Achieving Success in Western Society:

Bulimia as the Ultimate Effort

By

Julia Magdalen Machara Carleton

Thesis submitted to the Faculty of the
Virginia Polytechnic Institute and State University
in partial fulfillment of
the requirements for the degree of

Master of Science

in

Sociology

Approved by

Carol A. Bailey, Chair

Cornelia Flora

Dale Wimberly

February 1994

ACHIEVING SUCCESS IN WESTERN SOCIETY:

BULIMIA AS THE ULTIMATE EFFORT

by

Julia Magdalen Machara Carleton

Committee Chair: Carol A. Bailey, Ph.D.

Sociology

ABSTRACT

Bulimia has recently emerged as an increasing threat to the health of young women in Western society. Though thought by some to be primarily prompted by psychological and physiological instabilities, this research attempts to explore the association between bulimic symptoms and the external pressures to conform to accepted standards of excessive thinness. It is noted that the bulimia trend primarily appears among the population which is overwhelmingly targeted by messages promoting the ideals of success through excessive beauty and thinness. Therefore, this study explores the relationships among several variables: the level of pressure felt by young, achievement-oriented women to control their weight in order to accomplish their goals; the level of difficulty experienced in achieving weight control; and the presence of

bulimic symptoms.

The sample for this study was taken from five undergraduate sociology courses at Virginia Polytechnic Institute and State University. The research found that among women who held career, social, and family relationships to be of high priority, the pressure to be thin in order to succeed in these areas, along with the difficulty experienced by the respondent in achieving weight loss, was positively associated with the appearance of bulimic attitudes and behaviors. Analysis of responses of males in the study did not produce significant findings with regard to the relationships between bulimic symptoms, the pressure to lose weight to achieve goals, and the difficulty in controlling one's weight.

This study concludes that the unrealistic expectations imposed on young women in Western culture regarding their bodily appearance, and the difficulty in adhering to these expectations, have a direct impact on the appearance of bulimia in young achievement-oriented women.

ACKNOWLEDGEMENTS

To Carol Bailey I owe tremendous thanks for her generous contribution of time, resources, and inspiration towards the completion of this work, and especially for her unflagging enthusiasm and confidence in my abilities. Her caring guidance (and demands!) have helped make this research into a work of which I can be very proud.

I am especially grateful for the patience and the advice of Neal Flora and Dale Wimberly, both of whose contributions and challenges have been indispensable to the completion of this work. I felt that my committee as a whole were extremely supportive and committed to helping my thesis be the best it could possibly be.

Last, but not least, this thesis is dedicated to my parents, Nicholas and Joan Machara, to my brothers and sisters, Mickey, Joe, Ruth, Marilyn, and Margaret, and to my husband Patrick Carleton, in eternal gratitude for all of their support and their encouragement. Thanks, y'all.

TABLE OF CONTENTS

LIST OF TABLES

ACHIEVING SUCCESS IN WESTERN SOCIETY: BULIMIA AS THE ULTIMATE EFFORT

STATEMENT OF THE PROBLEM

Until recently, the body of knowledge and research concerning bulimia has been predominantly psychological in spite of the fact that researchers have observed several social characteristics which appear to be common to most bulimics. Specifically, this disorder occurs most often in white females, beginning in adolescence or early adulthood. These women are usually college-bound or college-educated, from upper- or middle-class families (Fairburn & Cooper, 1982). In almost every case, the objective is to achieve a below-normal weight. Figures on bulimic behavior (using DSM III criteria) range from 3.9% to 19% of all college females (Halmi, Falk, & Schwartz, 1981; Katzman, Wolchik, & Braver, 1984; Pyle, Mitchell, Eckert, Halvorson, Neuman, and Goff, 1983). Despite their prevalence, social characteristics such as these have traditionally been given secondary importance in analysis of bulimia by psychologically-oriented explanations.

Feminist theorists have begun to examine bulimia as a problem which is indicative of social constraints which are part of the feminine experience in Western society. The purpose of this study is to contribute to this body of

research an examination of the social risk factors associated with the onset of bulimia, rather than the psychological or physiological factors. This work is guided by a socialist-feminist perspective. Specifically, this study will use a self-reported survey administered to 181 college students to explore the relationship between the degree of bulimic symptoms, the acceptance of thinness as a means to achieve personal goals, and the ongoing search for a successful method of weight-control. The importance of this research is that it attempts to assess the root cause of a woman's vulnerability to bulimia in the series of choices which she makes in assessing her capability to reconcile personal goals and societal expectations. Influenced by a belief system which is reinforced in a capitalistic patriarchy, women are taught that their appearance is a determining factor in the fulfillment of their personal and professional aspirations. Therefore, women are likely to be especially weight-conscious if they are ambitious about goals for which an attractive appearance provides an advantage. The importance of weight as a primary criterion for success is especially salient for young achievement-oriented women, which, not surprisingly, is the population which is at risk for eating disorders such as bulimia. The focus of this research is the relationship between one's necessity to conform to appearance standards

and the occurrence of bulimic behavior.

It is hoped that if we are able to identify the pattern of factors and decisions which are common to most young women with bulimia, we can facilitate the development of treatment and prevention programs with wider applicability and greater success.

THE LITERATURE REVIEW

Hypotheses on Bulimia

The following is a literature review of the trend of hypotheses dominating research concerning bulimia. Current literature predominantly flows from a psychological or physiological orientation.

An early hypothesis which emphasizes the interaction of physiological and psychological pathologies in the production of bulimic tendencies is proposed by Russell (1979). According to Russell, some psychological disorder causes certain women to reject their "healthy" weight in preference of a thinner ideal. Urges to eat cause emotional distress: dieting, vomiting, or other purge methods are utilized to cope with distress after eating. Reduced weight may then be the cause of various physiological disturbances including, essentially, hypothalamic disorders. Russell proposed that the hypothalamus responds to the suboptimal body-weight by triggering bouts of overeating, and may play a part in attitudes towards food before or during eating. Although Russell's model fails to identify the exact nature of these mechanisms and their effects, he does emphasize the self-perpetuating mechanisms involved in this disorder.

Hawkins and Clement (1984) have suggested that a cultural emphasis on thinness and weight-consciousness are

especially salient to females, the pressure to conform reaching its peak in late adolescence. They theorize that binge-eating results only as a result of certain "pathogenic predispositions" which are biological (such as "an elevated set-point for body-fat") or cognitive (such as a distorted body-image). The psychosocial pressure to conform, plus these "pathogenic predispositions" result in a certain personality type, that of someone who is bulimic, in which low self-esteem, "compulsive rigidity", preoccupation with food, fear of losing control, and depressive tendencies are integral.

Using this framework, Hawkins has suggested that the college life-style poses tension between dieting concerns and work orientation for the late-adolescent female. Events such as "daily hassles", romantic difficulties, or academic problems may cause an adolescent who already has deficiencies in problem-solving abilities or in cognitive appraisal of events to turn to binge-eating as a solace for her problems, a coping mechanism. At the core of Hawkins' hypothesis is the belief that those with bulimia hold irrational beliefs and thought processes, and need to develop alternative coping strategies in order to overcome the syndrome.

Similarly, Mizes (1983) has proposed that the familial environment may set the stage for bulimia by over-

emphasizing traditional female sex roles. This may lead a woman to develop excessive passivity, the need for someone else (a man) to take care of her, excessive need for approval, or high self expectations. These factors may lead to sex-role disturbance, body-image distortion, and be the cause of poor heterosexual relationships, self-dissatisfaction, and low self-esteem. These combinations can lead to perceived or actual failure and the reliance upon binge-eating as a coping mechanism, and upon purging or dieting as a means to achieve perfectionist standards.

To contrast Hawkins and Clement (1984) and Mizes (1983) who hypothesized that strained relationships and irrational methods of coping lead to bulimia, Wooley and Wooley (1981) propose a reverse relationship. Women with histories of weight difficulties, who are overweight or have problems with dieting, discover binging and purging as an "easy" way to address their struggles with weight. Bulimia, they suggest, is comparable to drug addiction and substance abuse, as the individual develops greater tolerance, indulges more frequently, allows other relationships to deteriorate for its sake, and sacrifices increasingly more time and money to support it. One of the few differences is that there is no subculture of "users"; instead, food abuse generally occurs in private. Though crediting a desire for thinness for the initiation of bulimia, this hypothesis

emphasizes mostly physical processes.

Boskind-Lodahl (1976), one of the first to develop a theory for bulimia, speculated that over-acceptance of the feminine ideal is causal in bulimia. The striving for thinness reflects perfectionist goals through which a bulimic person hopes to gain approval from others. This need for perfection is generalized to other areas of achievement, and the binge-purge behavior, which begins as a dieting mechanism, becomes a coping strategy for anxieties associated with sexuality, dating, and occupational or academic achievement.

A different view is presented by Rosen and Leitenberg (1982) and by Leitenberg, Gross, Peterson, and Rosen (1984). This model offers the perspective that bulimia is induced by a morbid fear of weight gain. Eating, produces rather than reduces anxiety, while purging is the relieving compulsion. If a woman fears weight-gain, she might not binge-eat if the ability to cleanse by purging was not viable. Thus, purging would seem to be the anxiety-reducing addiction.

Johnson and Larson (1982) agree with the idea that the purge, not the binge, is the key focus in understanding bulimia. However, they incorporate several themes of other hypotheses to explain the syndrome's emergence. They propose that some predisposing factor (i.e. familial or biochemical) may cause some people to select food as a

mechanism for stress reduction. However, since the pressure to conform to a thinness standard pervades the culture, these people use purging techniques to guard against the social stigma of being overweight. Eventually, unrestrained eating leads to a sense of losing control and begins to initiate its own emotional stress. Ultimately, the purging impulse replaces the binge-eating impulse as the primary tension-reducing mechanism, having reconciled the need to use food to stabilize anxieties and social norms concerning weight.

Critique of Current Hypotheses

Most of these theories acknowledge that feminine stereotypes are instrumental in the formation of bulimia. However, they seem to place feminine ideals-- specifically the ideal of thinness-- in the position of being merely a target for channelling previously held a maladaptive "tendencies" such as perfectionism, irrational coping strategies, or addiction to certain behavior. Johnson and Larson hypothesized that it was the need for food as a tension-reducer, Rosen and Leitenberg (1982) and Leitenberg, Gross, Peterson and Rosen the abnormal fear of gaining weight. In the hypothesis of Boskind-Lodahl (1976) it was perfectionism, in that of Wooley and Wooley (1981) it was physical vulnerability to addiction. To Mizes (1983) it was

low self-esteem or excessive dependence on a strong male figure. In Hawkins' and Clement's hypothesis (1984) the "tendency" was irrational beliefs and cognitive processes. And Russell (1979) credited some vague "psychological disorder" which somehow persuaded women to reject their "healthy weight" for the thin "ideal". In all of these hypotheses, a woman is assumed to have reached these strategies through physiological, psychological, or emotional deficiencies of her own, or of her singular upbringing.

It cannot be denied that each of these hypotheses enjoy some degree of empirical support for their assertions, mainly because bulimics do tend to score highly on tests designed to measure conformity to feminine ideals (Hatsukami et al., 1982), the need for approval and perfectionist standards (Katzman & Wolchik, 1984) and depressive tendencies (Fairburn & Cooper, 1982; Katzman & Wolchik, 1984; Johnson et al., 1982; Weiss & Ebert, 1983). In addition, the suggestion that bulimics have a poor body image and that dieting is a high priority was also found to have empirical support (Katzman & Wolchik, 1984; Weiss & Ebert, 1983).

It may be hypothesized, however, that those characteristics-- overidentification with feminine stereotypes, insecurity, perfectionism, depression, and poor

body image-- could emerge as a consequence of the relationship between some women and their social environment. For these women, bulimia could be the logical reaction to their social constraints, and the related personality characteristics could be additional effects of a common cause. Examination of social context is therefore crucial in understanding bulimia.

Social Research on Bulimia

Though most of the literature on this subject gives only token acknowledgement to social factors and their consequences, a small yet significant amount of sociological research has addressed the subject of eating disorders in association with gender-related cultural values. Most contain some assertion linking the ideology of a society and the emergence of eating disorders.

Szekely's work (1987), for example, found support that the development of bulimic behavior begins in response to social influences. The use of extreme forms of weight-control is seen as an appropriate response to societal demands concerning weight. Though a percentage of women may become pathologically bulimic, the less severe forms of the syndrome are merely regarded as maintaining perseverance towards an accepted goal.

A study by Hesse-Bilier (1991) shows not only that

these behavior patterns are much more common in women than in men, but also that the majority of these women exhibit few if any of the psychological traits which have been commonly associated with other eating disorders. This suggests sociocultural factors are the major influence in the emergence of bulimic behaviors.

Nasser and Meriat's 1988 study likewise examines the relationship between sociocultural factors and eating disorders. They found that these syndromes are first described in Western cultures and are reported as being particularly rare or absent in other cultures. They hypothesize that the increase in frequency of these disorders over the past two decades are probably due to the emergence of cultural norms which increasingly equate feminine beauty with thinness. Furthermore, they note that the adoption of Western cultural values by other societies have been associated with the increasing occurrence of similar syndromes.

Another Hesse-Bilier study (1991) addressed the difference between a socially prescribed body image and a medically prescribed body image. Women who subscribed to socially imposed appearance criterion were three times more likely to score highly on eating-disorder tests than women who were more conscious about a medical definition of fitness. This work emphasizes the fact that, for women,

popular conceptions of fitness evolve from social values which do not necessarily consider what is best for the human body, and that women do respond to these social values when making decisions about their body.

Studies have also shown that how a woman perceives her appearance is likely to affect her opinion about her other traits. According to Hesse-Bilier,Clayton-Matthews and Downey (1987) women who ranked their own appearance as favorable were likely to self-rank their academic ability, social traits, and psychological traits as favorable also. In addition, this influence of body image over perception of other traits was significantly greater in women than in men.

This research hopes to add to the current literature an understanding of the specific reasons for some women's extreme response to social evaluations of their appearance. In a patriarchal, capitalistic society, these evaluations have a concrete effect on the achievement of women's goals. Given the structural obstacles to a woman's success, high incidence of bulimia should not be surprising in cases where appearance is judged as a vital contributor to achievement of a particular goal.

The adoption of bulimic methods to control one's weight may then be a logical (if not knowledgeable) choice for those for whom weight control is critical. Presumably, the purpose of the purge would be the prevention of weight-gain

from eating. What about the "binge"? As was pointed out in the work of Rosen and Leitenberg (1982), for many individuals the binge may never actually occur if the purge did not provide assurance that food consumption will not necessarily result in weight gain. The binge may simply be an exercise of self-indulgence allowed by the subsequent purge, perhaps in a social circumstance where self-indulgent freedoms are perceived to be rare. Therefore, perhaps for some women bulimia has been purposely selected for the purpose of weight reduction or stabilization without forgoing pleasure of eating.

The Emotional Significance of Eating Behavior

At the essence of bulimia exists two principal drives; the excessive consumption of food; and it's forced expulsion from the body, undigested, in order to prevent weight-gain. Upon examination, the existence of these two drives should not be very surprising. The subject of food and all it involves presents a dilemma to women in Western society.

To begin with, food is a natural craving to all human beings. Food is not only a necessity for life and health, but a source of sensual pleasure, immediately gratifying. Good food not only staves hunger but is pleasant to taste, and the enjoyment and preparation of good food has become a gourmet art. Furthermore, food is a major symbol of reward

and love. Not only have birthday cakes and holiday dinners become institutions for celebration, but the preparation and offering of food represent the offering of love and affection. This is witnessed by such traditional examples as the stereotypical grandmother urging large dinner helpings, girlfriends baking for their boyfriends, and romantic dinners as the perfect setting for a date. Noticeably, it is especially for women that food seems to play such an important part in the symbols of giving and acceptance.

However, in the midst of this is a clear message for women, indicating, ironically, that food is not theirs to enjoy. From the time that young girls begin emulating their mothers, television stars, movie stars, and models, they learn that women must curb their enthusiasm for food. The rituals of dieting and weighing and measuring themselves with a critical eye very often becomes an initiation process from girlhood to womanhood. Instead of being free to enjoy the pleasures of good food, women feel that food is taboo. This is exemplified by women who are uncomfortable eating in the presence of others or who are secretive about their cravings for "junk food."

Because of its associations of comfort and love, food is used to some degree by all human beings, for both emotional and physical sustenance. However, women who

indulge their appetites can face serious social consequences if they gain weight. Therefore, the prevention of weight-gain can be critical. Women are placed in a situation wherein they can only satisfy the natural, human want of food by discovering a way to stabilize their weight. For some, bulimia seems a way to have both.

The Costs of Bulimia

To imagine a setting where bulimia is conceivably "normal", one must imagine that the particular goal (weight control) is made either difficult or unattainable using standard means.

Clearly, not everyone is physically capable of achieving a slender build by simply adhering to formulas which are taken for granted by most of us-- reasonable diet and exercise. There exists evidence that both obese and nonobese people have a natural set point that determines their weight regardless of what they eat (Nisbett, 1972) and that periodic dieting results in increased weight in the long run, as the body reacts naturally to deprivation by lowering the metabolism and storing fat (Herman & Mack, 1975; Herman & Polivy, 1975; O'Neil et al., 1981; Ruderman & Christensen, 1983). Consequently many obese people speak the truth when they remark that they do not eat excessively (Rothblum, 1990). Those who encounter difficulties in

slimming, yet still strive for a thin body, must discover an alternative to conventional methods if they are to reach their goal. For some, bulimia may seem to be a viable alternative weight reduction method. However, women who choose this venue may not be knowledgeable about bulimia's costs.

There can be no doubt that bulimia has several highly undesirable outcomes. These negative consequences include effects which range in destructive capacities from discomfort or disfigurement to death.

One mechanism often utilized by the bulimic person, the overuse of laxatives, often leads to constipation. She may mistakenly take this as a signal that she needs to use more laxatives, which then only further disturbs her digestive system (Sacker & Zimmer, 1987). Likewise, the abuse of diuretics, another often-used technique, causes dehydration. This may cause the consumption of excessive fluids, water-weight gain, and perhaps further abuse of diuretics to counteract the gain (Sacker & Zimmer, 1987).

Self-induced vomiting, a common tactic of those with bulimia, produces its own hazards. One of its first casualties is the bulimic's teeth (Sacker & Zimmer, 1987). Repeatedly regurgitated stomach acid erodes tooth enamel and causes advanced tooth decay and gum disease (House, Grisius, & Bliziotes, 1981). Stomach acid and the pressure occurring

in a forced purge can also cause severe inflammation of the esophagus, even to the point of the esophagus's rupture. This extremely serious condition requires extensive surgery, and is potentially fatal (Sacker & Zimmer, 1987).

Another hazard of bulimia is the intense emotional stress which accompanies it. Bulimia can in a very literal way be a manifestation of a war which a person wages with the natural processes of her own body, war with the urges to eat, and war with naturally occurring weight-gain to which her body may be predisposed. The frame of mind which one must adopt to accommodate the binge-purge ritual can be extremely anxiety-provoking. Furthermore, since bulimia is a source of shame and guilt for the majority of bulimics (Katzman & Wolchik, 1983; Leon et al., 1985; Mizes, 1983; Pyle et al., 1981; and Russell, 1979), efforts made to hide the behavior and fear of being caught also produces extreme anxiety. This stress takes its toll both on the body in the form of ulcers (Sacker & Zimmer, 1987), and on the spirit as it burdens social relationships (Wooley & Wooley, 1981).

Various other undesirable physical consequences include hair breakage and amenorrhea (Johnson et al., 1982; Pyle et al., 1981), fatigue (Abraham and Beaumont, 1982; Johnson et al., 1982), urinary tract infection (Russell, 1979), and parotid gland swelling (Levin, Falko, Dixon, and Gallup, 1980). The heart also suffers as a result of bulimic

behavior. Binging and purging can cause a serious electrolyte imbalance which can trigger irregular heartbeat (cardiac arrhythmia) and low blood pressure. These heart problems are dangerous enough to cause death (Sacker & Zimmer, 1987).

Admittedly, then, bulimic behavior has some serious repercussions, and its effects are not to be taken lightly. For a rational person to take these kinds of risks with her health, it is logical to assume that she is either not entirely aware of the risks, or that her ultimate goal is extremely important to her and she sees no alternative venue to goal attainment. In order to understand why any person would take those risks it is important to understand the social mechanisms which lead to the placement of an inflated emphasis on a woman's body image.

THEORY

Feminist Theory

Feminist thought consists of a wide range of diverse theoretical perspectives which try to address women's social inequality. Facets of feminism from liberal to Marxist, radical, existentialist, psychoanalytical, and post-modern feminism all contain different explanations and recommendations for the female experience. A basic premise to which all feminist theorists agree is that gender structures every aspect of everyday life (Tong, 1989). Experts know that bulimia primarily affects young women who occupy social positions with potential for upward mobility. Though bulimia may be seen by some researchers as a maladaptive, idiosyncratic behavior which coincidentally occurs in persons of a certain sex and social class, feminists see a relationship between mechanisms for gaining acceptability and the structures (sex and class) that determine power distribution. Socialist feminism concerns itself with both the consequences of patriarchy and social class for women. Because bulimia appears to involve a connection between a woman's body image and her prospects for power and esteem in a capitalist society, socialist feminism may be most useful in the understanding of bulimia.

Socialist Feminism

Through the examination of gender relations from a socialist feminist perspective, a hypothesis explaining the perseverance of bulimic behavior can emerge. The socialist feminist theoretical view maintains that in a capitalist patriarchy, women are placed at an economic and social disadvantage. Because of this disadvantage and the ideology perpetuating it, women are more likely to sacrifice personal and sexual resources in order to attain the degree of success which most men enjoy without that personal sacrifice (Tong, 1989).

Socialist feminism draws from Marxist feminism its analysis of capitalism and its effect on the social position of women. Capitalism is the economic structure in which an exchange value is placed on all commodities, and a person is rewarded to the extent that his or her endeavors net a value, or capital, on the market. Under capitalism, a person has little chance for survival without market rewards. In Western industrialized societies, women have traditionally been bound to labor sectors which produce little or no capital compensation, and this has deeply affected their societies' conceptions regarding women's worth comparable to men. Marxist theory has pointed out that capitalism is a brutal system in which those without power sacrifice control over their talents, desires, and

identity in exchange for survival (Tong, 1989).

Radical feminism has contributed to socialist feminism its inquiry of a patriarchal ordering of society and it's consequences for women. Patriarchy is the form of power distribution in which men have maintained control over economic and social institutions of all or nearly all societies in the world, both past and present. Radical theory illuminates the fact that control over women's sexuality and body image are particularly effective and insidious ways of reinforcing a patriarchal ordering of society (Tong, 1989).

Socialist Feminism considers the effects of patriarchy and capitalism in conjunction with each other and finds that these systems are mutually reinforcing, and together provide a particularly effective vehicle for the oppression of women. It is this oppression and its ideology, argue Socialist feminists, which instigate and reinforce bulimic behavior in women.

Women's Place in Patriarchal Capitalism

One way that capitalism and patriarchy combine to promote the oppression of women is by designating women as a marginal and exploitable labor force (Young et al., 1981). A capitalistic mode of production makes use of a secondary labor force to reconcile market fluctuations and the need

for a stable labor pool. Because a patriarchal ideology trivializes women, it has justified the use women as a labor force which can be paid lower wages, hired and discharged with minimal political consequence, and whose careers can be left to stagnate in undesirable, lower echelon jobs. Though these circumstances may be changing, it cannot be denied that women experience an economic and professional disadvantage to men in Western society.

One direct result of this is that women's sexuality is reduced to a commodity. Because of their inferior economic and social status, women must submit to more demands in the workplace than their typical male counterpart, including more stringent appearance expectations. Women are penalized or rewarded in the areas of hiring, salary, and promotion depending on their level of physical attractiveness. Consequently, women in a professional setting must mold their outward appearance in order to get a favorable reaction in the workplace (Spitzack, 1990). Their place in the hierarchy depends as much on their acceptance of dominant values and norms as it does their abilities.

Because a woman's appearance is transformed from a personal expression into a tool used to facilitate her personal and professional success, it becomes the focal point of her relations with men. Many men initially relate to a woman on a superficial level according to her

appearance, while her other attributes are overshadowed. While men are assumed to succeed because of intelligence, perseverance, and ability, women are expected to rely on their looks, sex, and feminine manipulation. Therefore, because women are overwhelmingly judged and rewarded on the basis of their appearance, they are much more acutely aware of their adherence to current standards of attractiveness.

Under a capitalist system, there is great profit to be made from the perpetration of cultural values of excessive beauty and thinness for women. Ideology equating a woman's worth to her beauty provides the foundation for industries which can sell acceptance and esteem to women. Fashion, cosmetic, and diet industries generate billions of dollars annually by marketing a woman's appearance (Spitzack, 1990). Under capitalism, the female body is a commodity which requires the purchase of other products to maintain or improve its value. It is necessarily in the interest of these industries to further this ideology in which a patriarchy defines feminine imagery.

Another way that a capitalistic patriarchy reinforces the devaluation of women is in its stereotypical beliefs about the nature of men and women. The ideology which subordinates women to men requires some justification, and stereotypes serve this purpose. This is accomplished by exaggerating the differences between what is "naturally

male" and what is "naturally female" (Millett, 1970). Since a patriarchy naturally favors men with flattering stereotypes, they seem to be endowed with the qualities necessary to assume powerful positions, such as strength, confidence, and intellectual ability. Feminine stereotypes disregard a woman's capacity for these virtues by emphasizing only her ability to assume peripheral roles in society. Patriarchy teaches that men have superior ability, intellect, strengths, courage, and endurance, while stereotypes indicate that "maternal instinct", "feminine wiles", and sexual provocativeness are the only empowering traits of women, no matter what other strengths they are able to display. Women who do assert themselves forcefully and confidently without pandering to critiques of their appearance are faulted or penalized for being unwomanly.

Because of the ideology which encourages these stereotypes, men are defined as "doers" and "observers", while women are defined as "objects" to be observed (Henley, 1977). Women are therefore trained to like themselves when their appearance is pleasing to others. A beautiful appearance for women is equated with both a healthy body and a healthy attitude.

Men and women are educated in this ideology in different ways and in varying degrees from their infancy to adulthood. They learn stereotypes and values from the role

models they emulate, the books and other media to which they are exposed, the ambitions for which they are socialized, and the requirements and expectations which are imposed on them. In turn, they pass on this indoctrination to others. This socialization is a necessary component of the capitalist patriarchal social structure, because it serves to validate and perpetuate the hierarchy.

Although everyone living in a capitalist patriarchy is affected to some degree by its perpetuating ideology, the consequences of this doctrine are more salient to some than to others. This research does not attempt to address all the factors which cause discrepancies in the way some women respond to this ideology. However, this study hopes to highlight the fact that a woman in Western society is evaluated to some degree on the basis of her appearance, and that consequently, for some women, conformity to appearance is essential to the realization of personal goals. In such cases, ambitious women may go to extensive lengths to reconcile their body image to the ideals of their society.

Being Thin In Western Culture

In the twentieth century, Western culture has increasingly placed an emphasis on thinness as a standard of attractiveness for women. Studies have confirmed that this ideal is pervasive throughout society, glorified by mass media, and for the most part taken for granted by the public. Although women seem more preoccupied with all aspects of appearance (except height) than men are (Jackson et al., 1987), thinness has especially become a prerequisite of feminine acceptability.

One study by Garner et al. (1980) revealed that Miss America beauty pageant contestants have averaged 10 to 15% below normal weight for their height. Another study by Silverstein et al. (1986) found that a majority (69.1%) of U.S. female television characters are thin, as compared to 17.5% of male characters. What is revealing about these studies is that both of them focus on groups of women who serve as role models for other young women in Western society, both in terms of attractiveness and achievement. It would seem that the common demand on female role-models, no matter what their other attributes and talents, is that they must be thin.

Silverstein's study also examined women's and men's magazines, finding overwhelmingly that women's magazines were concerned with the subjects of diets, body images, and

food, promoting the message that women must stay in shape and be slim while at the same time attending to the domain of food and cooking. Not surprisingly, research by Franzoi and Herzog (1987) confirms that, in the eyes of both men and women, the chief concern affecting the attractiveness of a woman is her weight. To anyone familiar with current trends in fashion and fitness, it is apparent that the public is bombarded with a notion that equates thinness with a woman's desirability.

Furthermore, women pay a high price for departing from their socially-prescribed weight. Large women are stigmatized by slurs on their desirability, their sexuality, their self-control, and their sanity. In fact, practically all aspects of life are made difficult for a large woman.

In the arena of fashion for instance, "overweight" women have great difficulty finding flattering clothes which fit, simply because few designers cater to their particular clothing needs (Brubach, 1987). Interviews with clothing designers and the proprietors of clothing outlets indicate the assumption that a woman cannot-- and does not deserve to-- be stylish and fashionable unless she takes that first step herself of conforming her own figure to prevailing ideals. This assumption is witnessed in condescending salespeople, scarcity of large-size clothing, and the "rules" of large-size dressing which emphasize the need to

conceal "figure-flaws". True, specialty stores are now beginning to undertake the outfitting of heavier women, but women must be willing and able to pay specialty prices.

Women who are labeled obese also bear a sexual stigma. Society reacts with distaste at the idea of an overweight women with a normal, healthy sex-drive. People commonly hold one of two opinions on the subject: that an overweight woman must be "easy" or oversexed, supposedly because they are desperate and grateful for any sexual attention, or entirely de-sexed altogether, with the assumption that an overweight woman is too unattractive and vulgar to be sexually alluring or responsive to anyone (Millman, 1980). Furthermore, men who are attracted to fleshy women are seen as having a perverted fetish, a fetish of which some of these men feel ashamed and compelled to hide (Goode and Preissler, 1983). Clearly widespread assumptions deny that an overweight woman is a normal human being with "normal" human sexuality.

People in this thin-conscious culture almost automatically assume that being overweight is a matter of laziness and lack of self-control, associating fat with lethargy and docility (Brubach, 1987). Overweight women encounter numerous accounts of such prejudice, experiencing lack of respect, blatant inquiries about their personal lives, and treatment as though they are undeserving of

common courtesy (Brown, 1990). Therefore, one looks down on heavy women because it is taken for granted that (#1) everyone should be striving to attain the "perfect body" and (#2) those who don't have it are too lazy and self-indulgent to get it. Those for whom "staying fit" is a matter of a minimal exercise each day and a normal diet have a hard time comprehending that not everyone has the physical capability to ever have a slender body.

An overweight woman's mental and emotional stability, even her sanity, is called into question by both physicians and lay people alike. Admittedly, overeating can be both a cause for obesity and a symptom for emotional disturbances, but this scenario is far too often over-generalized. Many "overweight" people are actually of <u>normal</u> weight for their body chemistry, genetics, or metabolism, and a significant weight loss results only from an extremely strict diet and exercise regimen. The medical vote is still out, but it may actually be highly unhealthy for these people to drastically lower their body weight (Chernin, 1981). Those who attempt weight-loss in good faith through repeated dieting rarely achieve long-term health or appearance benefits. Known as weight-cycling, this causes lower metabolism and a bodily storage of fat, which hinders future attempts at weight-loss (Blackburn et al., 1989). Nevertheless, various hypotheses assert that overweight people are in fact afflicted by

sexual repression, misguided mothering, weakness of character, low self-esteem, and the need to protect oneself through a "wall of fat". These hypotheses might apply to someone who is morbidly obese, but they are increasingly applied in a misguided way to people who are only a bit heavy by current aesthetic standards.

Men too are often conscious about being overweight, but they are not stigmatized as women are, and it does not seem to have the bearing on their lives as it does for women (Millman, 1980). A series of interviews by Millman revealed that for men bigness seemed to be associated with power if it played a part in their self-concept. However, most of the men interviewed claimed that being overweight was not something that really concerned them or affected the way they felt about themselves. If anyone commented on their weight, most men were able either to respond with humor or an apt come-back, which conveyed the fact that they refused to become defensive about their weight. Men who were weight-conscious seemed to only be so for health purposes, and a man could get away with being far more overweight than a woman could before people even noticed or made comments. Clearly, even though Western society seems very thinness-oriented and weight-conscious, the anti-fat crusade is directed more pointedly to, and is felt much more deeply by women.

Therefore, given the importance placed on a woman's appearance in Western society, it should not be surprising that the quest to become thin is a priority in many young women's lives. There may be some women who feel that the strength of their other attributes (i.e. extraordinary competence on the job, outstanding social skills) compensate for the fact that they may be heavy by social standards. However, most have been socialized since childhood that their quality of life can be enhanced or undermined by their body shape. In fact girls as early as elementary school seem to obsessively fear obesity, fearing it far more than any other affliction or handicap (Lifshitz, 1989).

Conforming to this standard of acceptability is often perceived as the key to a woman's success, and becoming overweight is often feared as a fatal obstacle to reaching her goals, whether they be social (i.e. finding a husband, being accepted in social circles) or professional (i.e. making it as a model or athlete, being taken seriously in the boardroom). Even occupations which do not require a glamorous appearance, athletic ability, or projections of power, such as food server or flight attendant, may be jeopardized by weighing above the accepted standard (Millman, 1980). It is for this reason that most women in today's society are somewhat weight-conscious, and that many women are obsessed with a dissatisfaction with their bodies.

Bulimia As a Method of Weight Loss

For a majority of women who feel that weight-loss is absolutely critical to their personal definition of success, some reach a degree of satisfaction through "normal" methods: a diet plan, use of products for appetite-control, an exercise regimen, attendance of a self-help group such as Weight Watcher's, submitting to the care of a physician, etc.. Still, some women become discouraged after trying these conventional methods because of the difficulty or delay in reaching their desired weight, which may be abnormal for their build, genetics, metabolism, or whatever it is about their make-up which determine's the individual's "normal weight". Women who encounter difficulties such as these are forced either to live with their body size or resort to more drastic measures of weight-reduction. These women who, for the above-mentioned reasons, consider weight-loss to be of highest priority may consider the next step to be adoption of a drastic means of weight-control such as bulimic methods.

This study attempts to discover if in fact bulimia does occur routinely among ambitious women who seem to choose this method of weight control under predictable conditions, rather than by physical or psychological compulsion.

STATEMENT OF HYPOTHESIS

The hypothesis which explains the common occurrence of bulimia among young, goal-oriented women involves several factors.

The first condition is the requirement that the individual conform to an appearance standard of thinness in order to attain her goals. As discussed in the Theory section, under "Being Thin in Western Culture," this requirement is imposed by a society in which appearance is a principle criterion by which women are judged in all aspects of their lives, including occupational, social, and sexual. In a patriarchal, capitalist society which espouses a cultural value of thinness, the social pressure to conform is especially salient to young women with aspirations for a bright future, whether social, professional, or romantic. If these goals are important to the individual and are coupled with the criterion of a beautiful appearance, the individual is more likely to become attentive to maintaining a slim body in accordance with appearance standards.

The second condition which influences the manifestation of bulimic behavior is the degree of difficulty experienced by the individual in attempts to control her weight. An individual for whom the necessity exists to remain slim in order to achieve important goals has no need to adopt binge-

purge methods of weight loss if weight control poses no real dilemma to her, for example, one who finds weight control to be fairly easy or a matter of following a simple reducing routine. However, as weight-loss becomes increasingly difficult, it is expected that the individual would try increasingly drastic methods of weight loss until she finds a successful method.

These factors are the critical elements to the analysis of the commonalty of bulimic behavior found in young, goal-oriented women. This study will compare the frequency and intensity of bulimic behavior with the association of the factors hypothesized to be germane to the prevalence of bulimia among college women. Bulimic behavior which is addressed in this study consists of a range of behavior associated with bulimia, including both actions and attitudes associated with eating and body image.

Therefore, in a sample from a college population, the incidence of bulimic behaviors and attitudes are expected to increase as the respondent's priorities require her to be thin, provided that the respondent finds weight loss to be a challenge. The conditions to be tested in this study as motivating bulimia among college students are set forth in the following hypothesis: The occurrence of bulimic behavior is more likely when all of the following conditions are present:

1) The individual feels pressure to conform to accepted standards of attractiveness, specifically thinness, in order to achieve success in relationships which are deemed to be a priority by the individual.

2) The individual has difficulty controlling her weight using conventional methods of weight-loss.

As any of these conditions intensify, it is predicted that the incidence of bulimic behavior will also increase.

METHOD

Survey Distribution

In order to test the hypothesis derived in the Statement of the Hypothesis section, a questionnaire has been devised and distributed to 181 college students at Virginia Polytechnic Institute and State University. The students were enrolled in one of 5 sociology classes which were selected for participation. Such a sample is appropriate to this research because the bulimia is prevalent among the female college student population. The sample consisted of both males and females, in order to provide an opportunity for analysis of gender as a possibly significant factor in the adoption of bulimic behavior patterns.

This sampling procedure is not random and thus will have all the problems associated with that. However, previous studies have shown that when random sampling techniques have been used on topics such as this, a low response rate is received and only those who are interested in the topic return the questionnaire, thus affecting the results. In-classroom administrations have been shown to have high response rates and therefore may produce a more accurate distribution of results. Classrooms were selected for distribution by soliciting assistance from instructors

in the Sociology department of Virginia Polytechnic Institute and State University.

Admittedly, 181 is a lower sample size than would be optimum. Unfortunately, conducting the survey at a busy time of the academic semester greatly limited the classes available for inclusion in the study. However, the results of this research can still be instrumental in helping to define some of the sources of bulimic behavior, and to perhaps aid the direction of future research.

Operationalization of Variables

The ATTITUDES AND LIFESTYLES SURVEY used in this study was created especially to address the variables outlined in the Statement of the Hypothesis. The variables for the study are operationalized as follows.

Independent Variables

The first independent variable measures the social pressure exerted on the individual to conform to weight standards in order to succeed at certain goals, given that those goals are a priority. There are two steps in providing a measure for this variable.

In the first step, the respondent is questioned about the repercussions to her career, social, romantic, and family relationships which would ensue were she to become overweight. A high score in each of these variables means

that the respondent feels that weight is a critical factor in the accomplishment of those goals, while a low score denotes that weight matters little or not at all. The following question analysis is used to determine a measure of weight relevance.

RELEVANCE OF WEIGHT FOR CAREER GOALS

This variable is an additive scale consisting of the sum of Questions 2 and 3 (reverse coded) and Question 4.

RELEVANCE OF WEIGHT FOR ROMANTIC GOALS

This variable is an additive scale consisting of the sum of Question 6 (reverse coded), and Questions 7 and 8.

RELEVANCE OF WEIGHT FOR SOCIAL GOALS

This variable is an additive scale consisting of the sum of Question 12 (reverse coded), and Questions 15 and 16.

RELEVANCE OF WEIGHT FOR FAMILIAL GOALS

This variable is an additive scale consisting of the sum of Question 19 (reverse coded) and Questions 20 and 21.

The second step in measuring this independent variable is to determine the importance of career, romantic, social, and familial relationships to the individual, and to categorize the respondents accordingly. This is necessary for the purposes of this study because the hypothesis states that the pressure to be thin with regards to these matters should not lead to bulimia if they are not considered a priority to the individual. To measure this, scales have

been created to establish how the individual prioritizes these aspects in her life.

IMPORTANCE OF CAREER TO INDIVIDUAL

This variable consists of Question 5, which is a scale in which the respondent is asked to rate from 1 to 10 the importance of his or her having a successful career. Respondents who scored career goals between 8 and 10 inclusively were categorized as considering career to be of high importance. Those who scored career goals from 4 to 8 were categorized as considering career goals to be of medium importance. Those who scored career goals under four were categorized as considering career to be of low importance.

IMPORTANCE OF ROMANTIC RELATIONSHIPS TO INDIVIDUAL

This variable consists of Question 9, which is a scale in which the respondent is asked to rate from 1 to 10 the importance of their having a fulfilling romantic relationship. Respondents who scored romantic goals between 8 and 10 inclusively were categorized as considering romantic goals to be of high importance. Those who scored romantic goals from 4 to 8 were categorized as considering romantic goals to be of medium importance. Those who scored romantic goals under four were categorized as considering romantic goals to be of low importance.

IMPORTANCE OF FRIEND RELATIONSHIPS TO INDIVIDUAL

This variable consists of Question 13, which is a scale

in which the respondent is asked to rate from 1 to 10 the importance of their having fulfilling friendships at this time. Respondents who scored friendship goals between 8 and 10 inclusively were categorized as considering social goals to be of high importance. Those who scored friendship goals from 4 to 8 were categorized as considering social goals to be of medium importance. Those who scored friendship goals under four were categorized as considering social goals to be of low importance.

IMPORTANCE OF FAMILY RELATIONSHIPS TO INDIVIDUAL

This variable consists of Question 17, which is a scale in which the respondent is asked to rate from 1 to 10 the importance of harmony in their family relationships. Respondents who scored family goals between 8 and 10 inclusively were categorized as considering familial goals to be of high importance. Those who scored family goals from 4 to 8 were categorized as considering familial goals to be of medium importance. Those who scored family goals under four were categorized as considering familial goals to be of low importance.

The second independent variable addresses the difficulty with which the respondent controls her weight. This is relevant because, as hypothesized, the first independent variable would not explain bulimia unless losing

weight posed a problem to the individual. In order to analyze this variable, questions are included to determine if the respondent has tried any of five common methods of weight loss. Questions are also included in which the respondent is asked to report the effectiveness of these methods in their attempt to lose weight. This variable is operationalized as follows:

WEIGHT LOSS METHODS ATTEMPTED BY THE INDIVIDUAL

This variable is an additive scale consisting of the sum of Questions 23, 25, 27, 29, and 31. This scale has been reverse-coded, with a lower score denoting fewer methods tried, a higher score denoting more methods tried.

EFFECTIVENESS OF WEIGHT LOSS METHODS ATTEMPTED

This variable is a scale which is determined by analyzing the answers to questions 24, 26, 28, 30, and 32. In these questions, respondents are asked to rate on a scale of 1 to 10 the effectiveness of the weight loss methods attempted. Those who rate effectiveness low for methods tried have a low score. Those who rate effectiveness fair for methods tried, or low for some but medium to high for others have a medium score. Those who rate effectiveness high for weight-loss methods tried receive a high score. (See Appendix C for a more complete explanation of the calculation of the effectiveness score.)

Dependent Variable

The dependent variable measures the occurrence of bulimic symptoms as reported by the respondent. This variable will be analyzed using the Bulimia Test (known as BULIT), a published test for detecting bulimia (Smith and Thelen, 1984). BULIT consists of a 36 item forced-choice self-report questionnaire in which item responses are scored and summed. The cut-off score which indicates a possibility of bulimia is 102. The BULIT questionnaire was chosen to measure the dependent variable in this study because it provides an additive scale for determining bulimic symptoms, and because it has already undergone thorough testing for reliability and validity. The BULIT scale for bulimia has been incorporated in its entirety into the ATTITUDES AND LIFESTYLES SURVEY, numbering questions 33 through 68. These questions will be scored and summed according to the guidelines of BULIT survey. While a score of 102 indicates a strong possibility for clinical bulimia, this study will analyze the scores as on a continuum, and consider that as the BULIT score for the respondent increases, the occurrence of bulimic attitudes and behaviors also increases.

Control Variables

Descriptive and control variables are included as follows:

Gender: Question 69.

Ethnic origin: Question 71.

Age in years: Question 72.

Height in feet and inches: Question 73.

Weight in pounds: Question 74.

Some questions included in the questionnaire were not ultimately utilized in data analysis. This is because they were judged to provide information which was not necessary to test the hypothesis, although they were originally included to facilitate hypothesis testing. Questions included in the survey but not used in analysis were items numbered 1, 10, 11, 14, 18, 22, and 70.

DATA ANALYSIS

Descriptive Statistics

The sample consisted of 111 women and 59 men, with 11 respondents who declined to reveal their gender. The ethnicity distribution for the sample consisted of 8 Asian, 10 African American, 2 Hispanic, 1 Filipino and 160 White students.

In Table 1 are the means and differences and similarities of the means by gender for the variables used in this analysis and for age, height, and weight. (See Table 1.)

Note: In Table 1, as in all the tables included in the Data Analysis section, the scores denoting the importance of weight to career, romance, friendship, and family relationships are shown only for those respondents for whom these relationships were of high priority. This is because the hypothesis outlined for this research only applies to those for whom those relationships were of high priority. Data pertaining to respondents who rated career, romance, social, and family relationships to be of medium or low importance are shown in Appendix C.

TABLE 1: UNIVARIATE STATISTICS

Variable	Overall	(n)	Men	(n)	Women	(n)	Dif.
AGE	19.91	(181)	20.21	(59)	19.77	(111)	*
HEIGHT	5'7"	(181)	5'10"	(59)	5'5"	(106)	***
WEIGHT	144.71	(181)	165.34	(59)	133.86	(111)	***
IMPORTANCE OF WEIGHT TO CAREER (PRIORITY)	8.12	(160)	8.11	(53)	8.15	(98)	
IMPORTANCE OF WEIGHT TO ROMANCE (PRIORITY)	7.92	(144)	7.81	(43)	8.00	(94)	
IMPORTANCE OF WEIGHT TO FRIENDSHIP (PRIORITY)	7.13	(170)	6.79	(58)	7.35	(104)	*
IMPORTANCE OF WEIGHT TO FAMILY (PRIORITY)	6.22	(152)	5.43	(49)	6.66	(97)	***
BULIT	61.74	(181)	54.38	(59)	65.36	(111)	***
NO. OF METHODS TRIED	1.86	(181)	1.29	(59)	2.16	(111)	***
EFFECTIVENESS OF METHODS TRIED	3.94	(181)	7.47	(59)	2.27	(111)	***

* $p \leq .05$ ** $p \leq .01$ *** $p \leq .001$

As shown in Table 1, among those who reported that friend and family relationships were important, women disclosed that weight was more important to achievement in these areas than men did. Interestingly, among those who reported career and romance as priorities there was no shown

difference between men and women in the relevance of weight to those goals.

Not surprisingly, women showed a higher incidence of bulimic attitudes and behavior than men, as measured by the BULIT, with 8.108% of the women (and 0% of the men) in the sample attaining a score which indicates clinical bulimia. The BULIT scores for women ranged from 39 to 143; the BULIT scores for men ranged from 37 to 79.

Women reported trying more weight-control methods than did men, and also reported having less success with these methods than did men.

Bivariate Correlations

A correlation analysis was done by gender for the primary variables in order to determine the relationship between the incidence of bulimic symptoms and the independent variables. In Table 2 are the bivariate correlations between the key variables and the bulimia scale, overall, and by gender. Standard deviations are also shown to clarify the effect that variance had on the correlations and their significance.

TABLE 2: BIVARIATE CORRELATIONS

	IMP OF WEIGHT TO CAREER GOALS (PRIOR.)	IMP OF WEIGHT TO ROMANTIC GOALS (PRIOR.)	IMP OF WEIGHT TO SOCIAL GOALS (PRIOR.)	IMP OF WEIGHT TO FAMILY GOALS (PRIOR.)	NO. OF METHODS TRIED	EFFECT. OF METHODS TRIED	BULIT SCORE
MALE							
BULIT	-0.124	-0.176	0.141	0.025	0.253	-0.055	1.000
Sig.							
S.D.	1.577	1.314	1.565	1.384	0.589	1.331	10.784
FEMALE							
BULIT	0.290	0.286	0.328	0.377	0.539	0.118	1.000
Sig.	**	**	***	***	***		
S.D.	1.495	1.600	1.694	1.930	1.061	1.066	21.515
OVERALL							
BULIT	0.216	0.219	0.308	0.372	0.551	-0.221	1.000
Sig.	**	**	***	***	***	**	
S.D.	1.536	1.551	1.663	1.831	1.004	2.712	18.776

* $p \leq .05$ ** $p \leq .01$ *** $p \leq .001$

As hypothesized, the BULIT score was correlated with all of the independent variables. However, when analyzed by gender, these correlations hold true for importance of weight to career priorities, importance of weight to romantic priorities, importance of weight to social priorities, importance of weight to family priorities, and number of weight-control methods tried, and only for women.

It is especially interesting that for women, importance of weight to career priorities and importance of weight to

romantic priorities are correlated with BULIT while for men they are not, because (as seen in Table 1) among respondents for whom career and/or romance were a priority there was no difference in the reported degree of importance weight had in the achievement of career and romance goals, respectively. Effectiveness of methods tried was not correlated with the respondent's BULIT score for either men or women.

Regression Analysis

In Tables 3A-D, 4A-D, and 5A-D are the results of a series of regressions run to test the hypotheses developed in the Statement of the Hypotheses section. Regressions for career, romance, social, and family variables were run separately, because each respondent may not consider career, romance, friendships, and family relationships all to be a priority.

TABLE 3A: REGRESSION ANALYSIS OVERALL
(WHEN CAREER GOALS ARE A PRIORITY)

Variable	Unstandardized Estimate (b)	Standard Error	Standardized Estimate (beta)
IMPORTANCE OF WEIGHT TO CAREER	2.205510	0.81321332	0.17957070 (**)
NO. OF METHODS TRIED	9.340901	1.28568747	0.50124260 (***)
EFFECTIVENESS OF METHODS TRIED	-0.515131	0.48493128	-0.07310860
R-square	0.3227		

* $p \leq .05$ ** $p \leq .01$ *** $p \leq .001$

n = 159

The above table presents the results of the regression analysis of the independent variables importance of weight to career priorities, number of weight-control methods tried, and effectiveness of methods tried on the dependent variable BULIT for the entire sample. The importance of weight to career when career is a priority has significant impact on the appearance of bulimic symptoms as does the number of weight loss methods tried. As each of those variables increases, so does the BULIT score of the respondent. The variable effectiveness of methods tried appears to have no significant effect on the BULIT score. Number of weight-control methods tried seems to be the most important variable. The R-square tells us that this combination of the variables explain 32% of the variance in

BULIT scores.

TABLE 3B: REGRESSION ANALYSIS OVERALL
(WHEN ROMANCE GOALS ARE A PRIORITY)

Variable	Unstandardized Estimate (b)	Standard Error	Standardized Estimate (beta)
IMPORTANCE OF WEIGHT TO ROMANCE	0.700871	0.93685365	0.05460208
NO. OF METHODS TRIED	10.034327	1.44554353	0.52938202 (***)
EFFECTIVENESS OF METHODS TRIED	-0.573926	0.53628029	-0.07762476
R-square	0.3310		

* $p \leq .05$ ** $p \leq .01$ *** $p \leq .001$

n = 143

In the next regression run on the entire sample, we find that the only significant variable is number of weight-control methods tried. As in the previous regression, effectiveness of methods tried has no significant impact on the BULIT score, and surprisingly, importance of weight to romantic priorities also has no effect. The variables in this regression are able to account for 33% of the variance of the BULIT score, with an R-square of .3310.

TABLE 3C: REGRESSION ANALYSIS OVERALL
(WHEN SOCIAL GOALS ARE A PRIORITY)

Variable	Unstandardized Estimate (b)	Standard Error	Standardized Estimate (beta)
IMPORTANCE OF WEIGHT TO FRIENDSHIP	2.184069	0.73994281	0.19055100 (**)
NO. OF METHODS TRIED	9.338249	1.28661318	0.49314315 (***)
EFFECTIVENESS OF METHODS TRIED	-0.372249	0.46184660	-0.05369025
R-square	0.3446		

* $p \leq .05$ ** $p \leq .01$ *** $p \leq .001$

n = 169

When the regression equation was run using importance of weight to social priorities, number of weight-control methods tried, and effectiveness of methods tried variables on the entire sample, number of weight-control methods tried was again the most important variable with importance of weight to social priorities also significant. As before, effectiveness of methods tried showed no significant effect on the BULIT score. The variables in this regression accounted for 34% of the variance in the BULIT score.

TABLE 3D: REGRESSION ANALYSIS OVERALL
(WHEN FAMILY GOALS ARE A PRIORITY)

Variable	Unstandardized Estimate (b)	Standard Error	Standardized Estimate (beta)
IMPORTANCE OF WEIGHT TO FAMILY	2.501268	0.72904805	0.24547681 (***)
NO. OF METHODS TRIED	9.379084	1.36839345	0.47809927 (***)
EFFECTIVENESS OF METHODS TRIED	-0.155239	0.49539441	-0.02164186
R-square	0.3565		

* $p \leq .05$ ** $p \leq .01$ *** $p \leq .001$

n = 151

Findings for this regression involving importance of weight to family priorities, number of weight-control methods tried, and effectiveness of methods tried were similar to those in the preceding regressions. Number of weight-control methods tried was shown to be the most important variable affecting the BULIT score of the respondent. Importance of weight in family relationships (when family relationships are a priority) was also a significant factor while effectiveness of methods tried showed no effect on the dependent variable. The variables in this regression can explain 35.6% of the variance in the BULIT score.

Regression models were then run separately for men and

women.

TABLE 4A: REGRESSION ANALYSIS MALES ONLY
(WHEN CAREER GOALS ARE A PRIORITY)

Variable	Unstandardized Estimate (b)	Standard Error	Standardized Estimate (beta)
IMPORTANCE OF WEIGHT TO CAREER	0.826787	0.97231893	0.11663601
NO. OF METHODS TRIED	4.850090	1.262947874	0.26600903
EFFECTIVENESS OF METHODS TRIED	0.378448	1.26074640	0.04331694
R-square	0.0808		

* $p \leq .05$ ** $p \leq .01$ *** $p \leq .001$

n = 52

The first regression model for the male sample showed that among the variables importance of weight to career priorities, number of weight-control methods tried, and effectiveness of methods tried, none were significant in affecting the BULIT score. The R-square showed that these variables can explain 8% of the variance.

TABLE 4B: REGRESSION ANALYSIS MALES ONLY
(WHEN ROMANCE GOALS ARE A PRIORITY)

Variable	Unstandardized Estimate (b)	Standard Error	Standardized Estimate (beta)
IMPORTANCE OF WEIGHT TO ROMANCE	-1.946250	1.24177282	-0.24822898
NO. OF METHODS TRIED	3.949756	2.82258432	0.22965378
EFFECTIVENESS OF METHODS TRIED	-0.586318	1.19897364	-0.07888848
R-square	0.0959		

* $p \leq .05$ ** $p \leq .01$ *** $p \leq .001$

n = 42

The second regression in the male model showed that among the variables importance of weight to romantic priorities, number of weight-control methods tried, and effectiveness of methods tried, none were significant in affecting the BULIT score of the respondent. These variables explain 9.5% of the variance of the BULIT scores.

TABLE 4C: REGRESSION ANALYSIS MALES ONLY
(WHEN SOCIAL GOALS ARE A PRIORITY)

Variable	Unstandardized Estimate (b)	Standard Error	Standardized Estimate (beta)
IMPORTANCE OF WEIGHT TO FRIENDSHIP	0.458477	0.96329119	0.06684638
NO. OF METHODS TRIED	4.038248	2.60172010	0.22360648
EFFECTIVENESS OF METHODS TRIED	-0.012077	1.12288415	-0.00149776
R-square	0.0646		

* $p \leq .05$ ** $p \leq .01$ *** $p \leq .001$

n = 57

The third male regression model showed that of the variables importance of weight to social priorities, number of weight-control methods tried, and effectiveness of methods tried, none were significant in affecting the BULIT score. The variables in this regression explain 6.4% of the variance of the dependent variable.

TABLE 4D: REGRESSION ANALYSIS MALES ONLY
(WHEN FAMILY GOALS ARE A PRIORITY)

Variable	Unstandardized Estimate (b)	Standard Error	Standardized Estimate (beta)
IMPORTANCE OF WEIGHT TO FAMILY	0.212025	1.16162545	0.02624887
NO. OF METHODS TRIED	4.824341	2.71109569	0.27214967
EFFECTIVENESS OF METHODS TRIED	0.302333	1.32275965	0.03495621
R-square	0.0694		

* $p \leq .05$ ** $p \leq .01$ *** $p \leq .001$

n = 48

The fourth male regression model showed that of the variables importance of weight to family priorities, number of weight-control methods tried, and effectiveness of methods tried, none were significant in affecting the BULIT score. These variables explain 6.9% of the variance in BULIT scores.

Regression models were then run using the data of the female respondents. The results were very similar to those in the regression models using data from the entire sample.

TABLE 5A: REGRESSION ANALYSIS FEMALES ONLY
(WHEN CAREER GOALS ARE A PRIORITY)

Variable	Unstandardized Estimate (b)	Standard Error	Standardized Estimate (beta)
IMPORTANCE OF WEIGHT TO CAREER	3.330456	1.22987519	0.23162149 (**)
NO. OF METHODS TRIED	9.796040	1.79490186	0.49565732 (***)
EFFECTIVENESS OF METHODS TRIED	-0.212794	1.84542490	-0.01042578
R-square	0.3227		

* $p \leq .05$ ** $p \leq .01$ *** $p \leq .001$

n = 97

The first female regression model, which used importance of weight to career priorities, number of weight-control methods tried, and effectiveness of methods tried, revealed that importance of weight to career priorities and number of weight-control methods tried significantly affected the respondents' BULIT scores, number of weight-control methods tried being the most important variable in the equation. Effectiveness of methods tried showed no significant effect. These variables accounted for 32% of the variance in BULIT scores.

TABLE 5B: REGRESSION ANALYSIS FEMALES ONLY
(WHEN ROMANCE GOALS ARE A PRIORITY)

Variable	Unstandardized Estimate (b)	Standard Error	Standardized Estimate (beta)
IMPORTANCE OF WEIGHT TO ROMANCE	1.948456	1.38180557	0.13923195
NO. OF METHODS TRIED	10.547263	1.87855996	0.52288132 (***)
EFFECTIVENESS OF METHODS TRIED	-0.813440	1.88479055	-0.03921948
R-square	0.3242		

* $p \leq .05$ ** $p \leq .01$ *** $p \leq .001$

n = 159

In the second regression model using the female data, we see that the only significant variable was number of weight-control methods tried, while importance of weight to romantic priorities and effectiveness of methods tried were not at all significant. These variables account for 9,5% of the variance in the BULIT scores.

TABLE 5C REGRESSION ANALYSIS FEMALES ONLY
(WHEN SOCIAL GOALS ARE A PRIORITY)

Variable	Unstandardized Estimate (b)	Standard Error	Standardized Estimate (beta)
IMPORTANCE OF WEIGHT TO FRIENDSHIP	3.591219	1.04914297	0.27936659 (***)
NO. OF METHODS TRIED	10.850955	1.70608506	0.53085042 (***)
EFFECTIVENESS OF METHODS TRIED	-1.833970	1.70211402	-0.09125466
R-square	0.3668		

* $p \leq .05$ ** $p \leq .01$ *** $p \leq .001$

n = 103

The third female regression model used the variables importance of weight to social priorities, number of weight-control methods tried, and effectiveness of methods tried. Number of weight-control methods tried was shown to be the most important variable while importance of weight to social priorities was also significant. These variables account for 36.6% of the variance in BULIT scores.

TABLE 5D: REGRESSION ANALYSIS FEMALES ONLY
(WHEN FAMILY GOALS ARE A PRIORITY)

Variable	Unstandardized Estimate (b)	Standard Error	Standardized Estimate (beta)
IMPORTANCE OF WEIGHT TO FAMILY	3.591219	1.04914297	0.27936659 (***)
NO. OF METHODS TRIED	10.850955	1.70608506	0.53085042 (***)
EFFECTIVENESS OF METHODS TRIED	-1.833970	1.70211402	-0.09125466
R-square	0.3668		

* $p \leq .05$ ** $p \leq .01$ *** $p \leq .001$

n = 103

In the above table we see the results of the regression analysis of importance of weight to family priorities, number of weight-control methods tried, and effectiveness of methods tried on the dependent variable BULIT for the female sample. The importance of weight to family relationships when family is a priority has significant impact on the appearance of bulimic symptoms as does the number of weight loss methods tried. Again, the variable effectiveness of methods tried appears to have no significant effect on the BULIT score. Among significant variables, number of weight-control methods tried is shown to be the most important. The R-square tells us that these variables explain 37% of the variance in BULIT scores.

To summarize, the BULIT score of the respondent was shown to increase as the independent variables (importance of weight to success in career, friendship, and family relationships provided that these relationships are a priority and number of weight-loss methods attempted) increased. This was true in analysis of the entire sample, but held true only for women when regressions were analyzed by gender. In none of the regressions did effectiveness of weight-loss methods or importance of weight to romantic relationships when romantic relationships are important to the respondent have a significant impact on the respondent's BULIT score.

DISCUSSION

Results of the study showed relationships between some of the independent variables and the incidence of bulimic behavior. To summarize, as the number of weight-control methods tried by the individual increases, and as weight-control is increasingly critical to maintenance of career, friendship, or familial relationships (provided those relationships are a priority), we see an increase in the BULIT score among women. These findings show that a significant portion of bulimic attitudes and behavior can be explained by the pressure to be thin in order to succeed at personal goals and the difficulty in adhering to an unrealistic socially prescribed body image.

One result which was unexpected was that the need to control weight in order to succeed in romantic relationships did not affect the respondent's BULIT score. This was especially puzzling in light of the fact that other variables which measured the need to control weight in order to fulfill priorities did affect bulimic behavior.

A possible explanation for this was that almost one-third of the respondents were not involved romantically at the time of their participation in the research, which may have affected their responses as to the necessity of weight-control or their hypothetical reactions under the proposed

circumstances. Another explanation could simply be that romantic relationships might be viewed a bit more idealistically than other relationships in the respondent's experience. Whatever the reason, the incidence of bulimic behavior did not seem to increase as did the pressure to control weight to succeed in romantic relationships when these relationships were a priority.

Another unexpected finding was that the respondent's rating of the effectiveness of weight-loss methods tried did not have a significant effect on the occurrence of bulimic behavior. This variable was included as part of the measure of the difficulty which the respondent experienced in losing weight. It is possible that this variable was not effectively operationalized or calculated, and therefore was not an adequate measure of the respondent's ability to control his or her weight.

Other results highlighted some differences between the responses of men and women. According to the underlying theory of this research, a major factor in the difference between men and women's weight-loss behavior is that women feel more societal pressure to conform to appearance standards in order to succeed at their goals. However, this study found that men and women say that they feel statistically the same about the importance that weight plays in the achievement of their career and romance goals.

(It may be noted that proportionately more women than men consider romance to be a high priority. See Appendix C.) However, these variables for women were much more highly correlated with BULIT scores than these same variables were for men. Also, the regression analyses showed that the predictive value of these variables were much more significant for women than for men.

One reason for this may be that men and women define "overweight" for themselves much differently. Thus although men may acknowledge weight as an important factor for their careers, their concept of desired weight is much different than that of women. They may realize that if they do not conform to appearance standards, their goals may suffer in some respects, but the appearance standards to which men are held have a much broader "acceptable range" than that of women (i.e. women may feel pressure to lose weight after gaining 5-10 pounds, but men may not feel that pressure unless they have gained 25-50 pounds). This study did not account for this difference in expectations and therefore may not have accurately measured the degree of pressure men felt to control their weight in order to achieve their goals. It therefore may not be possible to accurately compare the experiences of men and women based on the information collected in this study.

The results of this study do show that in women the

variables of (1) the importance of weight to achieving certain goals and (2) the necessity of the individual to try various methods of weight-control are instrumental in the adoption of bulimic attitudes and behavior, and can account for approximately 32 to 37 percent of the variance in BULIT scores among women. These findings can apply to women's scores on the BULIT scale, whether or not the scores are high enough to indicate clinical bulimia. Although this study cannot explain the psychological and developmental complexities involved in the formation of one who is clinically bulimic, the cultural value of thinness in a patriarchal capitalistic society may play a large part in influencing the particular compulsions displayed by these individuals. If not for these cultural values and the consequential pressures placed on women, self-destructive tendencies may be manifested in some other compulsive behavior. Therefore the findings of this research are able to build on previous studies which link the presence of certain personality characteristics to clinically bulimic behavior. Furthermore, this study offers insight as to why these personality characteristics may manifest themselves in binge-purge behavior, and, especially, why psychologically and emotionally stable women also may periodically engage in this same behavior.

It is hoped that this research can further the

understanding of societal pressures and their effect on the increasing rate of bulimia in Western culture. As we come to realize that the enormous pressures placed on young women to conform to an unrealistic ideal of thinness have real consequences for women's physical, mental, and emotional well-being, we as a society may see the need to re-examine our values and ideas about gender.

REFERENCES

Abraham, S.F., & Beumont, P.J.V. (1982). How patients describe bulimia or binge eating. Psychological Medicine, 12, 625-635.

Blackburn, G. L., Wilson, G. T., Kanders, B. S., Stein, L. J., Lavin, P., Adler, J. A., & Brownell, K. D. (1989). Weightcycling: the experience of human dieters. American Journal of Clinical Nutrition, 49, 1105-1109.

Boskind-Lodahl, M. (1976). Cinderella's stepsisters: A feminist perspective on anorexia nervosa and bulimia. Signs' Journal of Women in Culture and Society, 2, 342-356.

Brown, Roxanne. (1990). Full-figured women fight back: Resistance grows to society's demand for slim bodies. Ebony, 45, 27-31.

Brubach, Holly. (1987). Fat pride. Atlantic, 250, 111-114.

Chernin, Kim. (1981). The Obsession: Reflections on the Tyranny of Slenderness. New York. Harper Colophon Books.

Fairburn, C.G., & Cooper, P.J. (1982). Self-induced vomiting and bulimia nervosa: An undetected problem. British Medical Journal, 284, 1153-1155.

Garner, Garfinkel, Schwartz, & Thomson. (1980). Cultural expectations of thinness in women. Psychological Reports, 47, 483-91.

Goode, Erich and Preissler, Joanne. (1983). The fat admirer. Deviant Behavior: An Interdisciplinary Journal, 4, 174-202.

Halmi, K.A., Falk, J.R., & Schwartz, E. (1981). Binge-eating and vomiting: A survey of a college population. Psychological Medicine, 11, 697-706.

Hawkins, II, R.C. & Clement, P.F. (1984). Binge eating: Measurement problems and a conceptual model. In R.C. Hawkins, Fremouw, W.J., & Clement, P.F. (Eds.), The Binge-Purge Syndrome. (pp. 229-251).

Hatsukami, D., Owen, P., Pyle, R., & Mitchell, J. (1982). Similarities and differences on the MMPI between women with bulimia and women with alcohol or drug abuse problems. Addictive Behaviors, 7, 435-439.

Henley, Nancy. (1977). Body Politics: Power, Sex, and Nonverbal Communication. Englewood Cliffs, New Jersey: Prentice Hall.

Herman, C.P., & Mack, D. (1975). Restrained and unrestrained eating. Journal of Personality, 43, 647-660.

Herman, C.P., & Polivy, J. (1975). Anxiety, restraint, and eating behavior. Journal of Abnormal Psychology, 84, 666-672.

Hesse-Bilier, Sharlene. (1991). Women, weight, and eating disorders: a sociocultural and political economic analysis. Women's Studies International Forum, 14, 3, 173-191.

Hesse-Bilier, Sharlene, Clayton-Matthews, Alan, & Downey, John A. (1987). The differential importance of weight and body image among college women and men. Genetic, Social, and General Psychological Monographs. 113, 4, November, 509-528.

Hesse-Bilier, Sharlene. (1989). Eating patterns and disorders in a college population: Are college women's eating problems a new phenomenon? Sex Roles. 20, 1-2, January, 71-89.

House, R.C., Grisius, R., & Bliziotes, M.M. (1981). Perimolysis: Unveiling the surreptitious vomiter. Oral Surgery, 51, 152-155.

Johnson, C., & Larson, R. (1982). Bulimia: An analysis of moods and behavior. Psychosomatic Medicine, 44(4), 341-351.

Johnson, C.L., Stuckey, M.K., Lewis, L.D., & Schwarts, D.M. (1982). Bulimia: A descriptive study of 316 cases. International Journal of Eating Disorders, 2(1), 3-16.

Katzman, M.A., & Wolchik, S.A. (1984). Bulimia and binge-eating in college women: A comparison of personality and behavioral characteristics. Journal of Consulting and Clinical Psychology, 52, 423-428.

Katzman, M.A., Wolchik, S.A., & Braver, S.L. (1984). The prevalence of frequent binge-eating and bulimia in a nonclinical college sample. International Journal of Eating Disorders, 3, 53-62.

Leitenburg, H., Gross, J., Peterson, J., & Rosen, J. (1984). Analysis of an anxiety model and the process of change during exposure plus response prevention treatment of bulimia nervosa. Behavior Therapy, 15, 3-20.

Levin, P.A., Falko, J.M., Dixon, K., & Gallup, E.M. (1980). Benign parotid enlargement in bulimia. Annals of Internal Medicine, 93, 827-829.

Millett, Kate. (1970). Sexual Politics. Garden City, New York: Doubleday.

Millman, Marcia. (1980). Such a Pretty Face: Being fat in America. New York: Berkeley Books.

Mizes, J.S. (1983). Bulimia: A review of its symptomatology and treatment. Unpublished manuscript, North Dakota State University. Fargo.

Nasser, Mervat. (1988). Culture and weight consciousness. Job Psychosomatic Research. 32, 6, 573-577.

Nisbett, R.E. (1972). Hunger, obesity, and the ventromedial hypothalamus. Psychological Review, 79, 433-453.

O'Neil, P.M., Paine, P.M., Riddle, F.E., Currey, H.S., Malcolm, R., & Sexauer, J.D. (1981). Restraint and age at onset of obesity. Addictive Behaviors, 6, 135-138.

Pyle, R.L., Mitchell, J.E., Eckert, E.D., Halvorson, P.A., & Geoff, G.M. (1983). The incidence of bulimia in college freshman students. International Journal of Eating Disorders, 2, 75-85.

Rosen, T.C., & Leitenberg, H. (1982). Bulimia nervosa: Treatment with exposure and response prevention. Behavior Therapy, 13, 117-124.

Rothblum, Esther D. (1990). Women and weight: Fad and fiction. The Journal of Psychology, 124 (1), 5-24.

Ruderman, A.J., & Christensen, H. (1983). Restraint theory and its applicability to overweight and normal weight individuals. Addictive Behaviors, 3, 129-134.

Russell, G. (1979). Bulimia nervosa: An omnivous variant of anorexia nervosa. Psychological Medicine, 9, 429-448.

Sacker, Ira M. & Zimmer, Mark A. (1987). Dying to Be Thin, New York, New York: Warner Books.

Silverstein, Predue, Peterson, & Kelley. (1986). The role of mass media in promoting a thin standard of bodily attractiveness for women. Sex Roles, 1986, 519-32.

Smith, Marcia C. & Thelen, Mark H. (1984). Development and validation of a test for bulimia. Journal of Consulting and Clinical Psychology, 52 (5), 863-812.

Spitzack, Carole. (1990). Confessing Excess: Women and the Politics of Body Reduction. Albany: State University of New York Press.

Szekely, Eva A. (1987). Society, ideology, and the relentless pursuit of thinness. Practice, Winter, 34-48.

Tong, Rosemarie. (1989). Feminist Thought: A Comprehensive Introduction, Boulder & San Francisco: Westview Press.

Weiss, S.R., & Egert, M.H. (1983). Psychological and behavioral characteristics of normal-weight bulimics and normal-weight controls. Psychosomatic Medicine, 45, 293-303.

Wooley, S.C., & Wooley, O.W. (1981) Overeating as substance abuse. In N.Mello (Ed.). Advances in substance abuse: Vol.2. (pp. 41-67). Greenwich, CT: JAI Press.

Young, Kate, Carol Wolkowitz, & Roslyn McCullagh, eds. (1981). Of Marriage and the Market: Women's Subordination in International Perspective. London: CSE Book.

ATTITUDES AND LIFESTYLE SURVEY

The following questionnaire is a survey of the attitudes and lifestyles of college students, and how they relate to eating behavior. This study is part of a Master's thesis in Sociology by Julia Machara. Dr. Carol Bailey is the thesis committee chair. We would greatly appreciate your contribution of information for our research. This survey should require approximately 15-20 minutes of your time.

To obtain information for our study, we are soliciting the cooperation of Virginia Tech college students. Your instructor has agreed that we may ask for your assistance in collecting this information. Your participation is **completely voluntary** and if you should decide you do not wish to complete this questionnaire, you are free to decline. If you feel uncomfortable answering any of the questions in this survey, you may skip them.

Please be assured that your answers are **anonymous**. There is no way for your answers to be identified as your own.

Again, thank you for agreeing to participate in our survey. If you have any concerns about this study or any part of the questionnaire, you may contact Dr. Carol Bailey at 231-8976, or Julia Machara at (703) 550-6461.

When you are ready, turn the page and begin.

ATTITUDES AND LIFESTYLES SURVEY

Fill in completely the circle on your answer sheet that corresponds to the answer number of your response.

The first few questions pertain to your occupational goals after completing your education. These may include, for example, such goals as white-collar professional, homemaker, blue collar worker, public servant, armed forces, volunteer, performer, athlete, etc..

1. How would you describe your feelings towards your chosen career?
   (1) Determined to become a leading expert in my profession
   (2) Hope to become fairly successful in my profession
   (3) Desire moderate success although my career is not one of the highest priorities in my life
   (4) Not ambitious at all about my career

2. Do you believe an attractive appearance will assist you in achieving your occupational goals?
   (1) Greatly
   (2) Somewhat
   (3) Minimally
   (4) Not at all

3. Do you believe becoming overweight would be <u>detrimental</u> to you in achieving your occupational goals?
   (1) Greatly
   (2) Somewhat
   (3) Minimally
   (4) Not at all

4. Suppose your boss approached you and confided that your career could be greatly enhanced if you lost about 10 pounds. Most likely your reaction would be to:
   (1) Ignore your boss's advice
   (2) Make minor lifestyle changes to lose the extra weight
   (3) Make major lifestyle changes in order to lose the weight
   (4) Resolve to lose the weight at all costs

5. On a scale of 1 to 10, how important is your career?

Not important **Extremely important**

1 2 3 4 5 6 7 8 9 10

The next few questions ask about some of your personal relationships and how perceptions about appearance may influence them.

6. Do you believe your chances of having a satisfying romantic relationship would suffer if you gained a significant amount of weight?

(1) Greatly
(2) Somewhat
(3) Minimally
(4) Not at all

7. If you are currently in a relationship, what are your romantic partner's opinions concerning your weight?

(1) Not applicable
(2) Thinks I'm attractive no matter what I weigh
(3) Prefers that I stay in shape, but never criticizes
(4) Would drop hints if I gained too much weight
(5) Would nag me if I gained too much weight
(6) Might break up with me if I gained too much weight

8. Suppose your romantic partner (current or hypothetical) suggested that you would really be more desirable if you lost 10 pounds. What would be your most likely reaction?

(1) Ignore the suggestion
(2) Make small changes in your routine in order to trim down
(3) Begin a vigorous plan to lose the excess weight
(4) Resolve to lose the weight no matter how tough it is

9. On a scale of 1 to 10, how important to you is having a romantic relationship?

Not important **Extremely important**

1 2 3 4 5 6 7 8 9 10

10. Which statement best describes your <u>current</u> feelings towards romantic relationships?

(1) I presently would rather not become romantically involved with anyone
(2) If the opportunity presented itself, I would be open to the idea of romantic involvement presently or in the near future
(3) I strongly hope for a successful romantic relationship at some point presently or in the near future
(4) To have a successful romantic relationship is possibly my strongest goal for the present or near future

11. How do you feel about others' opinions about your appearance?

(1) I don't care about others' opinion
(2) I hope others find me attractive, but I don't worry about it
(3) I care somewhat whether or not others find me attractive
(4) I care quite a bit whether or not others find me attractive
(5) I can't feel good about myself unless I know others find me attractive

12. Do you think that your chances of having many satisfying friendships (non-romantic relationships) would suffer if you gained a significant amount of weight?

(1) Greatly
(2) Somewhat
(3) Minimally
(4) Not at all

13. On a scale of 1 to 10, to what extent is having fulfilling friendships a priority to you at this time?

Not important **Extremely important**

1 2 3 4 5 6 7 8 9 10

14. About how much of your free time do you voluntarily spend with non-romantic friends?

(1) All or almost all of my free time
(2) A lot of my free time
(3) A fair amount of my free time
(4) A small amount or none of my free time

15. Does your circle of friends hold strong opinions about people who have gained weight?

(1) Among my friends gaining weight or eating a lot is perfectly acceptable
(2) My friends are completely neutral about overweight people
(3) At least one of my close friends is somewhat critical about overweight people
(4) In general, my circle of friends is somewhat critical of overweight people
(5) In my circle of friends, eating a lot or becoming overweight is highly discouraged and/or criticized.

16. Suppose you discover that your friends think that you should lose about 10 pounds to look better. How do you think you would react?

(1) Ignore the suggestion
(2) Make minor lifestyle changes in order to lose the weight
(3) Make major lifestyle changes in order to lose the weight
(4) Resolve to lose the weight at all costs

17. On a scale of 1 to 10, how important do you rate harmony in your family relationships?

Not important **Extremely important**
1 2 3 4 5 6 7 8 9 10

18. About how often do you consult a family member for advice on important decisions?

(1) Always or almost always
(2) Usually
(3) Sometimes
(4) Hardly ever or never

19. If you gained weight, do you believe it would produce difficulty in your family relationships?

(1) Greatly
(2) Somewhat
(3) Minimally
(4) Not at all

20. Does your family hold strong opinions about family members who gain weight?

(1) In my family, gaining weight and eating a lot is acceptable and/or encouraged
(2) My family is completely neutral about overweight people
(3) At least one family member is somewhat critical about overweight people
(4) In general, my family is somewhat critical of overweight people
(5) In my family, becoming overweight and eating a lot is highly discouraged and/or criticized

21. Suppose a parent or a sibling remarked that you would look much better if you lost about 10 pounds. How would you probably react?

(1) Ignore the suggestion
(2) Make small lifestyle changes in order to lose the weight
(3) Make major lifestyle changes in order to lose the weight
(4) Resolve to lose the weight at all costs

22. On a scale of 1 to 10, do you think weight control in general is important?

Not important **Extremely important**
1 2 3 4 5 6 7 8 9 10

The following questions ask about which common methods of weight-control you may have tried and their effectiveness in achieving **long-term** weight goals. **Long-term** refers to your ability to use this method to control your weight consistently for three months or longer.

23. Have you ever tried dieting to control your weight?

(1) Yes
(2) No (Go to 25)

24. **How effective has dieting been for you in achieving long-term weight-control?**

Not effective **Extremely effective**

1 2 3 4 5 6 7 8 9 10

25. Have you ever tried group weight-loss programs such as Weight-Watchers, Jenny Craig, Nutrisystem, Overeaters Anonymous, etc. in order to control your weight?

(1) Yes
(2) No (Go to 27)

26. How effective have group weight-loss programs been for you in achieving long-term weight-control?

Not effective **Extremely effective**

1 2 3 4 5 6 7 8 9 10

27. Have you ever consulted a private physician for advice on weight-control?

(1) Yes
(2) No (go to 29)

28. How effective has medical advice been for you in achieving long-term weight-control?

Not effective **Extremely effective**

1 2 3 4 5 6 7 8 9 10

29. Have you ever tried adopting an exercise regimen in order to control your weight?

(1) Yes
(2) No (Go to 31)

30. How effective has an exercise regimen been for you in achieving long-term weight-control?

Not effective **Extremely effective**

1 2 3 4 5 6 7 8 9 10

31. Have you ever tried commercial pharmaceuticals such as creams or diet pills in order to control your weight?

(1) Yes
(2) No (Go to 33)

32. How effective have commercial pharmaceutical such as creams or diet pills been for you in achieving long-term weight-control?

Not effective **Extremely effective**

1 2 3 4 5 6 7 8 9 10

The next questions ask about your eating habits and your feelings about your eating habits. Pick the one answer that most accurately describes your behaviors and feelings.

33. Are you satisfied with your eating patterns?
(1) Satisfied
(2) Somewhat satisfied
(3) Not really satisfied
(4) Not at all satisfied

34. Do you ever eat uncontrollably to the point of stuffing yourself (i.e. going on eating binges)?
(1) Once a month or less (or never)
(2) 2-3 times a month
(3) Once or twice a week
(4) 3-6 times a week
(5) Once a day or more

35. Have you ever kept eating until you thought you'd explode?
(1) Practically every time I eat
(2) Very frequently
(3) Often
(4) Sometimes
(5) Seldom or never

36. Would you presently call yourself a "binge eater"?
(1) Yes, absolutely
(2) Yes
(3) Yes, probably
(4) Yes, possibly
(5) No, probably not

37. How and where do you prefer to eat?
(1) At home alone
(2) At home with friends
(3) In a public restaurant
(4) At a friend's house
(5) Doesn't matter

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

(1) Most or all of the time
(2) A lot of the time
(3) Occasionally
(4) Rarely
(5) Never

39. Do you use laxatives or suppositories to help control your weight?

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

40. Do you ever eat until you feel too tired to continue?

(1) At least once a day
(2) 3-6 times a week
(3) Once or twice a week
(4) 2-3 times a month
(5) Once a month or less (or never)

41. How often do you prefer eating ice cream, milk shakes, or puddings during a binge?

(1) Always
(2) Frequently
(3) Sometimes
(4) Seldom or never
(5) I don't binge

42. How much are you concerned about your eating binges?

(1) I don't binge
(2) Bothers me a little
(3) Moderate concern
(4) Major concern
(5) Probably the biggest concern in my life

43. Would people be amazed if they knew how much food you can consume in one sitting?

(1) Without a doubt
(2) Very probably
(3) Probably
(4) Possibly
(5) No

44. Do you ever eat to the point of feeling sick?
(1) Very frequently
(2) Frequently
(3) Fairly often
(4) Occasionally
(5) Rarely or never

45. Are you afraid to eat for fear you won't be able to stop?
(1) Always
(2) Almost always
(3) Frequently
(4) Sometimes
(5) Seldom or never

46. Do you dislike yourself after you eat too much?
(1) Always
(2) Frequently
(3) Sometimes
(4) Seldom or never
(5) I don't eat too much

47. How often do you intentionally vomit after eating?
(1) 2 or more times a week
(2) Once a week
(3) 2-3 times a month
(4) Once a month
(5) Less than once a month (or never)

48. Which of the following describes your feelings after binge eating?
(1) I don't binge eat
(2) I feel OK
(3) I feel mildly upset with myself
(4) I feel quite upset with myself
(5) I hate myself

49. Do you ever eat a lot of food when you're not even hungry?
(1) Very frequently
(2) Frequently
(3) Occasionally
(4) Sometimes
(5) Seldom or never

50. Would you say your eating patterns are different from the eating patterns of most people?

(1) Always
(2) Almost always
(3) Frequently
(4) Sometimes
(5) Seldom or never

51. Have you tried to lose weight by fasting or going on "crash" diets?

(1) Not in the past year
(2) Once in the past year
(3) 2-3 times in the past year
(4) 4-5 times in the past year
(5) More than 5 times in the past year

52. Do you ever feel sad or "blue" after eating more than you planned to eat?

(1) Always
(2) Almost always
(3) Frequently
(4) Sometimes
(5) Seldom or never, or not applicable

53. When engaged in an eating binge, do you tend to eat foods that are high in carbohydrates (sweets and starches)?

(1) Always
(2) Almost always
(3) Frequently
(4) Sometimes
(5) Seldom or never

54. Compared to most people, your ability to control your eating behavior seems to be:

(1) Greater than others' ability
(2) About the same
(3) Less
(4) Much less
(5) I have absolutely no control

55. One of your best friends suddenly suggests that you both eat at a new restaurant buffet that night. Although you'd planned on eating something light at home, you go ahead and eat out, eating quite a lot and feeling uncomfortably full. How would you feel about yourself on the ride home?

(1) Fine, glad that you tried that new restaurant
(2) A little regretful that you'd eaten so much
(3) Somewhat disappointed with yourself
(4) Upset with yourself
(5) Totally disgusted with yourself

56. Would you presently label yourself a "compulsive eater" (one who engages in episodes of uncontrolled eating)?

(1) Absolutely
(2) Yes
(3) Yes, probably
(4) Yes, possibly
(5) No, probably not

57. What is the most weight you've ever lost in 1 month?

(1) Over 20 pounds
(2) 12 - 20 pounds
(3) 8-11 pounds
(4) 4-7 pounds
(5) Less than 4 pounds

58. If you eat too much at night, do you feel depressed the next morning?

(1) Always
(2) Frequently
(3) Sometimes
(4) Seldom or never
(5) I don't eat too much at night

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

(1) Yes, it's no problem at all for me
(2) Yes, it's easier
(3) Yes, it's a little easier
(4) About the same
(5) No, it's less easy

60. Do you feel that food controls your life?

(1) Always
(2) Almost always
(3) Frequently
(4) Sometimes
(5) Seldom or never

61. Do you feel depressed immediately after you eat too much?

(1) Always
(2) Frequently
(3) Sometimes
(4) Seldom or never
(5) I don't eat too much

62. How often do you vomit after eating in order to lose weight?

(1) Less than once a month (or never)
(2) Once a month
(3) 2-3 times a month
(4) Once a week
(5) 2 or more times a week

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

(1) More rapidly than most people have eaten in their lives
(2) A lot more rapidly than most people
(3) A little more rapidly than most people
(4) About the same rate as most people
(5) More slowly than most people (or not applicable)

64. What is the most weight you've ever gained in one month?

(1) Over 20 pounds
(2) 12-20 pounds
(3) 8-11 pounds
(4) 4-7 pounds
(5) Less than 4 pounds

65. When was your last menstrual period? (If you are male, please go to 66)

(1) Within the past month
(2) Within the past 2 months
(3) Within the past 4 months
(4) Within the past 6 months
(5) Not within the past 6 months

66. Do you ever use diuretics (water pills) to help control your weight?

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

67. How do you think your appetite compares with that of most people you know?

(1) Many times larger than most
(2) Much larger
(3) A little larger
(4) About the same
(5) Smaller than most

68. Does your menstrual cycle occur once a month? (If you are male, please go to the next paragraph)

(1) Always
(2) Usually
(3) Sometimes
(4) Seldom
(5) Never

We need now to ask you just a few last questions. These ask for information about some of your personal characteristics which pertain to our research. Again, you do not have to answer any questions which make you feel uncomfortable.

69. What is your gender?

(1) Male
(2) Female

70. How would you describe your weight?

Very Underweight						**Very Overweight**
1	**2**	**3**	**4**	**5**	**6**	**7**

71. What is your racial/ethnic origin?

(1) American Indian
(2) Asian
(3) African American
(4) Hispanic
(5) White
(6) Other: _____ *Please use the space provided at the bottom of your answer sheet.

72. What is your age? _____ **years**

73. How tall are you? _____ **feet** _____ **inches**

74. How much do you weigh? _____ **lbs.**

Thank you for your cooperation in this study. If this questionnaire has brought up issues about eating disorders that cause you to feel concerned, you should know that you can contact Virginia Tech Counseling Services, where there are staff members trained to recognize and make recommendations about eating disorders.

If you desire, please add any additional comments you have about this survey on the back of your answer sheet. To obtain any further information about this study, you can contact Dr. Bailey (231-8976), or Julia Machara (703-550-6461).

ADDITIONAL TABLES AND EXPLANATIONS

The following tables provide relevent information not presented in the text.

Table 6: Means and Standard Deviations for Importance of Weight to the Achievement of Career, Romantic, Social, and Family Goals by Gender.

	Overall		Males		Females		Significance of Gender Difference
	Mean	S.D.	Mean	S.D.	Mean	S.D.	
CAREER	7.879	1.689	7.933	1.681	7.928	1.644	N.S.
	n=181		n=59		n=111		
ROMANTIC	7.832	1.632	7.441	1.557	8.078	1.619	*
	n=181		n=59		n=111		
SOCIAL	7.064	1.732	6.746	1.563	7.318	1.758	*
	n=181		n=59		n=111		
FAMILY	6.286	1.810	5.576	1.589	6.711	1.866	***
	n=181		n=59		n=111		

N.S. = Not Significant * $p \leq .05$ ** $p \leq .01$ *** $p \leq .001$

Table 7: Means and Standard Deviations for Importance of Career, Romantic, Social, and Family Goals to the Respondent by Gender.

	Overall		Male		Female		Significance of Gender Difference
	Mean	S.D.	Mean	S.D.	Mean	S.D.	
CAREER GOALS	8.300	1.577	8.458	1.304	8.180	1.701	N.S.
	n=181		n=59		n=111		
ROMANTIC GOALS	8.599	1.580	8.169	1.840	8.809	1.378	*
	n=181		n=59		n=111		
SOCIAL GOALS	8.508	1.575	8.500	1.556	8.514	1.612	N.S.
	n=181		n=59		n=111		
FAMILY GOALS	8.431	1.690	8.254	1.917	6.595	1.429	N.S.
	n=181		n=59		n=111		

N.S. = Not Significant * $p \leq .05$ ** $p \leq .01$ *** $p \leq .001$

Table 8: Means and Standard Deviations by Gender for Importance of Weight to Career Goals When Career is of High, Medium, and Low Priority.

	Overall		Males		Females		Significance of Gender Difference
	Mean	S.D.	Mean	S.D.	Mean	S.D.	
HIGH	8.106	1.536	8.113	1.577	8.153	1.495	N.S.
	n=160		n=53		n=98		
MEDIUM	6.222	1.927	6.333	1.862	6.455	1.864	N.S.
	n=18		n=6		n=11		
LOW	5.000	0.000	---	---	5.000	0.000	N.S.
	n=2		n=0		n=2		

N.S. = Not Significant * $p \leq .05$ ** $p \leq .01$ *** $p \leq .001$

Table 9: Means and Standard Deviations by Gender for Importance of Weight to Romantic Goals when Romance is of High, Medium, and Low Priority.

	Overall		Males		Females		Significance of Gender Difference
	Mean	S.D.	Mean	S.D.	Mean	S.D.	
HIGH	7.924	1.551	7.814	1.314	8.000	1.600	N.S.
	n=144		n=43		n=94		
MEDIUM	7.545	1.986	6.467	1.807	8.563	1.750	**
	n=33		n=15		n=16		
LOW	6.000	---	6.000	---	---	---	N.S.
	n=1		n=1		n=0		

N.S. = Not Significant * $p \leq .05$ ** $p \leq .01$ *** $p \leq .001$

Table 10: Means and Standard Deviations for by Gender for Importance of Weight to Social Goals when Social Relationships are of High, Medium, and Low Priority.

	Overall		Males		Females		Significance of Gender Difference
	Mean	S.D.	Mean	S.D.	Mean	S.D.	
HIGH	7.129	1.663	6.793	1.565	7.346	1.694	*
	n=170		n=58		n=104		
MEDIUM	6.000	3.098	4.000	---	8.000	3.464	N.S.
	n=3		n=1		n=3		
LOW	---	---	---	---	---	---	
	n=0		n=0		n=0		

N.S. = Not Significant * $p \leq .05$ ** $p \leq .01$ *** $p \leq .001$

Table 11: Means and Standard Deviations by Gender for Importance of Weight to Family Goals when Family Relationships are of High, Medium, and Low Priority.

	Overall		Males		Females		Significance of Gender Difference
	Mean	S.D.	Mean	S.D.	Mean	S.D.	
HIGH	6.224	1.831	5.420	1.384	6.660	1.930	***
	n=152		n=49		n=97		
MEDIUM	6.913	1.756	6.444	2.404	7.231	1.235	N.S.
	n=3		n=1		n=13		
LOW	5.000	---	5.000	---	---	---	
	n=1		n=1		n=0		

N.S. = Not Significant * $p \leq .05$ ** $p \leq .01$ *** $p \leq .001$

TABLE 12: Correlations by Gender Between BULIT scores and Importance of Weight to Medium and Low Priority Levels of Career, Romantic, Social, and Family Goals.

	BULIT SCORE CORRELATION / STD. DEVIATION		
	OVERALL	MALES	FEMALES
[IMPORTANCE OF WEIGHT TO]			
CAREER (MEDIUM PRIORITY)	0.084 / 1.926 n=18 N.S.	0.494 / 1.862 n=6 N.S.	-0.216 / 1.864 n=11 N.S.
CAREER (LOW PRIORITY)	. / 0. n=2 N.S.	. / 0. n=0 N.S.	. / 0. n=2 N.S.
ROMANCE (MEDIUM PRIORITY)	-0.059 / 1.986 n=33 N.S.	-0.130 / 1.807 n=15 N.S.	-0.200 / 1.750 n=16 N.S.
ROMANCE (LOW PRIORITY)	. / 0. n=1 N.S.	. / 0. n=1 N.S.	. / . n=0 N.S.
SOCIAL (MEDIUM PRIORITY)	0.493 / 3.098 n=6 N.S.	. / 0. n=1 N.S.	0.839 / 3.464 n=3 N.S.
SOCIAL (LOW PRIORITY)	. / 0. n=0 N.S.	. / 0. n=0 N.S.	. / . n=0 N.S.
FAMILY (MEDIUM PRIORITY)	0.128 / 1.756 n=23 N.S.	0.073 / 0. n=9 N.S.	0.092 / 1.235 n=13 N.S.
FAMILY (LOW PRIORITY)	. / 0. n=2 N.S.	. / 0. n=1 N.S.	. / . n=0 N.S.

N.S. = Not Significant * $p \leq .05$ ** $p \leq .01$ *** $p \leq .001$

Table 13: Means and Standard Deviations by Gender for Number of Methods Tried and Effectiveness of Weight Loss Methods Tried.

	Overall		Males		Females		Significance of Gender Difference
	Mean	S.D.	Mean	S.D.	Mean	S.D.	
NO. OF METHODS TRIED	1.862 n=181	1.004	1.288 n=59	1.331	2.162 n=111	1.066	***
EFF. OF OF METHODS	3.939 n=181	2.712	7.475 n=59	1.331	2.270 n=111	1.061	***

N.S. = Not Significant * $p \leq .05$ ** $p \leq .01$ *** $p \leq .001$

Calculating the Number of Weight-Loss Methods Tried

This variable was created by summing the responses of Questions 23, 25, 27, 29, and 31 in the ATTITUDES AND LIFESTYLES SURVEY.

These questions each asked whether the respondent tried a particular method of weight loss, scoring 1 for a "yes" answer and 0 for a "no" answer. Therefore, the more weight-loss methods tried by the respondent, the higher his or her score for this variable.

Calculating the Effectiveness of Weight Loss Methods Tried

This variable was created by using scales to determine the effectiveness of five different methods of weight loss,

as reported by the respondent.

Each of Questions 24, 26, 28, 30, and 32 in the ATTITUDES AND LIFESTYLES SURVEY ask the respondent to score the effectiveness of weight-loss methods tried on a scale of 1 to 10. I therefore broke down these scales into three parts to label them each of low, medium, or high effectiveness.

Example: Question 24 asks the respondent to rate their success level with dieting, 1 meaning no success, 10 meaning high success.

Therefore, 3 statements are made for dieting effectiveness:

- If dieting is rated less than 4, then its effectiveness is scored 0.
- If dieting is rated greater than or equal to 4 AND less than or equal to 8, then its effectiveness is scored 1.
- If dieting is rated greater than 8 or is equal to 0 (for those who have never tried dieting), then its effectiveness is scored 2.

Those who have never tried a method of weight-loss are categorized with those who have tried methods of weight loss and found them to be effective.

The same process is completed for Questions 26, 28, 30, and 32, which ask about other methods of weight-loss.

Then, effectiveness of weight loss methods tried is calculated by adding, for each respondent, the effectiveness scores of all five methods included in this survey.

Problems With the Calculation of Effectiveness of Methods Tried

As mentioned in the Discussion section, this variable has its problems as calculated above.

a) It may not have been valid to categorize those who did not try a method with those who tried and were successful. The reasoning behind this was that if someone did not try certain methods, they probably didn't need to (they were attaining success elsewhere). This was done so that the fact that they did not try a method would not bring their average score down. However, this assumption ignored the fact that there could be many other reasons why a person

would fail to try a certain method.

b) A person's rating of a method as successful or unsuccessful could be misleading. For example, Question 24 simply asked about success with diets. A person could have tried many different diets (Slimfast diet, Grapefruit diet, a high carbohydrate diet, etc., etc...) and found success with one of them. They may answer "highly successful" if they only considered the one that worked, or "somewhat unsuccessful" if they considered all of the diets they tried.

c) Another reason that the respondent's answer could be misleading is that it is possible that they may have a different concept of success than the survey intended (i.e. if they lose weight, but experience unwanted side effects which made the method undesirable for them, or find that the method is hard to continue with for varying reasons). Because of this, there may not be consistency with the way the respondent answered the question, and the way it is interpreted.

d) This effectiveness variable could also have been invalid in its calculation because the question of how the ratings averaged out may not have been adequately addressed. (How

is a person who scores all weight loss methods in the middle of the scale compared to someone who scores some of them "highly successful" and some of them "unsuccessful"?)

For the reasons cited above, some problems exist with the use of this variable in analyzing the data for the purposes of this survey.

Curriculum Vita

Julia M. Machara Carleton

Address

7416 Old Mill Road
Norfolk, Virginia 23518

Telephone: (804) 587-2181

Academic & Professional Training

1994 Master of Science in Sociology
Virginia Polytechnic Institute
and State University
Blacksburg, Virginia

Major Professor: Carol A. Bailey, Ph.D.

Master's Thesis: Achieving success in Western society: bulimia as the ultimate effort.

1988 Bachelor of Science in Sociology
Radford University
Radford, Virginia

Major Professor: Steve Lerch, Ph.D.

Honors: Graduated cum laude (1988)

Julia Magdalen Machara Carleton

Julia Magdalen Machara Carleton