is upsetting and/or traumatic to one person may not be to another. Have you ever been through what YOU considered to be a very upsetting/traumatic experience(s)?

Yes ☐ No ☐

If yes, could you give a short description of what was involved and how old you were when it / they happened?

.....

.....

.....

.....

.....

.....

.....

Appendix 1.5 Modified CTS

The following questions (pages 5-10) refer to parental style and their upbringing techniques in your relationship with your parents.

Please read the following questions and ring the number that reflects the frequency of the experience in your life, up to and including the age of 16 years.

Below is an example of how a question might be answered:

Did you ever fall off your bike as a **child?**	***Never*** **1**	**2**	**3**	**4**	**5**	**6**	***Always*** **7**
1) Were you ever left at home alone, when an adult should have been with you?	**Never** 1	2	3	4	5	6	**Always** 7
2) Were either of your parents so caught up with their own problems that they were unable to show or tell you they loved you?	**Never** 1	2	3	4	5	6	**Always** 7
3) Were there times when either of your parents did not provide the food you needed?	**Never** 1	2	3	4	5	6	**Always** 7
4) Were there times you needed to go to a doctor/hospital, but your parents did not arrange for you to do so?	**Never** 1	2	3	4	5	6	**Always** 7
5) Were either of your parents ever drunk or high, so they could not take care of you?	**Never** 1	2	3	4	5	6	**Always** 7
6) Were you ever slapped on the face, head or ears by your parents?	**Never** 1	2	3	4	5	6	**Always** 7
7) Were you ever hit on with something like a belt, hairbrush, stick or some other hard object by your parents?	**Never** 1	2	3	4	5	6	**Always** 7
8) Were you ever violently thrown down by your parents?	**Never** 1	2	3	4	5	6	**Always** 7

9) Were you ever hit with a fist or kicked hard by your parents?	**Never** 1	2	3	4	5	6	**Always** 7
10) Were you ever grabbed around the neck and choked by your parents?	**Never** 1	2	3	4	5	6	**Always** 7
11) Were you ever burned or scalded by you parents on purpose?	**Never** 1	2	3	4	5	6	**Always** 7
12) Were you threatened with a knife or gun by your parents?	**Never** 1	2	3	4	5	6	**Always** 7

Appendix 1.6 PEA-Q (response for female caregiver)

Please could you circle the number (with reference to the scale below) that is appropriate to YOUR experiences relating to your main female caregiver up to and including 16 years old.

If you were not raised by your biological mother, please could you state the relationship of the female caregiver you are referring to i.e. grandmother/auntie etc. .....

If you did not have a female caregiver please go to page 11 (the questions relating to your main male caregiver).

Below is an example of how a question might be answered:

Did you ever fall off your bike as a	***Never***			***Sometimes***		***Always***	
child?	1	2	3	4	5	6	7
How upset were you by this?	**Not Upset**			**Moderately Upset**		**Very Upset**	
	1	2	3	4	5	6	7
1a)Did your mother ever get really angry with you when you thought there was no reason?	**Never**			**Sometimes**		**Always**	
	1	2	3	4	5	6	7
1b) How upset were you by this?	**Not Upset**			**Moderately Upset**		**Very Upset**	
	1	2	3	4	5	6	7
2a) Did your mother ground you or take away your privileges?	**Never**			**Sometimes**		**Always**	
	1	2	3	4	5	6	7
2b) How upset were you by this?	**Not Upset**			**Moderately Upset**		**Very Upset**	
	1	2	3	4	5	6	7
3a)Did your mother blame you for things you didn't do?	**Never**			**Sometimes**		**Always**	
	1	2	3	4	5	6	7
3b) How upset were you by this?	**Not Upset**			**Moderately Upset**		**Very Upset**	
	1	2	3	4	5	6	7
4a) Were you ever shouted/yelled/ screamed/cursed at by your mother?	**Never**			**Sometimes**		**Always**	
	1	2	3	4	5	6	7
4b) How upset were you by this?	**Not Upset**			**Moderately Upset**		**Very Upset**	
	1	2	3	4	5	6	7
5a) Did your mother try to make you feel dependent on her?	**Never**			**Sometimes**		**Always**	
	1	2	3	4	5	6	7
5b) How upset were you by this?	**Not Upset**			**Moderately Upset**		**Very Upset**	
	1	2	3	4	5	6	7
6a) Did your mother show a lack of interest toward you?	**Never**			**Sometimes**		**Always**	
	1	2	3	4	5	6	7
6b) How upset were you by this?	**Not Upset**			**Moderately Upset**		**Very Upset**	
	1	2	3	4	5	6	7

7a) Did your mother try to make you feel like you couldn't cope without her?	**Never**			**Sometimes**			**Always**
	1	2	3	4	5	6	7
7b) How upset were you by this?	**Not Upset**			**Moderately Upset**			**Very Upset**
	1	2	3	4	5	6	7
8a) Did your mother try to prevent you from growing up?	**Never**			**Sometimes**			**Always**
	1	2	3	4	5	6	7
8b) How upset were you by this?	**Not Upset**			**Moderately Upset**			**Very Upset**
	1	2	3	4	5	6	7
9a) Did your mother seem emotionally cold to you?	**Never**			**Sometimes**			**Always**
	1	2	3	4	5	6	7
9b)How upset were you by this?	**Not Upset**			**Moderately Upset**			**Very Upset**
	1	2	3	4	5	6	7
10a) Were you ever blamed for your mother's wrongdoing?	**Never**			**Sometimes**			**Always**
	1	2	3	4	5	6	7
10b) How upset were you by this?	**Not Upset**			**Moderately Upset**			**Very Upset**
	1	2	3	4	5	6	7
11a)Did your mother try to control everything you did?	**Never**			**Sometimes**			**Always**
	1	2	3	4	5	6	7
11b) How upset were you by this?	**Not Upset**			**Moderately Upset**			**Very Upset**
	1	2	3	4	5	6	7
12a) Were you ever made to feel that you should 'stay out of the way' by your mother?	**Never**			**Sometimes**			**Always**
	1	2	3	4	5	6	7
12b) How upset were you by this?	**Not Upset**			**Moderately Upset**			**Very Upset**
	1	2	3	4	5	6	7
13a) Did you feel uncomfortable with your mother because you didn't know what to talk about?	**Never**			**Sometimes**			**Always**
	1	2	3	4	5	6	7
13b) How upset were you by this?	**Not Upset**			**Moderately Upset**			**Very Upset**
	1	2	3	4	5	6	7
14a) Did your mother make you feel like you were a bad person?	**Never**			**Sometimes**			**Always**
	1	2	3	4	5	6	7
14b) How upset were you by this?	**Not Upset**			**Moderately Upset**			**Very Upset**
	1	2	3	4	5	6	7
15a) Did you feel emotionally isolated from your mother e.g. you didn't know what she expected from you or how she felt about you?	**Never**			**Sometimes**			**Always**
	1	2	3	4	5	6	7
15b) How upset were you by this?	**Not Upset**			**Moderately Upset**			**Very Upset**
	1	2	3	4	5	6	7
16a) Did you ever feel unloved by your mother?	**Never**			**Sometimes**			**Always**
	1	2	3	4	5	6	7
16b) How upset were you by this?	**Not Upset**			**Moderately Upset**			**Very Upset**
	1	2	3	4	5	6	7
17a) Was your mother overprotective of you?	**Never**			**Sometimes**			**Always**
	1	2	3	4	5	6	7
17b) How upset were you by this?	**Not Upset**			**Moderately Upset**			**Very Upset**
	1	2	3	4	5	6	7

18a) Were you ever made to feel that you were a burden to your mother?	**Never**			**Sometimes**			**Always**
	1	2	3	4	5	6	7
18b) How upset were you by this?	**Not Upset**			**Moderately Upset**			**Very Upset**
	1	2	3	4	5	6	7
19a) Did you ever feel unwanted by your mother?	**Never**			**Sometimes**			**Always**
	1	2	3	4	5	6	7
19b) How upset were you by this?	**Not Upset**			**Moderately Upset**			**Very Upset**
	1	2	3	4	5	6	7
20a) Were you ever emotionally rejected by your mother?	**Never**			**Sometimes**			**Always**
	1	2	3	4	5	6	7
20b) How upset were you by this?	**Not Upset**			**Moderately Upset**			**Very Upset**
	1	2	3	4	5	6	7

Appendix 1.7 PEA-Q (response to male caregiver)

Please could you circle the number (with reference to the scale below) that is appropriate to YOUR experiences up to and including 16 years old.

If you were not raised by your biological father, please could you state the relationship of the male caregiver you are referring to i.e. grandfather/uncle etc. ……

1a) Did your father ever get really angry with you when you thought there was no reason?	**Never**			**Sometimes**			**Always**
	1	2	3	4	5	6	7
1b) How upset were you by this?	**Not Upset**			**Moderately Upset**			**Very Upset**
	1	2	3	4	5	6	7
2a) Did your father ground you take away or your privileges?	**Never**			**Sometimes**			**Always**
	1	2	3	4	5	6	7
2b) How upset were you by this?	**Not Upset**			**Moderately Upset**			**Very Upset**
	1	2	3	4	5	6	7
3a) Did your father blame you for things you didn't do?	**Never**			**Sometimes**			**Always**
	1	2	3	4	5	6	7
3b) How upset were you by this?	**Not Upset**			**Moderately Upset**			**Very Upset**
	1	2	3	4	5	6	7
4a) Were you ever shouted/yelled/ screamed/cursed at by your father?	**Never**			**Sometimes**			**Always**
	1	2	3	4	5	6	7
4b) How upset were you by this?	**Not Upset**			**Moderately Upset**			**Very Upset**
	1	2	3	4	5	6	7
5a) Did your father try to make you feel dependent on him?	**Never**			**Sometimes**			**Always**
	1	2	3	4	5	6	7
5b) How upset were you by this?	**Not Upset**			**Moderately Upset**			**Very Upset**
	1	2	3	4	5	6	7
6a) Did your father show a lack of interest toward you?	**Never**			**Sometimes**			**Always**
	1	2	3	4	5	6	7
6b) How upset were you by this?	**Not Upset**			**Moderately Upset**			**Very Upset**
	1	2	3	4	5	6	7
7a) Did your father try to make you feel like you couldn't cope without her?	**Never**			**Sometimes**			**Always**
	1	2	3	4	5	6	7
7b) How upset were you by this?	**Not Upset**			**Moderately Upset**			**Very Upset**
	1	2	3	4	5	6	7
8a) Did your father try to prevent you from growing up?	**Never**			**Sometimes**			**Always**
	1	2	3	4	5	6	7
8b) How upset were you by this?	**Not Upset**			**Moderately Upset**			**Very Upset**
	1	2	3	4	5	6	7

9a) Did your father seem emotionally cold to you?	**Never**			**Sometimes**			**Always**
	1	2	3	4	5	6	7
9b) How upset were you by this?	**Not Upset**			**Moderately Upset**			**Very Upset**
	1	2	3	4	5	6	7
10a) Were you ever blamed for your father's wrongdoing?	**Never**			**Sometimes**			**Always**
	1	2	3	4	5	6	7
10b) How upset were you by this?	**Not Upset**			**Moderately Upset**			**Very Upset**
	1	2	3	4	5	6	7
11a) Did your father try to control everything you did?	**Never**			**Sometimes**			**Always**
	1	2	3	4	5	6	7
11b) How upset were you by this?	**Not Upset**			**Moderately Upset**			**Very Upset**
	1	2	3	4	5	6	7
12a) Did you feel uncomfortable with your father because you didn't know what to talk about?	**Never**			**Sometimes**			**Always**
	1	2	3	4	5	6	7
12b) How upset were you by this?	**Not Upset**			**Moderately Upset**			**Very Upset**
	1	2	3	4	5	6	7
13a) Did your mother make you feel like you were a bad person?	**Never**			**Sometimes**			**Always**
	1	2	3	4	5	6	7
13b) How upset were you by this?	**Not Upset**			**Moderately Upset**			**Very Upset**
	1	2	3	4	5	6	7
14a) Did you feel emotionally isolated from your father e.g. you didn't know what he expected from you or how he felt about you?	**Never**			**Sometimes**			**Always**
	1	2	3	4	5	6	7
14b) How upset were you by this?	**Not Upset**			**Moderately Upset**			**Very Upset**
	1	2	3	4	5	6	7
15a) Did you ever feel unloved by your father?	**Never**			**Sometimes**			**Always**
	1	2	3	4	5	6	7
15b) How upset were you by this?	**Not Upset**			**Moderately Upset**			**Very Upset**
	1	2	3	4	5	6	7
16a) Was your father overprotective of you?	**Never**			**Sometimes**			**Always**
	1	2	3	4	5	6	7
16b) How upset were you by this?	**Not Upset**			**Moderately Upset**			**Very Upset**
	1	2	3	4	5	6	7
17a) Did you ever feel unwanted by your mother?	**Never**			**Sometimes**			**Always**
	1	2	3	4	5	6	7
17b) How upset were you by this?	**Not Upset**			**Moderately Upset**			**Very Upset**
	1	2	3	4	5	6	7
18a) Were you ever emotionally rejected by your father?	**Never**			**Sometimes**			**Always**
	1	2	3	4	5	6	7
18b) How upset were you by this?	**Not Upset**			**Moderately Upset**			**Very Upset**
	1	2	3	4	5	6	7

Appendix 1.8 EDI

Please indicate below how often you think you agree with the following statements.

1 – always 2 – usually 3 – often 4 – sometimes 5 – rarely 6 – never

1) I eat sweets and carbohydrates without feeling nervous.	1	2	3	4	5	6
2) I think my stomach is too big.	1	2	3	4	5	6
3) I eat when I am upset.	1	2	3	4	5	6
4) I stuff myself with food.	1	2	3	4	5	6
5) I think about dieting.	1	2	3	4	5	6
6) I think my thighs are too large.	1	2	3	4	5	6
7) I feel ineffective as a person.	1	2	3	4	5	6
8) I feel extremely guilty after eating.	1	2	3	4	5	6
9) I think my stomach is just the right size.	1	2	3	4	5	6
10) I am terrified of gaining weight.	1	2	3	4	5	6
11) I feel alone in the world.	1	2	3	4	5	6
12) I feel satisfied with the shape of my body.	1	2	3	4	5	6
13) I feel generally in control of things in my life.	1	2	3	4	5	6
14) I wish I were someone else.	1	2	3	4	5	6
15) I exaggerate or magnify the importance of my weight.	1	2	3	4	5	6
16) I feel inadequate.	1	2	3	4	5	6
17) I have gone on eating binges where I have felt that I could not stop.	1	2	3	4	5	6
18) I like the shape of my buttocks.	1	2	3	4	5	6
19) I am preoccupied with the desire to be thinner.	1	2	3	4	5	6
20) I feel secure about myself.	1	2	3	4	5	6
21) I think about binging or overeating.	1	2	3	4	5	6
22) I have a low opinion of myself.	1	2	3	4	5	6
23) I feel that I can achieve my standards.	1	2	3	4	5	6
24) I think my hips are too big.	1	2	3	4	5	6

25) I eat moderately in front of others and stuff myself when they're gone.	1	2	3	4	5	6
26) If I gain a pound, I worry that I will keep gaining.	1	2	3	4	5	6
27) I feel I am a worthwhile person.	1	2	3	4	5	6
28) I have the thought of trying to vomit in order to lose weight.	1	2	3	4	5	6
29) I think my thighs are just the right size.	1	2	3	4	5	6
30) I feel empty inside emotionally.	1	2	3	4	5	6
31) I think my buttocks are too large.	1	2	3	4	5	6
32) I eat or drink in secrecy.	1	2	3	4	5	6
33) I think my hips are just the right size.	1	2	3	4	5	6

Appendix 1.9 SPAQ

The following questions (17 – 20) refer to unwanted sexual interactions between you and another person(s). They have been included in this booklet because the responses given here may relate to other responses. If you feel uncomfortable answering these questions please skip to page 5.

17) Has anyone ever touched you in a sexual manner and against your will?

Yes ☐ No ☐

If yes, how many times did it happen? .....

How old were you when it happened? .....

Who was it?

- Family member ☐
- Friend ☐
- Acquaintance ☐
- Stranger ☐

18) Has anyone ever forced you to touch him or her in a sexual manner against your will?

Yes ☐ No ☐

If yes, how many times did it happen? .....

How old were you when it happened? .....

Who was it?

- Family member ☐
- Friend ☐
- Acquaintance ☐
- Stranger ☐

19) Has anyone ever tried to force you to have sexual intercourse against your will?

Yes ☐ No ☐

If yes, how many times did it happen? .....

How old were you when it happened? .....

Who was it?

- Family member ☐
- Friend ☐
- Acquaintance ☐
- Stranger ☐

20) Have you ever had another unwanted or threatening sexual experience that is not named above? Yes ☐ No ☐

If yes, how many times did it happen? .....

How old were you when it happened? .....

Can you explain what was involved?.....

.....

.....

.....**Appendix**

1.10 Positive-Negative Perfectionism Scale

Please circle the appropriate number under the column that applies best to each of the following statements. Please ensure none are missed out.

5 – strongly agree	**4 – agree**	**3 – don't know**	**2 – disagree**	**1 – strongly disagree**
1) When I start something I feel anxious I might fail.	5	4	3	2	1
2) My family and friends are proud of me when I do really well.	5	4	3	2	1
3) I take pride in being meticulous when I do really well.	5	4	3	2	1
4) I set impossibly high standards for myself.	5	4	3	2	1
5) I try to avoid the disapproval of others at all costs.	5	4	3	2	1
6) I like the acclaim I get for an outstanding performance.	5	4	3	2	1
7) When I am doing things I cannot relax until it's perfect.	5	4	3	2	1
8) It feels as if my best is never good enough for other people.	5	4	3	2	1
9) Producing a perfect performance is a reward in its own right.	5	4	3	2	1
10) The problem of success is that I must work even harder to please others.	5	4	3	2	1
11) If I make a mistake I feel the whole thing is ruined.	5	4	3	2	1
12) I feel dissatisfied with myself unless I am working towards a higher standard all the time.	5	4	3	2	1
13) I know the kind of person I know or want to be, but feel I always fall short of this.	5	4	3	2	1
14) Other people respect me for my achievements.	5	4	3	2	1
15) As a child however well I did, it never seemed good enough to please my parents.	5	4	3	2	1

16) I think everyone loves a winner.	5	4	3	2	1
17) Other people expect nothing less than perfection from me.	5	4	3	2	1
18) When I am competing against others, I'm motivated by wanting to be the best.	5	4	3	2	1
19) I feel good when pushing out the limits.	5	4	3	2	1
20) When I achieve my goals I feel dissatisfied or disillusioned.	5	4	3	2	1
21) My high standards are admired by others.	5	4	3	2	1
22) If I fail people, I fear they will cease to respect or care for me.	5	4	3	2	1
23) I like to please other people by being successful.	5	4	3	2	1
24) I gain great approval from others by the quality of my accomplishments.	5	4	3	2	1
25) My successes spur me on to greater achievements.	5	4	3	2	1
26) I feel guilty or ashamed if I do less than perfect.	5	4	3	2	1
27) No matter how well I do I never feel satisfied with my performance.	5	4	3	2	1
28) I believe that rigorous practice makes for perfection.	5	4	3	2	1
29) I enjoy the glory gained by successes.	5	4	3	2	1
30) I gain deep satisfaction when I have perfected something.	5	4	3	2	1
31) I feel I have to be perfect to gain people's approval.	5	4	3	2	1
32) My parents encouraged me to excel.	5	4	3	2	1
33) I worry what people think if I make mistakes.	5	4	3	2	1
34) I get fulfilment from totally dedicating myself to a task.	5	4	3	2	1
35) I like it when other recognise that what I do requires great skill and effort to be perfect.	5	4	3	2	1

36) The better I do, the better I am expected to do by others.	5	4	3	2	1
37) I enjoy working towards greater levels of precision accuracy.	5	4	3	2	1
38) I would rather not start something than risk doing it less than perfectly.	5	4	3	2	1
39) When I do things I feel others will judge critically the standard of my work.	5	4	3	2	1
40) I like the challenge of setting very high standards for myself.	5	4	3	2	1