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# The Impact of Maladaptive Schema on Disordered Eating: A Collective Case Study

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The Impact of Maladaptive Schema on  
Disordered Eating: A Collective Case Study

by

Susan Hurley

A dissertation submitted in partial fulfillment  
of the requirements of the degree of  
Doctor of Philosophy  
Department of Counselor Education  
College of Education  
University of South Florida

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Table of Contents

List of Tables ..... iv

List of Figures ..... v

Abstract ..... vi

Chapter 1 – Introduction ..... 1

    Introduction ..... 1

        Background ..... 1

        Statement of the Problem ..... 5

        Purpose of the Study ..... 6

        Research Questions ..... 7

        Assumptions of the Study ..... 7

        Conceptual Framework ..... 8

        Definitions of Major Terms ..... 9

        Limitations of the Study ..... 11

        Summary ..... 12

        Organization of the Study ..... 13

Chapter 2 – Literature Review ..... 14

    Anorexia Nervosa ..... 14

    Compulsive Overeating Resulting in Obesity ..... 17

    Bulimia Nervosa ..... 22

    Analysis of Literature Review ..... 45

    Summary ..... 48

Chapter 3 – Design and Methodology ..... 49

    Design and Methodology ..... 49

        Research Issues ..... 50

        Research Design ..... 51

        Research Participants ..... 53

            Participant Selection ..... 53

            Participant Characteristics ..... 55

            Participant Descriptions ..... 56

                Cathy ..... 56

                Laura ..... 57

                Margaret ..... 57

                Joan ..... 58

	ii
Carla.....	58
Jade .....	58
Donna.....	59
Jillian.....	59
Monica .....	59
Andrea.....	60
Data Collection .....	60
Questions.....	61
Interview Procedure .....	62
Data Analysis .....	64
Transcript Analysis .....	64
Data Organization .....	65
Data Coding .....	66
Memo Writing.....	71
Audit Process .....	72
Establishing Trustworthiness .....	73
Summary .....	77
Chapter 4 – Result.....	78
Results.....	78
Case Studies .....	80
Compulsive Overeating Resulting in Obesity.....	80
Cathy .....	81
Joan .....	90
Laura .....	99
Margaret.....	107
Bulimia Nervosa .....	115
Donna.....	116
Jade .....	123
Carla.....	133
Anorexia Nervosa .....	142
Jillian.....	143
Monica .....	150
Andrea.....	155
Summary .....	163
Chapter 5 – Summary and Conclusions.....	169
Summary .....	170
Statement of the Problem.....	170
Methodology .....	171
Findings.....	172
Compulsive Overeating Resulting in Obesity.....	174
Conclusions Regarding Compulsive Overeating Resulting in Obesity .....	184
Bulimia Nervosa .....	188
Conclusions Relating to Bulimia Nervosa.....	197

	iii
Anorexia Nervosa .....	202
Conclusions Regarding Anorexia Nervosa.....	209
General Conclusions .....	211
Contributions of This Study.....	217
Recommendations for Use.....	220
Case Conceptualization.....	220
Planning Interventions .....	221
Training Implications.....	221
Recommendations for Additional Research .....	222
Limitations .....	224
References.....	229
Appendices.....	236
Appendix A – Sample Recruitment Letter	237
Appendix B - Sample Recruitment Letter	238
Appendix C – Sample Questions	240
Appendix D – Informed Consent	242
Appendix E – Journal Log	246
Appendix F - Words and Phrases Most Often Associated With Maladaptive Schema	247
Appendix G -Coding Cathy	249
Appendix H -Coding Joan	261
Appendix I -Coding Laura	274
Appendix J - Coding Margaret	286
Appendix K - Coding Donna	297
Appendix L - Coding Jade	308
Appendix M -Coding Carla	320
Appendix N - Coding Jillian	330
Appendix O - Coding Monica	340
Appendix P - Coding Andrea	349
Appendix Q - Auditor Background Information	359
Appendix R - Auditor Letter of Attestation	360

## Tables

Table 1 Basic Demographic information .....	56
Table 2 Relationship of maladaptive schema to each of the disordered eating categories .....	71; 217

## List of Figures

Figure 1: Relationship among maladaptive schema and disordered eating.....	8
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## Abstract

This qualitative study is based on the reality that disordered eating such as anorexia nervosa, bulimia nervosa, and compulsive overeating resulting in obesity represent a major and growing problem in community health. Treatment models using cognitive behavioral therapy suggest that those diagnosed with an eating disorder tend to judge themselves in terms of their body shape, weight, and eating habits. However, the recovery rate for those treated for an eating disorder that only addresses those three issues identified above is less than 60%. A number of quantitative studies have provided evidence that other maladaptive schema may contribute to bulimic and anorexic behaviors. Fewer studies have addressed this issue in relationship to compulsive overeating resulting in obesity. This collective case study further explored and identified other maladaptive schema associated with anorexia nervosa, bulimia nervosa and compulsive overeating resulting in obesity that interfere in the long term recovery. This case study will allow the participants to express thoughts and emotions surrounding their disordered eating in their own voices. This collective case study provides evidence that persons diagnosed with disordered eating have carried early life events into adulthood and that these events have created maladaptive schema which may be interfering in their recovery process.

## Chapter One

### Introduction

This chapter provides background information regarding the general state of eating disorders and current treatment concerns regarding the role of maladaptive schema. In addition, the chapter explains the statement of the problem and the purpose of the study. At the end of the chapter is an outline indicating how the dissertation in total is organized.

#### *Background*

Disordered eating such as anorexia nervosa, bulimia nervosa, and compulsive overeating resulting in obesity represent a major and growing problem in community health. Recent studies from around the world suggest that the number of recorded cases is increasing across a wide range of ethnicities and cultures (Shiina et al., 2005). In 1999 it was estimated that 8 million women in the United States alone were diagnosed with anorexia nervosa or bulimia nervosa (Wilson & Blackhurst, 1999) and, when left untreated, these disorders may become lethal (Neuman & Halverson, 1983).

Treatment has been a major topic of research for many years. Research in the comparison of various types of therapy used in the treatment of disordered eating suggests that cognitive behavioral therapy is considered the best choice (Agras, Walsh, Fairburn, Wilson, & Kraemer, 2000; Anderson & Maloney, 2001; Hughes, Hamill, vanGerko, Lockwood, & Waller, 2006; Leung, Waller, & Thomas, 2000; Lundgren,

Danoff-Berg, & Anderson, 2003; Rose, Cooper, & Turner, 2006; Waller, Ohanian, Meyer, & Osman, 1999; Wilson & Fairburn, 1993). In general, the treatment protocol for cognitive behavioral therapy when treating eating disorders traditionally includes 20 outpatient sessions that focus on reducing symptoms and building skills (Young, Klosko, & Weishaar, 2003). The cognitive behavioral therapy protocol for the treatment of bulimia nervosa proposed by Fairburn & Cooper in 1989 included 19 sessions of individual treatment over the course of about 20 weeks and focused on addressing (a) body shape, (b) weight, and (c) eating (Wilson & Fairburn, 1993).

Treatment outcomes usually report a high rate of success at approximately 40% to 50% (Agras, 1997; Anderson & Maloney, 2001). However, a study by Agras found that in the treatment of bulimia nervosa there was a 16% drop out rate and of those remaining in treatment about 40% completed the treatment and were considered to be in recovery. While a treatment success rate of 40% is considered high, 50% to 60% of those seeking treatment fail to get results.

Of those women who complete treatment there is also a relatively high rate of relapse reported. Women treated for anorexia report a relapse rate of 36% and women treated for bulimia report a relapse rate of 35% (Keel, Dorer, Franko, Jackson, & Herzog, 2005). The limited scope of treatment focusing on body weight, shape, and eating may provide insight into why approximately 36% of women treated for anorexia and bulimia relapse, and why approximately 50% of those who do seek treatment do not recover. Recent studies suggest that other maladaptive schemas may play a role in disordered eating, and that identifying and including these maladaptive schema in treatment may

increase the rate of recovery (Rose et al.; Waller, Ohanian et al.), as well as decrease the rate of relapse.

Young, Klosko, & Weishaar (2003), defined schema as a broad pervasive theme comprised of memories, emotions, cognitions, and bodily sensations regarding oneself and one's relationships with others. These factors are developed during childhood or adolescence and elaborated on throughout one's lifetime. Once individuals have developed ways of thinking about themselves, there is a strong tendency for these schemas to be maintained, causing a bias in what is attended to, what is remembered, and what people are prepared to accept as true about themselves (Pervine & John, 2001). These schemas control, or at least greatly influence, how people process information. Maladaptive schemas are self-defeating emotional and cognitive patterns that can repeat throughout one's life. If a schema is maladaptive, then negative behaviors may develop in response, which, in turn, distort life events in order to maintain that schema (Young et al.).

Young et al., indicate schemas that develop as a result of toxic childhood experiences may be the core of many chronic Axis I disorders. A child who has been abandoned, abused, neglected, or rejected may experience some type of life event as an adult that is perceived as similar to the childhood experience. This may trigger maladaptive schemas such as defectiveness/shame or mistrust/abuse which could cause a strong negative emotional reaction (Young et al.). However, not all schemas are based in some type of childhood trauma. A person could be overprotected as a child and develop dependent/incompetence schema as an adult.

While not all maladaptive schema are developed through childhood trauma, they are all considered to be destructive and most likely caused by some toxic, repetitive experience that has occurred during childhood and adolescence (Young et al., 2003). Because individuals perceive these schema as absolute truths, they play a major role in how they think, feel, act, and relate to other people, and as adults, they continue to recreate their most harmful childhood experiences (Young et al.). The research suggests that people with disordered eating who have experienced childhood trauma and developed maladaptive schema attempt to cope with the thoughts and emotions surrounding these experiences by either overeating, restricting or bingeing, and purging (Cooper & Fairburn, 2001; Dingemans, Spinhoven & van Furth, 2006; van Hanswijck de Jonge, Waller, Fiennes, Rashid, Lacey 2003; Waller, Meyer & Ohanian, 2001).

Waller et al. (1999) found that binge eating and vomiting related to bulimia nervosa were associated with two of Young's maladaptive schema, defectiveness/shame and emotional inhibition. Bingeing and vomiting were believed to serve to reduce awareness of these maladaptive schema and the emotional consequences that go with it. In their study of sexual abuse in morbidly obese women, van Hanswijck de Jonge et al. (2003) found that overweight or obese women struggling with sexual abuse had more negative core beliefs including defectiveness/shame, vulnerability to harm, social isolation, and subjugation. Women with a higher Body Mass Index also carried stronger maladaptive beliefs regarding emotional deprivation, concerns for abandonment, mistrust, social isolation, unrelenting standards, and subjugation. In a study of bulimia and maladaptive schema, Leung et al. (2000) found that participants with more maladaptive core beliefs were less successful in treatment in a cognitive behavioral

therapy group. Defectiveness/shame, isolation and social undesirability were considered high predictors of a failure to stop vomiting, or at the least reduce vomiting in bulimic participants.

*Statement of the problem*

Cognitive Behavioral models of treatment suggest that people with disordered eating tend to judge themselves in terms of their eating habits, weight, and body shape, and they lack the ability to control these three maladaptive schema (Fairburn, Cooper, & Shafran, 2003). However, the recovery rate when addressing eating habits, weight, and body shape is less than 50% (Agras, 1997). There is also a reported 36% relapse rate for anorexia and 35% for bulimia (Keele et. al., 2005). Several quantitative studies have provided evidence that other early maladaptive schemas may contribute to bulimic behaviors (Leung et al., 2000; Meyer, Waller & Watson, 2000; Spranger, Waller, & Bryant-Whaugh, 2001; Waller, Dickson, & Ohanian, 2002). Fewer studies have addressed this issue in relationship to anorexia nervosa or compulsive overeating resulting in obesity, but the results do suggest similar findings.

Since approximately 50% of those seeking treatment for disordered eating fail to reach the recovery phase, and 36% of those individuals who are reported to reach the recovery phase of treatment relapse, then identifying and addressing other contributing maladaptive schemas may increase the rate of long term recovery. “Once patients identify their maladaptive schema and are provided with coping styles, they may begin to exert some control over their responses” (Young et al., 2003 p. 29) which may provide them better control over their disordered eating, resulting in a happier, more successful recovery experience.

Except for one, all the studies reviewed used quantitative measures. Waller, as well as others, grouped bulimia, anorexia binge/purge subtype, and binge eating disorders together and used small unequal sample sizes. Separating the disorders and studying them individually through the use of a collective case study may yield an expansion on the specific maladaptive schema involved by allowing participants to describe their experiences in their own voices. A qualitative approach will help to establish an empathetic understanding through thick description and a narrative approach which may provide the reader an opportunity to gain an experiential understanding of each case (Stake, 1995).

#### *Purpose of the Study*

The purpose of this study is to further explore and identify potential maladaptive schemas associated with anorexia nervosa, bulimia nervosa, and compulsive overeating resulting in obesity that may interfere in long term recovery. This collective case study will use a natural setting where participants may express, in their own voices, thoughts and emotions they have surrounding their disordered eating. The words they provide will allow this researcher to interpret phenomena based on the meanings people bring to it.

A pilot study conducted by Hurley (2008) identified maladaptive schema associated with bulimia nervosa, anorexia nervosa, and obesity. The study consisted of three individual cases. Each participant was diagnosed with either bulimia nervosa, or anorexia nervosa, or was deemed obese based on the Body Mass Index definition for obesity. All had sought and completed treatment on at least one occasion. However none were able to remain in recovery and had returned to overeating, binging/purging, or restricting food intake. Fifteen of the maladaptive schema categories developed by

Young et al., (2003) were identified through conversation with the participants including, but not limited to, statements associated with mistrust/abuse, emotional deprivation, defectiveness/shame, failure, and social isolation.

This study was limited by the number of participants. Increasing the size of the study within the boundaries of a collective case study may provide further information and the ability to cross analyze the data collected. Through the participants' own voices the results may provide better insight into the development of more successful treatment protocols resulting in a longer and more satisfying recovery.

#### *Research Questions*

The following questions will guide this inquiry: What maladaptive schemas are associated with the development of anorexia nervosa, bulimia nervosa, and compulsive overeating resulting in obesity in adult females? What maladaptive schemas are held in common by these three types of disordered eating?

#### *Assumptions of the Study*

The primary assumption guiding this study is that maladaptive schema, beyond body shape, weight and diet, contribute to the inability to sustain long term recovery for persons with disordered eating, and that effective long term recovery is dependent upon the identification and treatment of these maladaptive schemas. Another assumption is that participants will express statements associated with the categories of maladaptive schema developed by Young et al., (2003). Based on the pilot study, it would be anticipated that all of the participants, regardless of their disorder, would express statements associated with mistrust/abuse, emotional deprivation, defectiveness/shame, dependence/ incompetence, failure, insufficient self control/self discipline, self sacrifice,



approval-seeking/recognition seeking, and unrelenting standards. A further assumption would be that this study will confirm that the compulsive overeaters resulting in obesity and the participants diagnosed with bulimia will express statements associated with abandonment; and the participants diagnosed with bulimia and anorexia will express statements associated with social isolation, enmeshment/undeveloped self, and subjugation. The final assumption guiding the study is that the compulsive overeater and the participants diagnosed with anorexia will make statements associated with emotional inhibition.

### *Conceptual Framework*

The conceptual framework presented in Figure 1 demonstrates the relationship of maladaptive schema to compulsive overeating resulting in obesity, anorexia nervosa, and bulimia nervosa.

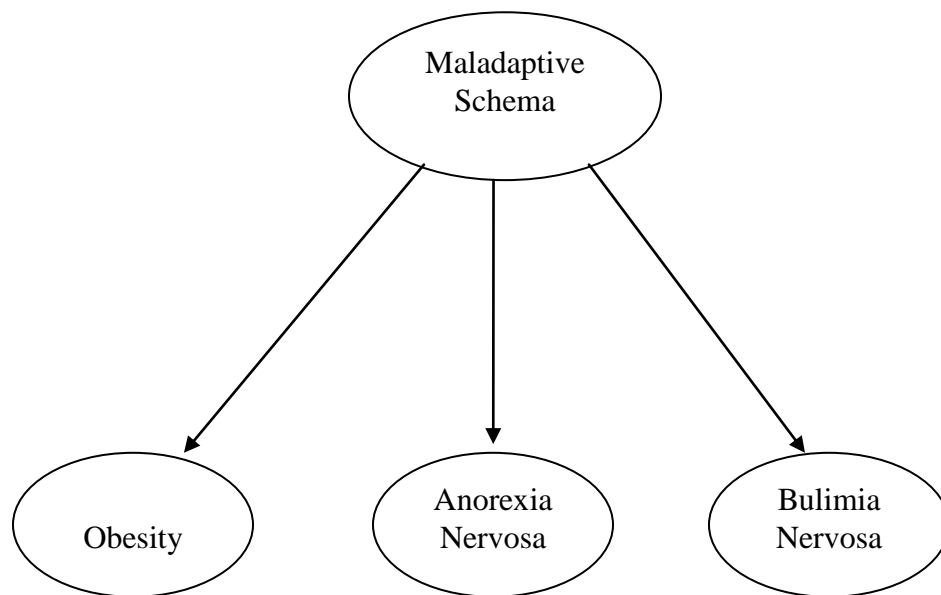


Figure 1  
Relationship among maladaptive schema and disordered eating

“Toxic childhood experiences are the primary origin of maladaptive schema” (Young et al., 2003, p. 10). The schema that develop earliest in life tend to be the strongest. When a maladaptive schema is activated by some situation that a person finds themselves in as an adult, it usually indicates a reoccurrence of an earlier childhood event. Schemas will develop throughout life. However, those that develop later in life tend to be less pervasive and not as powerful. Behavior is not a part of the schema. Instead it is the coping mechanism that drives the behavior, and people use different coping styles to alleviate these maladaptive schema (Young et al.). Some of these behaviors may include the use of compulsive overeating, bingeing and purging, or restricting food in order to not feel certain emotions attached to these maladaptive schemas. Therefore, for the purposes of this study, maladaptive schema are considered to contribute to disordered eating and not the reverse. The goal of this study is to follow as many of the rules as possible regarding qualitative research and the use of case studies to contribute new information regarding the impact of maladaptive schema on the treatment of disordered eating.

#### *Definitions of Major Terms*

*Anorexia Nervosa* – A refusal to maintain body weight at or above a minimally normal weight, resulting in the maintenance of body weight at less than 85% of the expected rate for age and height (American Psychiatric Association, 2000).

*Binge-eating* – Eating within a short period of time an amount of food that is considered larger than an amount the majority of people would eat in a similar amount of time and a sense of being out of control during the eating episode (American Psychiatric Association, 2000).

*Body Mass Index (BMI)*- A measure of body fat calculated by dividing weight in pounds by height in inches squared, and multiplied by a conversion factor of 703 (Center for Disease Control (CDC), retrieved 2009). BMI applies to both men and women, provides a reliable indicator of body fatness for most people, and is used to screen for weight categories that may lead to health problems. For adults 20 years of age and older, BMI is interpreted using standard weight status categories that are the same for men and women of all ages. For adults the standard categories are as follows: a BMI below 18.5 is considered underweight, 18.5 to 24.9 is considered normal, 25.0 – 29.9 is considered overweight, and 30.0 and above is considered obese (CDC).

*Bulimia Nervosa* – Recurrent episodes of binge eating with inappropriate reoccurring behavior to prevent weight gain including vomiting, misuse of laxatives, diuretics, enemas, or other medications; fasting or excessive exercise (American Psychiatric Association, 2000).

*Core Beliefs*: Implicit priori truths that are taken for granted and are considered central to the organization of personality. These core beliefs are generally activated by events that happen relevant to a specific belief (Schmidt, Joiner, Young, & Telch, 1995). (See also Schema).

*Compulsive Overeating* – For the purposes of this study, compulsive overeating is characterized by uncontrollable eating and ultimately weight gain due to excessive caloric intake. Compulsive overeaters generally use food to block out emotional issues.

*Maladaptive Schema* – Life events that have become distorted in order to maintain the validity of an early memory, emotion, cognition, or bodily sensation (Young et al., 2003).

*Obesity* – A condition of abnormal or excessive fat accumulation in the fat tissues of the body caused by consuming more calories than can be expended (European Food Information Council, 2009). For the purposes of this study obesity is a label used for a range of weight due to overeating that is considered to be greater than what is generally considered to be healthy for a given height according to the Body Mass Index (BMI), not due to illness or medical condition. For example, a woman who is five feet six inches tall would be considered obese if she weighed 190 pounds. It also identifies a range of weight that has been shown to increase the likelihood of attracting certain diseases and other health problems.

*Purge* – Self-induced vomiting or the misuse of laxatives, diuretics, or enemas (American Psychiatric Association, 2000).

*Restricting* – Weight loss or weight control by unrealistically limiting the number of calories eaten during a day, fasting or the excess use of exercise (American Psychiatric Association, 2000).

*Schema* – a broad pervasive theme comprised of memories, emotions, cognitions, and bodily sensations regarding oneself and one's relationships with others, which are developed during childhood or adolescence and elaborated on throughout one's lifetime (Young et al., 2003) (See also Core Beliefs).

#### *Limitations of the Study*

For the purposes of this study, participants will be selected based on a diagnosis of anorexia nervosa or bulimia nervosa regardless of subtypes for a total of three participants in each category. The subtype will be noted, however the results of the data collected will not reflect the various subtypes of each disorder. The literature reviewed

for this study does not clearly distinguish between the subtypes of either disorder and regularly included anorexia nervosa binge purge subtype in studies with participants diagnosed with bulimia binge purge subtype. This may suggest that there are no clear differences among the subtypes of the disorders regarding maladaptive schema. This may prove to be a limitation of this study if clear differences between subtypes and maladaptive schema do appear. This study may also be limited by the level of treatment or recovery of the participants. The research is dependent upon the reporting ability of each of the participants and their ability to honestly discuss their thoughts and feelings regarding their eating disorder, family systems, their treatment, and recovery. Another limitation may be the participant's ability to consistently and honestly journal their eating habits and emotions associated with food by under or over reporting behavioral symptoms.

### *Summary*

This qualitative study is based on the reality that disordered eating represents a major health problem around the world (Shiina et al., 2005), and that cognitive behavioral therapy focusing on weight, body shape, and food alone is only effective in approximately 50% to 60% of patients who are treated. Of those women who are reported to reach recovery through treatment, there is a reported relapse rate of 35% to 36% (Keel et al., 2005). Quantitative studies have found that maladaptive schema, beyond body shape and weight, and eating play a role in disordered eating and may have an impact on recovery, but these studies may be limited by the design and scope of the instruments used in data collection. Stake (1995) suggests that qualitative research is used to construct a more sophisticated reality that can withstand skepticism. The use of a

collective case study will add to the body of knowledge by providing meanings that people place on events in their lives as they express in their own voices the role of maladaptive schema in disordered eating.

### *Organization of the Study*

This dissertation will be organized into five chapters. Chapter 1 is an overview of the dissertation topic that is the center of this study. Chapter 2 provides the framework on which the study is grounded and the literature review. Chapter 3 provides a description of the method used for the study and a description of the sample population. Chapter 4 will provide the results of the study, and Chapter 5 will include the discussion of the study including theoretical and practical implications.

## Chapter 2

### Literature Review

This chapter describes previous research regarding maladaptive schema in relationship to anorexia nervosa, bulimia nervosa, binge eating, and compulsive overeating resulting in obesity. It is divided into three sections:

1. A description of anorexia nervosa and related literature
2. A description of compulsive overeating resulting in obesity and related literature.
3. A description of bulimia nervosa and binge eating and related literature

#### *Anorexia Nervosa*

Anorexia is characterized by limited food intake, the misuse of laxatives, and extreme weight loss (Fairburn, Shafran, & Cooper, 1998). Individuals with this disorder fear gaining weight or becoming fat (American Psychiatric Association, 2000). It is a life-threatening condition that carries a significant risk of death due to cardiac complications, including electrocardiography abnormalities, reduced heart rate, metabolic and electrolyte disturbances, blood pressure changes, and mitral-valve prolapsed (Katzman, 2005). There are several points of view regarding the scope of factors involved in the disorder including socio-cultural, family, cognitive behavioral and neurobiological issues (Fairburn, et al.). Anorexia includes two subtypes: (1) restricting

subtype, characterized by restriction of the amount of food sometimes to the point of completely eliminating food from a daily routine, and (2) binge purge subtype which includes the person actively engaging in the use of self-induced vomiting, laxatives, diuretics, or enemas in order to restrict calorie intake (American Psychiatric Association, 2000). Only one study examined the relationship of obsessiveness, dependency, hostility directed at self and assertiveness in undergraduate women as it related to attitudes and behaviors of anorexia (Rogers and Petrie, 1996). The participants included 196 undergraduate women all taking psychology classes at one university. The mean age was 21 years of age and the breakdown of ethnicity included 83% Caucasian/non-Hispanic, 6% Hispanic, 5% African American, 3% Asian American, and 2% Native American Indian.

Each participant was asked to fill out a total of five self-reporting questionnaires. The Eating Attitudes Test (EAT; Garner & Garfinkle, 1979 as cited in Rogers & Petrie) was used to assess symptoms of anorexia in the participants. The Leyton Obsessional Inventory-Questionnaire (LOI-Q; Snowden, 1980 as cited in Rogers & Petrie) was also administered. This is a forced choice questionnaire concerning chronic thoughts about obsessive symptoms and traits of rigidity, perfectionism, and excessive attention to detail. The third measure used was the Interpersonal Dependency Inventory (IDI; Hirschfield et al., 1977 as cited in Rogers & Petrie). This measure was used to assess thoughts, feelings, beliefs, and behaviors associated with the needs and values of other people important in the participant's life. Fourth, the Hostility and Direction of Hostility Questionnaire (Caine, Foulds, & Hope, 1967 as cited in Rogers & Petrie) uses 51 items selected from the Minnesota Multiphasic Personality Inventory which measures the



degree and direction of hostility. Lastly, each participant was asked to take the Rathus Assertiveness Schedule (RAS; Rathus, 1973 as cited in Rogers & Petrie). This schedule measures the extent to which the participants expressed assertive behaviors in various simulated social situations. The students were all tested at the same time in a group session where all five tests were administered back to back.

The results indicated that higher EAT scores were related to obsessive traits ( $r = .42$ ) and a higher emotional reliance on other people ( $r = .35$ ) both of which are essential features in the diagnosis of anorexia nervosa. There did not appear to be a correlation between anorexic symptoms and self-directed hostility ( $r = .18$ ). There also appeared to be no relationship between symptoms of anorexia and assertiveness ( $r = -.09$ ). Earlier studies had found that anorexics and bulimics had difficulty in asserting themselves and indicated being hostile toward themselves. The authors suggested that the lack of a relationship in this study may be due to the fact that none of the participants had been diagnosed or treated for anorexia prior to this study. They also suggested that the women may know how to answer the questions in an assertive manner when responding to an assertiveness questionnaire, but may not actually respond assertively when confronted in real life situations.

Limitations reported in the study included the reliance on self report measures and the number and amount of time given to fill out all five measures. Another limitation was that none of the women involved in this study had been previously diagnosed with an eating disorder and the EAT only reports that there is a propensity for the test taker to have an eating disorder. The EAT does not provide a diagnosis. The authors were also concerned with the possibility that some participants may have under or over reported

symptoms. Lastly, the sample was drawn from a single source which restricts the generalizability of the results.

There appear to be limited studies specific to anorexia restrictive type involving core beliefs beyond weight and body shape. Studies regarding bulimia also included anorexia, particularly the binge purge subtype. Those studies are reported in the section on bulimia nervosa.

### *Compulsive Overeating Resulting in Obesity*

Childhood and adult obesity is considered a major health problem particularly in the United States (Cooper & Fairburn, 2001; Flegal, Carroll, Kuczmarski, & Johnson, 1998). On a daily basis one can find reports, articles, and stories in the media regarding the growing concerns for obesity in the U.S. and the health risks involved in being overweight or obese. People with weight problems are more likely to have any number of health issues including heart disease, hypertension, stroke, diabetes, osteoarthritis, and some forms of cancer (Bray, Bouchard & James, 1998 as cited in Cooper & Fairburn). Approximately 50% of the population in the United States is overweight and 20% are considered to be extremely overweight or obese (Flegal et al., 1998; Visscher & Seidell, 2001).

There are numerous popular diets and weight loss programs that promise to provide a solution to being overweight however none appear to provide a long-term solution to the problem. Research indicates that people who are obese can lose weight. However, they almost always regain it: one-half regain the weight lost within the first year, and approximately 80% regain all the weight or exceed their former weight within

five years (Byrne, Cooper, & Fairburn, 2003). If simply losing the weight was the issue, then maintaining the loss would not be a problem.

For the purposes of this study, compulsive overeating resulting in obesity is the condition of elevated fat masses in the body caused when the use of food and eating are the result of emotions, rather than due to physical feelings of hunger. The underlying cause is a positive energy balance that leads to weight gain because the number of calories consumed exceeds the number of calories expended (European Food Information Council, 2009). While there can be medical reasons for obesity, such as thyroid disease, for the purposes of this study, overeating is considered to be an emotional response to thoughts and feelings. Compulsive overeaters tend to eat in an effort to control or regulate mood, or to avoid negative feelings, and they have a dichotomous thinking style (Byrne, Cooper, & Fairburn, 2003).

Only two studies were found that discussed a connection between core beliefs and compulsive overeating resulting in obesity. vanHanswijck de Jonge et al. (2003), investigated sexual abuse and negative core beliefs associated in morbidly obese adults. The hypothesis was that adults who were victims of childhood sexual abuse would have a higher Body Mass Index (BMI) and less weight fluctuation than obese individuals who had no history of sexual abuse (vanHanswijck de Jonge et al.). Participants were men (n=6) and women (n=24) who were referred for assessment as candidates for gastric bypass surgery. No other demographic information was provided.

Each participant provided a weight history and completed two questionnaires that measured childhood experiences of abuse, neglect, and current core beliefs. The first was the Childhood Abuse and Trauma Scale is a 38-item self report questionnaire that

addresses various childhood and adolescent traumatic experiences (Saunders & Becker-Lausen, 1995 as cited in vanHanswijck de Jonge et al.). A review of the responses indicated that 10 of the 30 participants reported a history of abuse.

The second measure was the Young Schema Questionnaire Short form (YSQ-S). Young (1998 as cited in vanHanswijck de Jonge et al., 2003) developed the YSQ as a measure to identify maladaptive schema. The original test contains 205 items and 18 scales and is now referred to as the YSQ-L. The short version includes 75 items and 15 of the original 18 scales (vanHanswijck de Jonge et al.).

The results indicated that morbidly obese patients who reported being sexually molested had significantly higher scores on the YSQ-S scales of defectiveness/shame ( $r = .47$ ), social isolation ( $r = .74$ ), vulnerability to harm ( $r = .45$ ), and subjugation ( $r = .60$ ). For the nonabused group, only dependence/ incompetence ( $r = .43$ ), and entitlement beliefs ( $r = .55$ ) appeared to be associated with a high BMI, but not considered morbidly obese. Those with a high BMI and reporting sexual abuse showed a wider range of negative core beliefs relating to emotional deprivation ( $r = .74$ ), abandonment ( $r = .67$ ), social isolation ( $r = .74$ ), subjugation ( $r = .60$ ), and unrelenting standards ( $r = .82$ ).

The researchers concluded that the level of weight fluctuation between the abused and nonabused groups was minimal; however, the abused group had more negative core beliefs. Women with a higher BMI had stronger maladaptive beliefs regarding emotional deprivation ( $r = .74$ ), concerns for abandonment ( $r = .67$ ), social isolation ( $r = .74$ ), unrelenting standards ( $r = .82$ ), and subjugation ( $r = .60$ ). Also, the degree to which their weight had changed during adulthood was positively associated with issues of abandonment and social isolation (vanHanswijck de Jonge et al.). The use of a small

sample size, and gathering participants from one source were both suggested limitations of this study. It was also noted that men and women tended to react differently to sexual abuse, and the inclusion of men in this study may have had a slight impact on the results.

Byrne et al. (2003) used a qualitative method to explore the psychological factors involved in successful or unsuccessful weight maintenance in women with a history of obesity. The main purpose of the study was to identify factors that differentiate participants who could maintain a weight loss and those who regained the weight. The 76 female participants ranged in age from 20 to 60 years and were recruited through an advertisement in a local newspaper. The women were divided into three groups, maintainers ( $n=28$ ), regainers ( $n=28$ ), and stable healthy weight ( $n=20$ ). The maintainers included women who had successfully lost 10% of their initial body weight and had maintained the weight loss for at least one year. The regainers were women who had lost 10% of their initial body weight but had not maintained the loss, and the stable healthy weight group was women who had no history of obesity and had maintained a healthy weight for at least two years.

The study was done in two phases. In phase one, in-depth interviews with 20 women from each group were held. The entire text of each interview was reviewed and coded into a total of 64 possible categories and statements that represented similar themes. For example, if the participant made a comment about body image, it was coded under that category. The mean intercoder reliability coefficient across all the interviews was  $r = 0.75$ ,  $P > 0.01$  (Byrne et al., 2003).

Phase two included two separate group interviews with eight women, four from the maintainers and four from the regainers groups who had not participated in an

individual session. The second part of the project was intended to identify whether the factors identified in part one could be supported by a new group of participants using a different method to collect data. A vignette was presented to each group regarding Mrs. Brown, a regainer. The story was read to the participants and then a series of questions followed asking the participants if they agreed that Mrs. Brown would have acted in the way described in the vignette. Discussion between the group members was encouraged and a researcher kept track of how many participants agreed or disagreed with Mrs. Brown's reaction. The transcripts from each group were then coded to determine if the hypothesis from phase one was supported. Factors that generated less than a 50% agreement were discounted.

The factors that differentiated maintainers from regainers fell into three broad categories: behavioral, cognitive, and affective factors (Byrne et al. 2003). Behaviorally, 87% of maintainers reported sticking to a low-fat diet versus 0% of regainers. Maintainers were able to be consistent with an exercise regime (73%) while only 7% of regainers continued to exercise regularly. Lastly, maintainers frequently monitored their weight (73%) whereas only 40% of the regainers continued to monitor weight.

Cognitively, 87% of the maintainers reported satisfaction from their weight loss and only 40% of regainers reported satisfaction. Regainers placed a higher value on weight and shape in reference to self-worth (73%) and were more critical about their lack of weight loss or lack of achieving a specific goal (40%). Maintainers placed a lower value on weight, shape, and self worth (13%). Even though both maintainers and regainers reported having serious life events occur since they lost weight, the maintainers did not use food to cope with stressful events. Ninety-one percent of the regainers

reported that they were more likely to use food under adverse circumstances to reduce stress or anxiety.

The results suggest that issues of obesity are not exclusively biological in nature, and psychological factors may play a role (Byrne et al., 2003). The strengths of this study were the use of two different methods to collect data and multi-coding using more than one independent researcher. Limitations of the study included potential subject recall bias indicating that the regainers may have been more likely to evaluate self-worth in terms of weight and shape simply because of their lack of success with weight loss (Byrne et al.).

### *Bulimia Nervosa*

Bulimia nervosa was first identified as a distinct disorder by Gerald Russell, M.D., in the 1970's (Mehler, Crews, & Weiner, 2004). Bulimia nervosa is characterized by gorging oneself on enormous amounts of food and then vomiting in an effort to reduce stress and anxiety (Anderson & Maloney, 2001). Bulimia has two subtypes, (1) the purging type involves the person regularly engaging in self-induced vomiting or misuse of laxatives, diuretics or enemas, and (2) non-purging subtype involves the person using other inappropriate compensatory behaviors such as fasting or excessive exercise, but does not regularly engage in self-induced vomiting or the misuse of laxatives, diuretics, or enemas (American Psychiatric Association, 2000). Both subtypes can result in serious medical problems.

Medical complications include renal and electrolyte abnormalities such as a loss of potassium due to chronic vomiting, diuretic use, and laxative abuse (Mehler et al.). After bulimic individuals binge on food, they will immediately vomit. The gastric juices used

in the stomach for the digestion are eliminated along with the food which will cause erosion of the enamel on the teeth. Esophageal rupture, although considered rare, is a life threatening complication for bulimic individuals. Other concerns are chronic constipation or flaccid colon causing a loss of control over bowel function. Bulimic individuals also may develop cardiac complications including mitral valve prolapsed (Mehler et al.). Bulimia appears to be the most researched of the eating disorders in reference to maladaptive schemas.

Beam, Servaty-Seib, & Mathews (2004) hypothesized that college age women who experienced a loss of a parent through divorce or death were more likely to have an eating disorder than peers who had not experienced the same loss. Using a quantitative study, 48 women from one college were randomly selected who either had divorced parents (N=16), had experienced the death of a parent (N=16), or were from intact families (N=16). The participants ranged in age from 18 to 24 years. No other demographic information was reported. Two quantitative instruments were used. The Mizes Anorectic Cognitions Scale (MAC) is a 33-item questionnaire with a five-point scale that measures cognitions associated with anorexia nervosa (Mizes & Klesges, 1989 as cited in Beam, et al.). The Bulimia Test-Revised (BULIT-R) contains 36 multiple-choice items that measure symptoms and behaviors associated with bulimia nervosa and are considered highly sensitive in identifying bulimia nervosa in college aged women (Thelen, Farmer, Wonderlich, & Smith, 1991 as cited in Beam et al.). To assess differences in eating patterns among the three groups a single-factor between-subject multivariate analysis of variance was conducted,  $F(4, 88) = 2.85, p < .05$ , using membership as the quasi-independent variable and the MAC and BULIT-R scores as the



dependent variables. The univariate main effect for the MAC was significant  $F(2, 45) = 3.80, p = .05$  (two-tailed). A Tukey post hoc analysis indicated that participants who had experienced the loss of a parent through death ( $M = 103.38, SD = 12.90$ ) had significantly higher scores than those who had experienced the loss of a parent through divorce ( $M = 89.38, SD = 14.69$ ).

Researchers reported no significant differences regarding bulimic-related behaviors among the groups. The results of the MAC indicated that students who had lost a parent through death scored higher than those experiencing a loss through divorce, or those with an intact family. It was suggested that students who experienced the loss of a parent were more at risk for developing anorexia than bulimia (Beam, et al., 2004). There was no significance to the scores of students with divorced parents or students with intact family systems. One possible explanation is that divorce is so commonplace in our society that children and adolescents tend to consider a divorced family as normal (Beam et al. 2004). It is also possible that because children of divorce generally still spend time with both parents they do not experience the loss in the same way as those children who have lost a parent due to death. Limitations included not addressing possible confounding variables such as socio-economic status, social support systems, emotional difficulties, age of loss, and the quality of the child-parent relationship all of which may play a part in how someone recovers or copes with loss.

Leung et al. (2000) investigated the role of core beliefs in the treatment of bulimia nervosa. The study included four groups of 20 adult females, diagnosed with bulimia nervosa. Each group received a 12-week program of cognitive behavioral therapy focused on beliefs regarding eating, body shape, and weight. Two questionnaires were

administered pre and post treatment, the BULIT-R and the MAC. The YSQ-L was administered only pretreatment. The BULIT-R, measures bulimic symptoms and the frequency of binge eating, purging, and weight fluctuations. Higher scores on the BULIT-R indicate higher levels of bulimic psychopathology. The MAC measures cognitions associated with anorexic and bulimic behaviors. High scores on the MAC indicate maladaptive cognitions in self-esteem, self-control, and approval from others (Leung et al.). Each participant also kept a log of their binge eating and purging activities throughout treatment.

There was a significant link between social undesirability and bulimic behaviors ( $F = 70.7, p < 0.0001$ ). The overall association of emotional deprivation beliefs and pretreatment MAC scores was significant ( $F = 16.1, p < 0.0001$ ). The overall pairs of variables with BULIT-R scores were also significant in all cases ( $F > 2.54, p \leq 0.05$ ). Multiple regression analyses were used to identify the most parsimonious set of core beliefs that would predict change in bulimic attitudes. The first regression showed changes in the BULIT-R predicted by the YSQ –L scale scores and pretreatment pathology (overall  $F = 4.62, p < 0.02$ ; explained variance = 43%). The results indicated that participants with more maladaptive core beliefs were less successful in treatment. Defectiveness/shame, isolation, and social undesirability were considered high predictors of a failure to stop, or even reduce, vomiting in bulimic participants. The study concluded that for some individuals the existing model of cognitive behavioral therapy could be more effective if it included more core beliefs other than those associated with food, body shape, and weight (Leung et al., 2000).

Jones, Harris, & Leung (2005) provided an exploratory study to investigate whether women in recovery from an eating disorder maintain different patterns and levels of core beliefs than women who are currently suffering from an eating disorder. This study investigated whether specific core beliefs were particularly related to eating disordered behaviors and attitudes. Surveys were sent to members of the Eating Disorders Association. All those included in the study reported that they were in recovery or currently suffering with an eating disorder. Each participant completed the YSQ-S (Young, 1998 as cited in Jones et al.) and the Eating Disorders Inventory (EDI; Gardner, Olmstead, & Polivy, 1998 as cited in Jones et al.). Of the 180 packets that were sent out, 95 were returned completed and useable. These results were divided into two groups: those who stated they were currently struggling with an eating disorder ( $N=66$ ), and those who indicated they were in recovery ( $N=29$ ). There was also a control group ( $N=50$ ) of women who denied ever having an eating disorder.

A significant effect across groups on the EDI subscale scores ( $F = 38.98, p < 0.001$ ) was found. The groups differed on all four EDI subscales: drive for thinness ( $F = 46.71, p < 0.0001$ ), bulimia ( $F(2, 142) = 13.54, p < 0.001$ ); body dissatisfaction ( $F = 19.60, p < 0.001$ ); and EDI total ( $F = 68.87, p < 0.001$ ). The results indicated that women currently struggling with an eating disorder showed more pathological scores on the EDI, and women who reported being in recovery showed more pathological scores on the drive for thinness scale. Across groups there was a significant overall effect on the subscales of the YSQ-S ( $F = 12.98, p < 0.001$ ), and the individual effects showed differences on 13 of 15 scales.

Women who admitted to currently struggling with an eating disorder scored significantly higher than either women in recovery or a control group on all core belief scales except for emotional deprivation, abandonment, and self-sacrifice. Women in recovery and the control group showed no difference in their levels on the subscales. Women in recovery showed lower scores on mistrust/abuse, social isolation, defectiveness/shame, failure to achieve, and vulnerability to harm than women with a current eating disorder, but their scores were still significantly higher than those in the control group. The study concluded that women who believe they are in recovery still have elevated scores on drive for thinness and eating psychopathology confirming previous studies that indicate that eating and weight concerns still persist, even in recovery (Srinivasagan et al., 1995; Stein et al., 2002 as cited in Jones et al., 2005). Also, women within the group who were currently struggling with bulimic behaviors had more beliefs about abandonment and vulnerability to harm than women who described themselves as having anorexic behaviors. The study does show that women who appear to be in recovery retain negative core beliefs at a lower level than those still struggling with the disorder. This may make them vulnerable to relapse.

A study on perfectionism and eating disorders was contributed by Joiner et al., (1997). The purpose of this study was to show that bulimic symptoms and perfectionism were highly related to one's perception of weight. Eight hundred questionnaires requesting demographic information including height and weight were randomly distributed at Boston University. Along with the demographic information the participants were asked to complete the perfectionism and bulimia subscales from the EDI (Garner, Olmsteac & Polivy, 1983 as cited in Joiner et al.). Of the 800 surveys that

were sent to a randomly selected sample of women, 435 were returned. The EDI Bulimia subscale correlated strongly with the diagnostic variable ( $r = .56, p < .001$ ) and with perceived weight status ( $r = .49, p > .005$ ). The EDI Bulimia subscale correlated strongly with the diagnostic variable ( $r = .56, p < .001$ ) with perceived weight status ( $r = .49, p < .001$ ), and with Body Mass Index ( $r = .35, p < .001$ ). The results indicated that those who were diagnosed with bulimia on the EDI and saw themselves as overweight were more likely to score high on the perfectionism scale.

To test predictions regarding the interaction between perfectionism and perceived weight status, a set wise hierarchical multiple regression/correlation was conducted. The EDI Bulimia subscale scores were used as the dependent variable. The perfectionism subscales and a dichotomous variable regarding perceived weight (1= do not feel overweight and 2 = feel overweight) were used in a regression equation simultaneously as a set, followed by the perfectionism and perceived weight status interaction term. The results indicated that perfectionism is weakly related to bulimic symptoms ( $\beta = .18, t(432) = 3.75, p < .05$ ); and perceived weight status provided a stronger relationship ( $\beta = .48, t(432) = 11.42, p < .05$ ). Perfectionism and perceived weight status interaction served as a significant predictor of EDI bulimia scale scores ( $\beta = .12, t(431) = 2.47, p < .05$ ).

Results from this study indicate that perfectionism is related to bulimic symptoms particularly when the participants believed they were not at the perceived ideal weight. One reported limitation of the study was the 54% return rate on the questionnaires which may suggest a biased response. It was also reported that because the participants were all undergraduate women from one university, the results may not generalize to other

populations. This study focused on perfectionism as it relates to body image and symptoms of bulimia. It did not address other maladaptive thoughts which may lead to perfectionism or how perfectionism may otherwise affect bulimic behavior. This may limit its use in identifying better treatment protocols regarding maladaptive schemas associated with eating disorders.

Glenn Waller participated in or has led several studies regarding the effects of core beliefs on the treatment of eating disorders. Waller, Ohanian, Meyer, & Osman, (1999) addressed the issue of core beliefs and the effect on binge purge behaviors in bulimic women. The questions addressed in this study were: (1) do different eating disorders (e.g., bulimia nervosa, anorexia nervosa binge purge subtype, and binge eating) show different patterns of core beliefs relative to each other and to a comparison group of women; and (2) are there links between core beliefs and the severity of bulimic symptomology (Waller et al.)?

The YSQ-L was used excluding the scales that focused on food, shape, and weight since these three core beliefs are currently being addressed within treatment. The study included 50 women diagnosed with bulimia nervosa (N=28), anorexia nervosa binge/purge subtype (N=12), and binge eating disorders (N=10). The breakdown also included a comparison group of non-clinical women (N=50; Waller et al.). The results of the MANOVA show a clear difference across groups ( $F= 2.21; p < .001$ ). Individual effects showed differences between the groups on 15 of the 16 YSQ-L subscales. The comparison group had lower scores on the core beliefs than at least one of the bulimia groups except for the subscale of entitlement which showed no significant difference. Multiple regressions were performed to predict levels of bingeing and vomiting among the

bulimic group. Only 15 of the subscales were used as independent variables, excluding social undesirability. Bulimic behavior was used as the dependent variable. The YSQ-L subscales together were able to reliably predict binge behavior ( $F = 2.43; p < .02$ , explained variance = 32.4%), but on the individual scales the only significant predictor was emotional inhibition ( $t = 3.46, p < .001$ ). The frequency of vomiting was also reliably predicted ( $F = 2.88, p < .03$ , explained variance = 30.0%) but the only significant predictor was defectiveness/shame ( $t = 2.09, p < .05$ ).

The research suggests that core beliefs can differentiate those with bulimia nervosa and may predict bingeing and vomiting behaviors. The results suggest that bingeing and purging are related to reducing the ability to experience emotions particularly those associated with shame and defectiveness. Vomiting is used to lessen awareness of negative feelings, and bingeing is used to try and regulate function. The findings suggest the importance of considering the inclusion of negative core beliefs in the treatment of eating disorders (Waller et al., 1999). A limitation of this study was the use of small and uneven sample sizes which may interfere with generalization of the results.

Waller, Dickson, & Ohanian (2002) compared the YSQ with the Eating Disorder Inventory (EDI-2; Garner, 1991) to establish which core beliefs are associated with ego-dysfunction characteristics and unhealthy attitudes toward eating. This study involved women diagnosed with bulimia nervosa (N=45), women with anorexia nervosa binge purge subtype (N=17), and women diagnosed with a binge eating disorder (N=13). The study hypothesized that the unhealthy core beliefs of poor self-esteem, problematic social relationships, maturity fears, perfectionism, self-denial, poor interoceptive awareness, and

poor impulse control are associated with the levels of predisposing factors to bulimic attitudes.

A Pearson's Product Moment Correlation was used between the scales on the YSQ and eating related scales of the EDI-2. The results indicated that restrictive eating was associated with the perception of dependence ( $r = .35, P < .01$ ), and an inability to express emotions ( $r = .43, P < .01$ ). Women who displayed more bulimic attitudes perceived themselves as socially different ( $r = .35, P < .01$ ), deprived of emotional support ( $r = .36, P < .01$ ), and as having low self-control ( $r = .49, P < .01$ ). When these results were compared to the EDI-2, there appeared to be no association between ego dysfunction and beliefs about dependence and incompetence. However, emotional inhibition was associated with characteristics of ego dysfunction (Waller et al. 2002). The research concluded that core beliefs beyond weight, body shape, and eating are central triggers for eating disturbances, and therefore, should be included in treatment programs. A limitation of this study is the use of small and uneven sample sizes. It was suggested that the study should be replicated using larger sample sizes (Waller et al.).

In a study focusing on binge eating, Waller (2002) hypothesized that core beliefs in individuals diagnosed with a binge eating disorder would differ from a nonclinical group, but that their beliefs would be less pathological than individuals diagnosed with bulimia nervosa. This is the first study where Waller utilized groups of equal size, age, and weight levels. The groups consisted of women diagnosed with a binge eating disorder (N=25), bulimia nervosa (N=25), and a control group of nonclinical women (N=25). All the individuals involved in this study completed the short version of the YSQ. The scales of the YSQ-S were compared using a multivariate analysis of variance,



with a conservative alpha level ( $p < 0.003$ ) to reduce Type I errors. Post hoc pair wise Tukey tests were performed to determine the source of any differences among the groups on individual scales of the YSQ-S. The overall effect of the MANOVA showed significance ( $F [32,114] = 6.26, p < 0.001$ ). The two clinical groups showed higher scores than the nonclinical women on 10 of the 15 YSQ-S subscales. However, only three subscales showed significant differences between the clinical groups. The binge eating group had more pathological core beliefs than the participants diagnosed with bulimia. Discriminate functional analysis showed that two functions could distinguish the three groups reliably ( $F [4, 70] > 6.40, p < 0.001$  in all cases). This included positive loadings for the scales of emotional inhibition, dependence/incompetence, abandonment, and a negative loading for self sacrifice.

The author concluded that the binge eating disordered group was characterized by more pathological core beliefs than was the control group. However, the pathology of the core beliefs between the binge eating group and the bulimic group showed similar levels but differed in the nature of the beliefs. For example, the binge eating group had negative beliefs about their ability to experience emotions, to function independently, and a need to sacrifice self for others, but had lesser concerns regarding the likelihood of being abandoned than did the bulimic group. This would suggest from a treatment perspective that binge eating disorder and bulimia groups would benefit from schema focused therapy.

Waller, Meyer, & Ohanian (2001) compared the use of the long and short forms of the Young Schema Questionnaire (YSQ) to identify core beliefs in bulimic women. The long form of the YSQ includes 205 items and takes time to fill out. The shorter

version is only 75 questions. The purpose of the study was to determine if the short version is as affective in identifying maladaptive schema as the longer version. The participants included women diagnosed with bulimia nervosa (N=60) and a control group of women with no clinical diagnosis (N=60). They were all asked to take the long version of the YSQ. For the purpose of this study, the 75 questions from the short version were extracted from the long version so that the participants only took the test one time. The comparison of scores on the long and short version of the YSQ showed that the comparison group had similar total scores but differed on six of the 15 individual scales, including functional dependence, subjugation, self sacrifice, social isolation, unrelenting standards, and vulnerability to harm ( $t > 2.80, p < .01$  in all cases). The bulimic group showed no differences on total scores but differed on five of the individual scales including functional dependence, insufficient self-control, unrelenting standards, self sacrifice, and entitlement ( $t > 2.20, p < .05$ , in all cases). The correlations of the overall scales for the clinical comparison of all groups was  $r = .98$ , and  $r = .93$  and the correlation between forms was  $r = .84$  ( $p > .001$ ) which would suggest that removing items from the long version has no real effect on the central tendency of the scores (Waller et al.).

The results suggest that the YSQ-S provides practical advantages because of its length and that it showed similar levels of internal consistency to the long version of the test. The authors reported some differences in the scores from both versions, but indicated that it was not enough to make a difference in the results. It was recommended as a reliable instrument for diagnostic purposes but recommended that a therapist might want to consider the longer version for detailed information regarding beliefs that make

up a specific schema. Limitations to this study include the use of the YSQ-L only and then adjusting it by removing questions that were not on the YSQ-S. It is suggested that another test should be run actually using both versions of the test. Lastly, it should be determined whether or not both versions of the test are comparable among different clinical groups and across genders. This would make the YSQ very useful as a research tool to assess core beliefs and their relationship to psychopathology (Waller et al., 2001).

Dingemans, Spinhoven, & van Furth (2006) expanded on earlier studies concerning the relationship of maladaptive core beliefs and the symptoms of eating disorders in an effort to tie the occurrence of specific core beliefs to specific eating disordered behaviors such as vomiting, bingeing, and misuse of laxatives. The participants included women ( $N=100$ ) and men ( $N=6$ ) diagnosed with an eating disorder and a control group of healthy females ( $N=27$ ). The participants were grouped according to a DSM IV- TR (American Psychiatric Association, 2000) diagnosis for Anorexia Nervosa ( $N=16$ ), Anorexia Nervosa Binge Purge Subtype ( $N= 31$ ), Bulimia Nervosa ( $N=23$ ), Binge Eating ( $N=36$ ) and a control group ( $N=27$ ). Each participant completed the YSQ and the Bulimic Investigatory Test Edinburgh (BITE), a 33-item self-report questionnaire that assesses the presence and severity of bulimic symptoms (Henderson & Freeman, as cited in Dingemans et al., 2006). Each participant also participated in a semi-structured interview.

A significant overall difference was found on the YSQ higher factors (ANOVA,  $p < 0.0001$ ) between the four groups and the control group. Post hoc Tukey's HSD tests showed that the participants with an eating disorder showed significantly more pathological core beliefs than the control group. They also found that patients with a

binge eating disorder showed significantly fewer maladaptive core beliefs than patients with anorexia nervosa, binge purge subtype. Through the interview process, a significant negative correlation was found between Body Mass Index (BMI) and maladaptive core beliefs and this finding was used as a covariate in the study.

For the purposes of this study, 16 of Young's maladaptive schema were organized into four higher order factors based on a previous study by Lee, Taylor, & Dunn (1999, as cited in Dingemans et al., 2006). The four higher order factors and the maladaptive schema which were included in each are: (a) disconnection, including abandonment/instability, defectiveness/shame, emotional deprivation, mistrust/abuse, social isolation and emotional constriction; (b) impaired autonomy, including dependence /incompetence, vulnerability to harm, enmeshment, failure, subjugation, insufficient self-control; (c) impaired limits, including entitlement/grandiosity and fear of loss; and (d) over-control, including self-sacrifice and hypercriticalness (Dingemans et al.) A post-hoc Tukey test indicated that a low BMI was associated with more maladaptive core beliefs on three of the four higher order factors: disconnection ( $r = -0.30, p < 0.001$ ), impaired autonomy ( $r = -0.29, p < 0.01$ ), and over-control ( $r = -0.31; p < 0.01$ ). No significant correlations were noted between frequency of binge eating and any of the four factors, however, significant correlations were found between frequency of vomiting and disconnection ( $r = .24, p < .05$ ), impaired autonomy ( $r = .26, p < .05$ ) and impaired limits ( $r = .27, p < .05$ ). There were also significant correlations between laxative use and disconnection ( $r = .36, p < 0.01$ ), impaired autonomy ( $r = .36, p < 0.01$ ), and impaired limits ( $r = .32, p < 0.01$ ) and fasting and disconnection ( $r = .30, p < 0.01$ ), impaired autonomy ( $r = .28, p < 0.01$ ) and impaired limits ( $r = .27, p < 0.01$ ).

The researchers concluded that those individuals with an eating disorder showed unhealthier core beliefs than did the control group. Anorexics and bulimics did not differ in the degree of unhealthy core beliefs, but those with a binge eating disorder scored much more like bulimics than anorexics. The results also indicated that those individuals who had inappropriate compensatory behaviors, such as vomiting, were more likely to exhibit maladaptive core beliefs (Dingemans et al. 2006), suggesting that purging and fasting behaviors may not be used just to control weight. They may also serve the purpose of providing a sense of empowerment, rebellion, punishment or self-defeating behaviors. Also, it was suggested that individuals who binge and purge find a sense of relief, relaxation, and/or numbness after vomiting (Dingemans et al.).

Limitations of the study included unequal and small sample sizes. The study was based on cross-sectional data which may not allow for statements about the causal relationships between core beliefs and patients with anorexia and binge eating disorders. Another possible limitation to the study may be the inclusion of a small number of men as van Hanswijck de Jonge et al. (2003) suggested men and women may react differently regarding events and core beliefs which may impact the results. By grouping Young's maladaptive schema into four categories, this study also did not identify the specific core beliefs related to each eating disorder.

Cooper, Rose, and Turner (2006) used a variety of tests to identify the specific core beliefs and schema that are associated with eating disorders but not associated with depression. The study included 52 adolescent females, recruited through high schools, who scored 30 or more on the Eating Attitude Test (EAT, Gardner & Garfinkle, 1979 as cited in Cooper et al.). A score of 30 or higher on the EAT is considered the clinical

cutoff to diagnose an eating disorder. The students were all volunteers and completed the testing measures individually and anonymously. Demographic information regarding age, weight and height was collected. Each participant was asked to complete the Beck Depression Inventory (BDI; Beck & Steer, 1993 as cited in Cooper et al.), the Eating Disorder Belief Questionnaire (EDBQ; Cooper, Cohen-Tovee, Tood, Wells, & Tovee, 1997 as cited in Cooper et al.) and the Young Schema Questionnaire (YSQ; Young, 1994 as cited in Cooper et al.).

Those participants who scored high on the EAT scored significantly higher than the low EAT group on the BDI (low EAT; mean 4.56, SD = 3.6; high EAT: mean = 20.2, SD = 10.2) indicating that the high EAT group showed more depressive symptoms. The high EAT group also scored significantly higher on the negative self beliefs subscale of the EDBQ, on the total YSQ and on all but one of the subscales of the YSQ. The number of clinically significant schema endorsed by the high EAT group (mean 13.8, SD = 11.8) was significantly higher than the low group (mean 3.0, SD = 3.0). Partial correlations and links to specific core beliefs and symptoms of eating disorders were found that were not explained by depression (Cooper et al.). Only three items from the YSQ were related to EAT with the BDI score partialled out mistrust/abuse, emotional inhibition, and insufficient self control ( $p = .05$  for all).

Cooper et al., (2006) conclude that this research provides a first step toward identifying specific core beliefs associated with eating disorders unrelated to depressive symptoms. Limitations of the study included the lack of a clinical group of participants diagnosed with an eating disorder, and not separating participants with symptoms of

anorexia versus those with symptoms of bulimia. A study should be considered separating the two eating disorders.

A two part study by Hayaki, Friedman, and Brownell (2002) expanded on other investigations of the relationship of shame related specifically to bulimia nervosa. The first study used female undergraduate students ( $N=137$ ) with mild to moderate levels of bulimic symptoms. The second study used a group of women ( $N=68$ ) who were being seen at an outpatient eating disorder clinic. In order to test specifically for shame, the study controlled for symptoms of guilt and depression both of which were considered to be possible competing predictors of binge purge behaviors. Both groups were asked to take the BULIT (Smith & Thelen, 1984 as cited in Hayaki et al.), the BDI (Beck, Ward, Mendelson, Mock, & Erbaugh 1961 as cited in Hayaki et al.), and the Test of Self Conscious Affect (TOSCA; Tangney, Wager, & Gramzow, 1989 as cited in Hayaki et al.). Special interest was paid to the shame and guilt subscales of the TOSCA. Each participant's BMI was calculated based on a self report of height and weight.

Using a Pearson Product Moment Correlation it was found that shame was not directly correlated with age ( $r = -.07$ ) or BMI ( $r = .08$ ), but did show a correlation to guilt ( $r = .35, p < .0001$ ), depression ( $r = .47, 0, p < .0001$ ), and bulimic symptoms ( $r = .50, p < .0001$ ). Bulimic symptoms were also significantly correlated with depressed mood ( $.42, p < .001$ ). Hierarchical regression analyses were performed testing the contribution of age, BMI, guilt, depressed mood, and shame to the composite scores of the BULIT. The results indicated that shame uniquely predicted .12 of the variance in BULIT above all other factors. A statistically significant increase was found ( $F [1, 131] = 23.68, P < .001$ ) indicating that shame is associated with bulimic symptoms when controlling for

depression and guilt. The second study found that shame was significantly correlated with depression and guilt ( $r = .71, P < .000$  and  $r = .33, P < .01$ ). An ANCOVA was performed to test differences in shame and guilt using depressed mood and guilt as covariates. The results indicated that the bulimic group showed higher levels of shame than the nonbulimic group ( $F [1, 56] = 6.76, P < .05$ ).

In both the undergraduate and clinical groups, shame was found to be highly correlated with bulimic symptoms, however within the clinical group; the relationship of shame was not independent of depressed mood and guilt. No clear explanation was offered as to why the clinical findings were unable to differentiate feelings of shame from depression except to suggest that women with higher levels of psychopathology may not associate shame uniquely to their eating disorder. Limitations of this study would include a lack of diagnostic information from both groups, and unequal sample sizes. It is possible that the number of self-scoring instruments may be a limitation. It is unclear how long the participants were given to complete the battery of tests, and test fatigue could alter the responses of the participants.

Leung & Price (2007) compared core beliefs and eating symptomology in eating disorders, symptomatic dieters, normal dieters, and a group of comparison women. The eating disorder group was a mixed group of participants diagnosed with either anorexia nervosa ( $N=16$ ) or bulimia nervosa ( $N=19$ ). The symptomatic dieters ( $N=16$ ) showed some eating disorder behaviors similar to anorexia and/or bulimia. The normal dieters ( $N=39$ ) were a group of women who had been attempting to lose weight for at least four weeks and had no previous history of an eating disorder. The comparison group consisted of women ( $N=34$ ) who were currently not on a diet and had never been



diagnosed with an eating disorder. They all completed the EDI (Garner, Olmsted, & Polivy, 1993 as cited in Leung & Price), the YSQ-S (Young, 1998 as cited in Leung & Price), the Beck Depression Inventory-II (BDI-II; Beck, Steer, & Brown, 1996 as cited in Leung & Price), and the Rosenberg Self-Esteem Inventory (Rosenberg, 1965 as cited in Leung & Price). The Rosenberg Self-Esteem Inventory uses a 10 point Likert scale where a higher score indicates a higher level of self esteem.

Normal dieters and comparison dieters showed the least pathological scores in relationship to the other groups. The eating disordered group scored significantly higher than the symptomatic group on the subscales of emotional deprivation ( $M = 3.08$ ,  $SD 1.46$ ), mistrust/abuse ( $M = 3.88$ ,  $SD 1.48$ ), social isolation ( $M = 3.94$ ,  $SD 1.436$ ), defectiveness/shame ( $M = 3.95$ ,  $SD 1.50$ ), failure to achieve ( $M = 3.65$ ,  $SD 1.79$ ), functional dependence ( $M = 3.17$ ,  $SD 1.50$ ), and vulnerability to harm ( $M = 3.23$ ,  $SD 1.50$ ). A multiple ANCOVA analyses indicated that the differences on the EDI scores among the groups remained significant after controlling scores on the BDI and RSE ( $p < 0.001$ ) for drive for thinness, bulimia and body dissatisfaction; this suggests that eating symptomology was not influenced by depression or self esteem. A multiple ANCOVA was also conducted regarding core beliefs. A significant difference was reported across groups on all scales even after controlling for the BDI and RSE ( $p < 0.01$  for self sacrifice;  $p < 0.001$  for all other scales), suggesting that core beliefs are not significantly influenced by depression.

The results indicated that symptomatic dieters and women with eating disorders did not differ greatly in their eating symptoms. However, the women diagnosed with an eating disorder showed very different patterns on their level of core beliefs. Women with

a diagnosed eating disorder scored higher on 8 of 15 core beliefs identified by Young et al., (2003). The authors conclude that individuals with an eating disorder are different from symptomatic dieters. One limitation of this study is that participants with an eating disorder were consistently put together as one group rather than testing them independently based on the specific eating disorder. This study also suggests that the sample size is small and therefore the results may not generalize.

Rogers & Petrie (2001) investigated psychological correlates to obsessiveness, dependency, over-controlled hostility, assertiveness, locus of control, and self esteem related to symptoms of anorexia and bulimia in a nonclinical population. Participants in this study were undergraduate women (N= 97) all taking courses at one southwestern university with a mean age of 22.17 years. The group's ethnicity was 72% Caucasian Non-Hispanic, 10% Asian American, 7% African American, 7% Hispanic, 2% Native American and 1% other (non-specified). All participants were requested to take a series of self reporting tests or questionnaires including the EAT (Garner & Garfinkle, 1979 as cited in Rogers & Petrie), the Bulimia Test Revised (BULIT-R; Thelen, Farmer, Wonderlich, & Smith, 1991, as cited in Rogers & Petrie), the Leyton Obsessional Inventory-Questionnaire (LOI-Q; Snowdon, 1980 as cited in Rogers & Petrie), the Interpersonal Dependency Inventory (IDI; Hirschfeld et al., 1977 as cited in Rogers & Petrie), the Hostility and Direction of Hostility Questionnaire (HDHQ; Caine, Foulds, & Hope, 1967 as cited in Rogers & Petrie), and the College Self Expression Scale (CSES; Galassi, DeLo, Galassi, & Bastein, 1974 as cited in Rogers & Petrie). The IDI is a 48-item inventory that measures thoughts, feelings, beliefs, and behaviors related to needs associated with persons considered to be valued by the test taker (Rogers & Petrie). The

HDHQ measures the degree and the direction of hostility. It is a 51-item true or false questionnaire based on five subscales: (a) urge to act out hostility, (b) criticism of others, (c) projected delusional hostility, (d) self-criticism, and (e) guilt. The CSES measures positive feelings, negative feelings, and self-denial in relationship to assertiveness using a five point Likert scale (Rogers & Petrie).

Regression analysis found that anorexic symptoms on the EAT were significant and the variables of obsessiveness accounted for 13% of the variable ( $\beta = .24, p < .05$ ), emotional reliance added another 5% ( $\beta = .29, p < .01$ ), and assertiveness added 3% ( $\beta = .20, p < .05$ ). In reference to bulimic symptoms on the BULIT-R, the variables of self-confidence accounted for an additional 14% of the variance ( $\beta = .28, p < .01$ ), and obsessiveness added 6% ( $\beta = .28, p < .01$ ) indicating that the best predictors of bulimia are self confidence and high levels of obsessive behavior. The findings indicate that personality characteristics are related to symptoms of disordered eating in a nonclinical sample.

The authors found that symptoms of anorexia may be characterized by a dependence upon someone who is considered close and a need to deny a reliance on that person. This appears to support the idea that women diagnosed with anorexia have been encouraged to show compliance, have dependent behavior and maintain enmeshed relationships (Rogers & Petrie 2001). In reference to bulimia, the BULIT-R scores identified a lack of self confidence as the only dependent factor which coincided with the belief that bulimics have a need to accommodate and please.

Limitations of this study included a possible bias as it relied heavily on self-reporting measures. Participants may have over or under stated their symptoms in

responses to each measure. The number of measures used may also result in test fatigue as the amount of time allowed for taking the tests is not reported. Also there is an issue of generalizability since the sample was selected from only one source. The results were not broken down according to ethnicity. These may be considerations for future studies.

A pilot study by Hurley (2008) using a collective case study included interviews with three women diagnosed with either anorexia nervosa (N=1), bulimia nervosa (N=1) or fit the BMI chart for obesity (N=1). All three women were interviewed and tape recorded regarding their family experiences or perceptions of growing up, their thoughts and feelings regarding specific family members, and information regarding their specific disorder. General demographic information was collected including date of birth, height, and weight. Each participant was asked to keep a sample food journal. The sample food journal was provided as a means for tracking eating behaviors, binge and purge episodes, and their relationship to maladaptive schemas. Once the interview was transcribed each participant was invited back to review the transcript. They were allowed to add, delete, or change any of the information they had provided at the recorded interview. None of the participants deleted or changed the transcribed interview. However, one participant provided more detail to some of her original responses. Once the information was added to the transcript she was asked to review it for a second time. At this time saturation was reached as she did not add, delete, or change any information provided over the course of member-checking. Using maladaptive schema definitions (Young, et al., 2003) each transcription was reviewed and coded for statements associated with maladaptive schema.

Upon reviewing the coded statements, it was found that there were very few maladaptive schemas that did not appear in each of the interviews. All three participants made statements associated with nine categories. Each of the participants expressed statements regarding mistrust/abuse, emotional deprivation, defectiveness/shame, dependence/incompetence, failure, insufficient self control/self discipline, self sacrifice, approval-seeking/recognition seeking, and unrelenting standards. The participants with issues of obesity and bulimia nervosa each made statements suggesting beliefs of abandonment. Both the bulimic and the anorexic participants made statements regarding their struggle with social isolation, enmeshment/undeveloped self, and subjugation. The anorexic participant and the obesity participant made statements which suggest they have problems in the area of emotional inhibition. Only two categories did not appear in any of the statements made by the participants, negative/pessimism or entitlement/grandiosity. Only the anorexic participant made a comment that appeared to fit the category of vulnerability to harm or illness, however, it was situational regarding her fears of an ex-boyfriend.

Each of the participants believed that they now had their eating disorder under control. However, some of their statements and the sample food journals that were returned suggested that the maladaptive schema continue to affect their ability to completely stop bingeing, purging, overeating, or restricting. This pilot study suggests that maladaptive schema appear to play a role in anorexia nervosa, bulimia nervosa, and compulsive overeating resulting in obesity and that at least 15 of the 18 maladaptive schema defined by Young et al., (2003) may be involved in the behaviors and beliefs that led to relapse.

A limitation of this study was sample size. Using one participant for each eating disorder provided comparison between eating disorders, but no comparisons within specific eating disorder. A larger sample size would allow for this type of comparison. Another limitation was the limited information provided on the food journals by the participants. It may not have provided a clear picture of success or lack of success in recovery. Also, one participant failed to return the journal for review.

### *Analysis of Literature Review*

Chapter 2 provides a review of the literature associated with maladaptive schema and eating disorders. Based on the research, there appears to be evidence that maladaptive schema beyond body shape, weight, and eating play a role in disordered eating. Using a quantitative approach to the research, a variety of testing measures were used. All totaled, 16 various questionnaires and surveys associated with eating disorders, depression, assertiveness, child abuse, hostility, and self esteem were used to collect information associated with bulimia, anorexia, binge eating disorder and obesity. At least 10 studies also compared the Young Maladaptive Schema Questionnaire with many of the aforementioned tests to identify specific maladaptive schema associated with each disorder. Several studies found positive results linking the Young et al., (2003) identified categories of maladaptive schema with disordered eating even though this measure was not written specifically for use with this population. Leung & Price (2007), Waller, Ohanian et al., (1999), and Waller, Dickson & Ohanian (2002), all concluded that the inclusion of maladaptive schema beyond body shape, weight, and eating would provide a more effective treatment with a lower rate of relapse. Dingemans et al. (2006) resolved that people with eating disorders had more negative core beliefs than a non-eating

disordered sample. Jones et al. (2005) concluded that women in recovery from disordered eating still carried more maladaptive schema although at lower levels than those who have not been in recovery. Hayaki et al. (2002), found that shame is associated with bulimic behaviors when controlling for depression and Cooper et al. (2006), found that maladaptive core beliefs not associated with depression were present in adolescent girls with eating disorder symptoms.

The majority of studies found some maladaptive schema beyond body shape, weight, and eating in women diagnosed with an eating disorder. However, not every study found the same schema. In studies on obesity, maladaptive schema associated with defectiveness/shame, social isolation, vulnerability to harm, and subrogation showed the highest correlations. In relationship to bulimia, anorexia, and binge eating disorders 12 of Young's et al., (2003), categories were identified, but not all studies identified all of the same categories. For example, van Hanswijck de Jonge et al. (2003) found that subjugation, social isolation, emotional deprivation, abandonment, and unrelenting standards were all highly correlated. Jones et al. (2005) identified high scores on mistrust/abuse, social isolation, defectiveness/shame, failure to achieve, and vulnerability to harm. Waller et al. (2002) found that restrictive eating was associated with dependence/incompetence, emotional deprivation, and insufficient self control. Several other studies focused on a specific maladaptive schema, such as perfectionism, and resolved that women diagnosed with an eating disorder were more likely to score high on the perfectionism scale (Heatherton et al., 2007).

Limitations of these studies included a high reliance on self reporting measures and an undisclosed or unreported amount of time allotted for test taking was not reported.

Each of these measures used standardized questions with either yes/no or some type of Likert scale with prepared forced responses. Some of the studies used only two questionnaires, while others used as many as five or six measures. This may have led to test fatigue. The results may not be as accurate as they could have been by using fewer tests and/or balancing the number of measures with the amount of time necessary to complete them without causing fatigue. Many of the studies combined several eating disorders together into one category. For example, several studies combined bulimia and anorexia binge/purge subtype into one category. Other studies used small unequal sample sizes.

Hurley's (2008) pilot study provided a qualitative approach to identifying maladaptive schema associated with disordered eating. This case study method offered an opportunity to associate real life events to maladaptive schema which may lead to disordered eating. With the use of words and phrases most often associated with maladaptive schema 15 of the 18 categories established by Young et al., (2003) were identified by at least one and in some cases all three of the participants. A limitation of this study was the use of one identified participant in each disordered group which did not allow for within group comparisons. The purpose of using a qualitative method in this study allowed each of the participants to tell her story in her own words. This allowed the researcher to identify maladaptive schema based on each participant's own stories and life events. This method is similar to conducting a psychosocial evaluation in a treatment setting. The results are instrumental in goal setting for treatment success. Further research from a qualitative perspective using a larger sample size would allow for



a stronger cross analysis across eating disorders as well as an analysis from a within group perspective.

### *Summary*

As seen in Chapter 2, numerous quantitative studies have found several categories of maladaptive schema beyond body shape, weight, and eating that appear to play a role in various eating disorders which may impact recovery and relapse. However, these studies are limited by the design and scope of the instruments used in data collection. Hurley (2008) used a qualitative method in a pilot study which allowed participants to describe in their own voices maladaptive schema which may have played a role in their recovery and relapse from disordered eating. The pilot study was limited by the number of participants and did not allow for an in depth analysis within or across groups. This dissertation is an expansion of the pilot case study. By increasing the number of participants in this study, this researcher will be able add to the body of knowledge and provide a more in depth analysis of the role of maladaptive schema in disordered eating. Chapter 3 covers the design and methodology for the current proposed collective case study. It provides a detailed explanation of the methodology to be used in this study, including a description of the participants, procedures, instrumentation, and the intended analysis.

## Chapter 3

### Design and Methodology

Chapter Two presented a literature review of previous research that provided evidence that maladaptive schema beyond body shape, weight, and eating play a role in disordered eating. The majority of studies used a quantitative approach and numerous testing instruments including Young's, (2003) Maladaptive Schema Questionnaire. The majority of the studies reviewed indicated that maladaptive schema beyond body shape, weight and eating play a role in disordered eating. Limitations of the majority of the studies reviewed were the high reliance on self reporting measures and the amount of time allotted for the numerous testing instruments that were sometimes required. In a pilot study this researcher used a qualitative approach to identifying Young's et al., maladaptive schema in disordered eating. However the limited number of participants did not provide for cross analysis or within group comparisons. The current study is an expansion of the pilot study. This study included 10 case studies and has allowed for a further comparison of information. This chapter provides a description of the current study's purpose, the research issues, research design, and method including a description of the participants, data collection procedures, recruitment procedures, and the process used to analyze the data.

*Research Issues*

The purpose of this study was to further explore maladaptive schema associated with disordered eating, specifically related to anorexia nervosa, bulimia nervosa and compulsive overeating resulting in obesity in order to better understand treatment, recovery, and relapse in disordered eating. Cognitive Behavioral Therapy focusing on body shape, weight, and eating has reported a high rate of recovery for those who complete the treatment protocol (Agras, 1997; Anderson & Maloney, 2001). However, there is also a reported 36% rate of relapse in persons treated for bulimia nervosa and anorexia nervosa (Keel et al., 2005). The current treatment models generally are based on 20 sessions of group and individual therapy focusing on a cognitive behavioral approach. The high rate of relapse may be associated with the concept that cognitive behavioral therapy assumes patients will be able to identify and access their cognitions and emotions within 20 treatment sessions. However the limited number of treatment sessions may have also limited the scope of treatment and therefore the focus has been limited to body shape, weight, and eating. Maladaptive schema are so much a part of who a person is that without identifying and altering these schema the chances of long term recovery may be limited (Young et al., 2003). Exploration into the identification and effect of maladaptive schema associated with disordered eating may further develop and improve treatment protocols. Two questions have been posed for this research. First, what maladaptive schemas may be associated with anorexia nervosa, bulimia nervosa, and compulsive overeating resulting in obesity in adult females? Second, what maladaptive schemas do these eating disorders hold in common? Identifying the specific maladaptive schema and which are held in common may help with the development of

stronger treatment protocols in the future. This may help to reduce the rate of relapse and support a more satisfying recovery.

### *Research Design*

A review of the previous literature identified limitations to research using a quantitative approach including small and unequal sample sizes. The majority of these studies also used numerous testing instruments in each study which may have resulted in test fatigue by the participants. Another possible limitation included how participants were grouped according to their eating disorder. While the DSM IV-TR (American Psychiatric Association, 2000) identifies two subtypes of anorexia nervosa and two subtypes for bulimia nervosa, much of the research grouped anorexia binge purge subtype and bulimia binge purge subtype together. No current literature was found on anorexia nervosa or bulimia nervosa and maladaptive schema which identified differences between the subtypes. While conceptual differences could exist in subtypes of eating disorders, the purpose of the current study was to identify maladaptive schema that applied generally to each disorder regardless of subtype.

A bounded collective case study was used to identify maladaptive schema associated with the general diagnosis of anorexia nervosa, bulimia nervosa, and compulsive overeating resulting in obesity. A collective case study uses several cases rather than focusing on one specific case (Stake, 1995) in order to provide compelling evidence, and make the study more robust (Yin, 2003). In this collective case study multiple individuals played a role. While each is defined as a case, the data is being reported as one case in the final analysis.

In qualitative research there are no computations or power analyses to determine the required minimum number and kinds of sampling units. Instead the reliance is primarily on the quality of the information collected rather than the actual size of the sample (Sandelowski, 1995). Bogdan and Biklen (1998) and Patton (1990) indicated that qualitative research should be comprised of small numbers of information rich participants. This method allows the researcher to focus on the central issues of importance for the purpose of research. A sample size that is too large may become cumbersome to manage and compromise the researcher's ability to provide a detailed analysis of the data collected. The use of a collective case study provides the researcher a more direct approach to working with participants and obtaining more personal information regarding a specific situation (Bogdan & Biklen).

Determining an adequate sample size is a matter of judgment and experience in evaluating the quality of the information collected which will allow for the deep, case-oriented analysis. The result will be a new and richly textured understanding of the topic being studied (Sandelowski, 1995). For the purposes of this study the individual female participants were each defined as a case. However, in the end the data collected is presented cumulatively. As a collective case study, it becomes important to select a sample size that will provide the best amount of data for analysis without diluting the overall analysis. The more cases studied the greater the possibility for lack of depth in any single case (Creswell, 1998). While balance and variety are important, opportunity to learn is most important when using a collective case study (Stake, 1995). The goal for this collective case study is to describe individual variations among the participants as well as identify common themes among the participants regarding maladaptive schema

associated with their particular eating disorder. For these reasons this collective case study consists of interviews with ten adult females between the ages of 20 and 45 specifically diagnosed with anorexia nervosa (N=3), bulimia nervosa (N=3), or compulsive overeaters resulting in obesity (N=4).

### *Research Participants*

The goal of this collective case study was to describe individual variations and identify common themes among the participants regarding maladaptive schema associated with their particular disordered eating. This study included females between the ages of 20 and 45 who either fit the American Psychiatric Association (2000) DSM IV-TR general diagnosis for anorexia nervosa or bulimia nervosa. The participants identified as compulsive overeaters were confirmed obese based on the Body Mass Index Scale which is calculated by dividing weight in pounds by height in inches squared and multiplied by a conversion factor of 703 (Center for Disease Control (CDC) retrieved 2009) which provided a reliable indicator of body fatness. This study excluded women who were considered obese due to any type of medical condition.

### *Participant Selection*

Bogdan and Biklen (1998) stated that qualitative research focuses on small numbers of information rich participants which allows the researcher to learn a great deal about issues of central importance regarding the purpose of the study. For the purposes of this study, it was determined that nine participants, three in each category of disordered eating would provide rich and thick data which would allow this researcher to learn what was of central importance to this study, and what maladaptive schema are associated with each of the disordered eating categories which were the focus of this

study. The participants were recruited through the University of South Florida Polytechnic (USFP) and the surrounding Polk County area located in the state of Florida. USFP is a regional campus for the University of South Florida and is located in Lakeland, Florida. It currently has a student population of approximately 3,450. This campus has a high percentage of female students at 64.6% who hold an average age of 30.5 years and a mode age of 22 years (University of South Florida Polytechnic, 2009). Faculty were contacted at USFP and were asked for permission to attend one class session to spend no more than 10 minutes of class time to announce the study and identify the criteria for participation. A letter was provided to every student in the classroom (Appendix A) allowing them to review the criteria and make contact with the researcher outside of the classroom to further discuss their participation. The letter clearly stated that the study involved the identification of maladaptive schema associated with disordered eating and the need to recruit participants diagnosed with anorexia nervosa, bulimia nervosa, or who fit the criteria for obesity based on the Body Mass Index and who perceived themselves as compulsive overeaters. The letter also explained the exclusion criteria that, if the person had a medical condition which caused obesity, that person would not be eligible to participate in this study. Each student was provided with contact information to call the researcher so that an individual appointment could be made to further discuss the study and their commitment. Eight classroom visits were made by this researcher to recruit students and a total of six students volunteered and met the criteria to become participants. Because USFP is a small regional campus it was anticipated that not all the participants would be recruited from a single source. For this reason the researcher also recruited through the Polk County community, particularly Lakeland and Winter Haven.

These two cities host the largest populations in Polk County. According to the official website of Polk County Florida (2009) the population of Lakeland in 2007 was 93,428 and Winter Haven's was 32,577. The majority of treatment clinics, psychiatrists, and therapists in Polk County have offices located in one, if not both of these two cities. A letter was sent to therapists and doctors introducing the study and this researcher and requested assistance in the referral of participants (Appendix B). The letter asked for an opportunity to meet with the clinician to further discuss the topic and gain support regarding referrals to the study. The letter also stated that no therapy was to be offered as a part of this study and that each of the participants would be referred back to their current therapist or doctor once the interview process was completed. Four participants were referred to this study by local therapists for a total of ten participants, four compulsive overeaters resulting in obesity, three participants identified in the category of bulimia nervosa and three participants identified in the category of anorexia nervosa. Any participant, who volunteered for the study that was not currently in treatment, but wanted to seek treatment based on the interviewing process, was referred to a therapist in the area currently treating disordered eating.

#### *Participant Characteristics*

Appropriate participants for this study were females between the ages of 20 and 45 years and diagnosed with anorexia nervosa, bulimia nervosa, or who currently admit to compulsive overeating and who have been considered obese according to the Body Mass Index. Basic demographic information is displayed in Table 1. Each of the participants volunteered and showed an interest in the study.



Table 1  
Basic Demographic Information

Code Name	Age	Ethnicity	Disorder
Cathy	35	Caucasian	Obesity/Compulsive Overeater
Laura	32	African-American	Obesity/Compulsive Overeater
Margaret	35	African-American	Obesity/Compulsive Overeater
Joan	25	Caucasian/Middle Eastern	Obesity/Compulsive Overeater
Carla	40	Caucasian	Bulimia Nervosa
Jane	28	Hispanic	Bulimia Nervosa
Donna	25	Caucasian	Bulimia Nervosa
Jillian	24	Caucasian	Anorexia Nervosa
Monica	29	Caucasian	Anorexia Nervosa
Andrea	41	Caucasian	Anorexia Nervosa

### *Participant Descriptions*

Cathy: Cathy is a 35 year old Caucasian female who identified herself as a compulsive stress eater. Due to her compulsive overeating, her weight has fluctuated between obesity and normal range according to the Body Mass Index. She was referred to the study by her therapist and volunteered to participate. She maintained a normal range weight for about 3 years. However, she is currently in the process of her second divorce and her emotions have triggered her compulsive overeating. As a result, her weight has increased to the range of overweight. She states she has tried numerous diet programs and can lose the weight, only to gain it all back. Because she has struggled with compulsive overeating and has weighed in the obese range for at least two years in

the past, combined with her clear understanding that she uses food to cope with her emotions, she was included in this study under the category of obesity due to compulsive overeating.

Laura: Laura is a 32 year old married African-American female who currently falls within the range of obesity for her height and weight. She admits to being a compulsive overeater. She is married and has two children. She is currently attempting to lose weight through what she described as healthy eating. However, she admits that when she becomes stressed or anxious she can make all the wrong food choices as well as overeat. Her food journal does support this statement. She stated she has lost weight in the past using portion control and exercise, but later gained it all back when she found that her schedule made it difficult to exercise at a gym. Laura volunteered to participate after the researcher spoke to her class about this research project.

Margaret: Margaret is a 35 year old single African-American female whose weight currently falls within the range for obesity based on her height and the Body Mass Index. She admits to being a compulsive overeater particularly when her mood is low, or when she is feeling overwhelmed or lonely. Her food journal supports this statement. She stated about five years ago she lost weight and was within normal range after her doctor warned her of the health hazards of being overweight. She indicated she is extremely disappointed in herself for not being able to maintain that normal range of weight. Her doctor has again warned her of the health hazards and she is motivated once again to change her eating habits. Margaret volunteered after hearing about the study from a friend on campus.

Joan: Joan is a 25 year old single female who is of Caucasian and Middle Eastern decent. She volunteered for the study after this researcher visited her classroom at the university. She lives at home with her mother whom she appears to be extremely dependent upon. She stated that she struggles with her weight and her inability to stick to an eating plan that would keep her in a healthy weight range. She admits to compulsively overeating when her mood is low and when she is feeling extremely anxious. Her food journal suggests that when she is under stress she does make poor choices about what to eat. Her current weight places her in the obese range on the Body Mass Index Scale.

Carla: Carla is a 40 year old Caucasian female who admits to bingeing and purging at the age of 16 and continued this behavior for five to six years. She did not seek treatment for bulimia. Once she joined the military she stated she stopped purging. However she admits to continuing bingeing when she is anxious or distressed. She states she has not purged in 15 years. Currently she is overweight for her height but considers herself to be a healthy eater. Her food journal would suggest that she may not make the best nutritional choices and this may explain her weight gain. Carla is married and helped to raise her step-daughter but has no children of her own. She volunteered for the study after hearing about it when this researcher made an announcement in a class that she was taking.

Jade: Jade is a 28 year old single Hispanic female who indicates she has struggled with bulimia nervosa since the age of 16. She stated that she has not purged in the past two years. However admits to occasionally bingeing on food when she is anxious or distressed. She failed to return her food journal for confirmation of her current eating habits. She did not receive treatment specifically for her bulimia nervosa; however, she

states she sought out a variety of 12 step programs looking for some type of support for her disease. She volunteered for the study after hearing about it through the counseling center at the university.

Donna: Donna is a 25 year old single Caucasian female who indicates she started bingeing and purging around the age of 16. She did not receive treatment specifically for her bulimia nervosa but has received treatment for other addiction issues. She states that currently she is working a 12 step program that supports her not only for her drug addiction but her disordered eating as well. She stated she has not binged or purged in the past two years. She failed to return her food journal. She heard about the study through her therapist and volunteered to participate.

Jillian: Jillian is a 24 year old Caucasian female who indicates she was diagnosed with anorexia nervosa at the age of 15. She has been hospitalized at least three times for this disorder due to her low weight. Her lowest weight at one time was 77 pounds. She continues to struggle with this disorder and is currently in outpatient therapy. She is attempting to maintain a weight above 100 pounds and at the time of this interview weighed 110 pounds. She is married with no children. She heard about the study through the university counseling center and volunteered to participate. Her food journal suggests that she is still struggling with food choices and eating proper amounts to maintain her health and an appropriate weight.

Monica: Monica is a 29 year old Caucasian female who indicates she was diagnosed with anorexia nervosa at the age of 15. She is married with no children. She stated she was never hospitalized but did seek treatment on at least two occasions. She stated that her weight went below 100 pounds twice and her lowest weight was 90

pounds. She is currently maintaining a healthy weight and has not had symptoms of the disorder for at least 7 years. She heard about the study from a friend on campus and volunteered to participate. Her food journal suggests that she does eat a balanced diet. She indicates she learned to count points (calories) while in treatment, and admits that she still tends to use this method to control her weight.

Andrea: Andrea is a 41 year old Caucasian female who indicated that she struggled with anorexia between the ages of 17 and 21 years of age. She is married and has no children. She indicated that due to the emotional turmoil of graduating high school and then immediately moving with her parents to another state. She was frustrated with her parent's decision to move away and felt that she lacked any control over her life. Her frustration, sadness and confusion about moving led her to not eat, and her weight dropped to dipping down to 80 pounds. She is in recovery but did share some maladaptive schema through the course of her interview for which she still struggles. Andrea heard about the study from a friend on campus and volunteered to participate.

#### *Data Collection*

Data collection consisted of interviews with four participants who self identified as compulsive overeaters and who met the BMI criteria for obesity; three participants who fit the American Psychological Association (2000) DSM IV-TR diagnosis of Bulimia Nervosa; and three participants who fit the DSM-IV-TR diagnosis for Anorexia Nervosa. According to Patton (1990), interviewing is a technique used in research to understand the participant's perspective. Bogdan and Biklen (1998) indicate that interviews can be the main source of data collection in qualitative research. The purpose of the interview in this study was to gather data using the participant's own words so that

this researcher could develop insight into each participant's world view and the role maladaptive schema may be playing in the participants disordered eating.

### *Questions*

In qualitative interviewing it is important to ask questions that are open-ended in order to ensure that the participants respond in their own words (Patton, 1990). Open-ended questions allow the participants to respond without feeling limited or restricted in their answers. This method increases the likelihood that their responses truly reflect their experiences related to this study. Open-ended questions (Appendix C) were used regarding a history of each participant's eating disorder, a description of family members, and home life which supported the flow of the conversation. The interview questions were based on questions that may be asked by any therapist conducting a standard psycho-social evaluation to gather as much information as possible regarding family, home life, childhood experiences, trauma, conflict, and health, which might have contributed to disordered eating. These open-ended questions were used successfully as part of the pilot study and therefore were used as part of this expanded study.

The general questions varied slightly based on the type of identified disordered eating. For example, those participants who were classified in the category of bulimia nervosa or anorexia nervosa were asked to provide as much detail as possible regarding the progression of the disorder (e.g., when it started, thoughts on what may have triggered the eating disorder; and the progression of the disorder). The compulsive overeaters were asked questions regarding the age at which each participant considered that they were obese, about childhood weight and the progression of the attempts to either diet or maintain a weight loss. Throughout the interviewing process the questions were intended

to open the lines of communication. Once the participant began talking, most of them answered the questions without prompting from this interviewer. Because the goal was to collect information through a conversational process, this was an unstructured interviewing process. The open-ended questions were used as a prompt if the participant became stuck or got off track.

Questions were included to obtain general demographic information including name, date of birth, ethnicity, eating disorder diagnosis, weight details and a brief weight history. However, due to the size of the sample used in a collective case study, attempting to use sampling variation based on race, class or socio-economic background may not provide enough variation for meaningful analysis and could detract from the goals of the study (Sandelowski, 1995) therefore limited demographic information was collected.

#### *Interview Procedure*

All ten participant's interviews were conducted by this researcher who is a Licensed Mental Health Counselor in the State of Florida. She has worked as a substance abuse counselor for approximately 20 years and has provided therapy and treatment services to people of all ages from adolescents through adulthood. Currently she is a counselor providing services to students at the University of South Florida Polytechnic. As a college counselor, she has provided therapy to several students with a variety of eating disorders struggling to stay in recovery.

The interviews took place in the counseling office at the University of South Florida Polytechnic located in Lakeland, Florida. This office provided a comfortable, warm, and private atmosphere conducive to the interviewing process. The first meeting

with each participant lasted approximately one hour. At this session participants were provided with detailed information regarding the study. All questions proposed by the participants were asked and responded to by the interviewer. The consent form to participate in the study was reviewed and signed by the participant. A copy of the consent is attached as Appendix D. Each participant was provided with a sample food journal (see Appendix E) and was asked to track what they ate and what emotions they might have felt at the time for one week. They were asked to bring the journal to the next meeting so that it might be discussed as part of the interview. The second meeting lasted approximately one and one-half to two hours in length and a more detailed recorded interview took place.

As part of the pilot study a list of words and phrases associated with maladaptive schema was created. These descriptive words were included in Young's et al., (2003) definitions of each category of maladaptive schema (see Appendix F). The words Young et al., chose to describe maladaptive schema were listed without identifying the associated category. This list was only presented if a participant appeared to be stuck or at a loss for words to accurately describe a given situation. If the list was presented, the participant was asked if any words on the list helped to describe thoughts or feelings they had about a given situation. The list was available but not always used if the participant was able to openly and freely express their thoughts and feelings.

In order to record the most accurate information, all interviews were audio taped with the knowledge and consent of the participant. Audio taping the sessions helped to cut back on but not completely eliminate note taking. Every effort was made by the interviewer to be objective, empathetic, and accurate in the transcription of each audio



taped interview. All audio tapes were kept in a secure location in order to protect confidentiality and will be destroyed once the study is completed. Once all the interviews were transcribed, each participant was invited to review the transcription in order to member-check the data. This provided the participant the opportunity to review what was said and correct, expand on, or delete information.

### Data Analysis

The data collection culminated in an abundance of data to analyze. Qualitative analysis involves taking the accumulated data, and organizing it, breaking it into manageable parts, coding it, synthesizing it, and looking for patterns (Bogdan & Biklen, 2003). For the purposes of this study five strategies were used to evaluate the data: (a) analyzing the transcripts, (b) organizing the data, (c) coding, (d) memo writing, and (e) the use of a peer auditor.

#### *Transcript Analysis*

Patton (1990) suggested that the data can be described through a case analysis which requires a complete case study for each participant, or cross-case analysis involving grouping together responses from common questions across participants. The goal of this collective case study is to describe individual variations among participants, as well as identify common themes among the participants regarding maladaptive schema which may be associated with their particular eating disorder. The two objectives for the analysis of the data collected were to first identify maladaptive schema held by each participant, and second to use a cross-case analysis to identify common themes associate with specific eating disorders. The first objective was accomplished through a case analysis of each transcript analyzing the information presented by each participant

independently of the others. Words and phrases that were associated with Young's, et al., (2003) defined maladaptive schema were identified and noted. Second, through the use of a cross-case analysis, the transcripts were evaluated to locate common themes regarding maladaptive schemas associated with a specific eating disorder. The researcher sought to identify data which fit into each of the categories of maladaptive schema defined by Young, et al. in order to support or refute the questions proposed by this study. In order to accomplish this task, each of the 10 transcribed interviews were read and re-read in an effort to become familiar with the information conveyed by each participant. Once each case was reviewed and the maladaptive schemas were identified, the findings were reviewed across cases to identify common themes among participants within the same eating disorder category. For example, all the participants with obesity due to compulsive overeating were compared to identify which maladaptive schema they held in common. Finally the data was analyzed in order to find themes or common threads that could link maladaptive schema to disordered eating, regardless of the specific diagnosis. All the cases were reviewed to identify which maladaptive schema all the eating disorders held in common. Identifying what each eating disorder holds in common with the others may help to improve future treatment for eating disorders by allowing treatment centers to address common maladaptive schemas in a general group setting.

#### *Data Organization*

The researcher became familiar with the data by reading and re-reading each participant's transcript. The goal of reading and re-reading each transcript was to assure that the researcher had a clear understanding of each transcript in order to better identify and code the maladaptive schema that appeared. Lincoln and Guba (1981) suggest that to

develop themes and categories involves deciding which data fits within a specific category and then flushing out information that will make each category more pronounced. As each of the transcripts was read and coded, each participant's story clearly unfolded. Each participant shared her experiences, beliefs, concerns and fears and as they did so, categories of Young's et al., (2003) pre-defined maladaptive schemas were identified. As each participant responded to questions and provided the details of her life and eating disorder, her use of words and phrases were coded into each of the maladaptive schema that applied. For example, when Jillian was asked to describe herself, she responded "I despise myself. A color that comes to mind is very black, very angry black. I hate the way I look because of the way I have put on the weight." This response was coded under the maladaptive schema of defectiveness and shame. It is clear by this statement that Jillian sees herself as defective and inferior which is one of the criteria for this category. More details regarding data coding are included in the next section.

### *Data Coding*

Coding is the process of analysis in a collective case study. It is the way to take transcripts, field notes, and journals and dissect them in a meaningful way while keeping the relationship of the parts intact (Miles & Huberman, 1994). Codes are tags and labels used to assign meaning to descriptive information collected during the study. They are usually complex or straight forward chunks of information of varying sizes including words, phrases, and sentences connected to a specific setting (Miles & Huberman) that allow the researcher to reduce large amounts of data into manageable portions for analysis (Bogdan & Biklen, 1998). Once the interviews were transcribed and member

checking was completed, this researcher reviewed and coded each transcript using Young's et al., (2003) categories of maladaptive schema. Young established 18 categories of maladaptive schema which are defined as follows. Abandonment/instability is the belief that significant others do not provide emotional support, connection, strength, or practical protection. Words associated with abandonment/instability include unreliable, unstable, unprotected, unpredictable, and abandoned.

Mistrust/abuse usually is the expectation of being intentionally hurt. It involves the perception that harm is intentional or the result of unjustified and extreme negligence, and may include the sense that one feels like they always end up cheated in comparison to others. Words and phrases associated with mistrust/abuse include hurt, humiliated, abused, cheated, lied to, manipulated, or taken advantage of. Emotional deprivation is the unfulfilled expectation of emotional support. This includes deprivation of nurturance, empathy, and protection. Words and phrases associated with emotional deprivation include absence of attention, lack of affection, lack of warmth, lack of companionship, lack of understanding, not listened to, unprotected, and lack of guidance.

Defectiveness/shame is defined by Young et al., (2003) as the individual seeing herself as defective, bad, unwanted, inferior, or a belief that she is unlovable. Individuals may be hypersensitive to criticism which would make them very self-conscious. They may also have a sense of shame regarding their perceived flaws. Other words associated with defectiveness/shame include rejected, criticized, self-conscious, blamed, insecure, and shame. Social isolation/alienation is described as feeling isolated from the world, being different from other people, and/or not a part of any group, or community. Words or phrases associated with social isolation/alienation include lack of belonging, alone, being

misunderstood, I don't fit, and no one would miss me if I were gone. Dependence/incompetence is the belief that one is unable to competently handle daily responsibilities without asking for support or input from others. Words and phrases associated with dependence/incompetence include helplessness, unable to take care of self, lack of good judgment, not making good decisions.

According to Young et al., (2003) vulnerability to harm or illness is an exaggerated fear of preventable imminent danger that can strike at anytime. This could be caused by a medical, emotional or an external catalyst. Words and phrases associated with vulnerability to harm include danger, fear, something bad will happen, and destitute. Enmeshment/undeveloped self is a belief that a significant other cannot survive or be happy without constant support (Young et al.). This may include feelings of being smothered by others or lack of individual identity. The individual may be emotionally over involved with one or more significant others leading to a lack of separation or normal social development. Words and phrases associated with enmeshment and undeveloped self include no life of my own, lack of separate identity, need to give in to other's wishes and let others make decisions for me. Failure is the belief that one is fundamentally inadequate in school, work, career, sports, etc. Words and phrases associated with failure include stupid, inept, untalented, ignorant, lower in status and less successful than their peers (Young et al.).

Entitlement/grandiosity is the belief that one is superior to others, entitled to special privileges or is not bound by rules that govern society. Words and phrases associated with entitlement/grandiosity include forcing one's point of view on others, controlling behavior of others, and lack of empathy (Young et al., 2003). Insufficient

self-control/self-discipline is an extreme difficulty or a refusal to exercise self control and frustration tolerance to achieve goals, or to refrain from expressing one's emotions.

Words and phrases associated with insufficient self-control/self discipline include the avoidance of pain, conflict, confrontation, and responsibility. Subjugation is a belief that one is coerced into giving up control in order to avoid making someone angry, being retaliated against, or abandoned by a significant other. There is usually a belief that their opinions, wants, and desires are not important. Words and phrases associated with subjugation include suppression of desires and needs, my feelings don't matter, and feeling trapped (Young et al.).

Self-sacrifice is an extreme need to put others before self. This is done in an effort to not cause pain to others as well as to not feel guilty or shameful toward self. Words and phrases associated with self-sacrifice include care for others, good listener, doing too much for others and not enough for self (Young et al., 2003). Approval-seeking/recognition-seeking is an extreme emphasis on gaining approval or fitting in at the expense of developing a true sense of self. Words and phrases associated with approval seeking/recognition-seeking include gaining approval, recognition, and self-esteem is dependent upon others. Negativity/pessimism is a lifelong focus on the negative and minimizing the positive aspects of life. Words and phrases associated with negativity/pessimism include fear of making a mistake, worried, indecisive, and lack of spontaneity (Young et al.).

Emotional inhibition is defined by Young et al., (2003) as the inability to spontaneously react, feel or communicate in an effort to avoid disapproval by others or feelings of shame or losing control of one's impulses. Words and phrases associated with

emotional inhibition include insecurity to show joy, affection, sexual excitement, and vulnerability. It includes insecurity to express feelings or needs. Unrelenting standards/hyper-criticalness is the belief that one must strive for very high internal standards of behavior and performance to avoid criticism. Words and phrases associated with unrelenting standards/hyper-criticalness include perfectionism, inordinate attention to detail, rigid rules, high moral and ethical percepts and preoccupation with time. Punitiveness is the belief that people should be harshly punished for making mistakes and that they should not be forgiven for their mistakes. Individuals have difficulty forgiving mistakes in themselves and in others. Words and phrases associated with punitiveness include angry, intolerant, impatience with others and lack of forgiveness (Young et al.).

As each case is being reviewed independently of the others, a matrix was set up which included the categories for each of Young's et al., named maladaptive schema, the definition of that maladaptive schema and the participant's statements which appeared to fit within the definition of each of those maladaptive schema. The matrices are presented in Appendices G through P. For cross-analysis of the data a second matrix was developed by category of disordered eating in order to identify themes within each category of disorder eating and across all the categories based on Young's et al. (2003), maladaptive schema. The results are presented Table 2 and discussed more fully in Chapter 5. In table two disordered eating is identified as Compulsive overeaters resulting in obesity as "OE", Bulimia Nervosa as "BN", and Anorexia Nervosa as "AN".

Table 2  
Relationship of maladaptive schema to each of the  
disordered eating categories

Disorder/ Maladaptive Schema	OE	OE	OE	OE	BN	BN	BN	AN	AN	AN
Abandonment	X	X		X	X	X	X			X
Defectiveness	X	X	X	X	X	X	X	X	X	X
Dependence	X		X			X		X	X	
Emotional Deprivation	X	X	X		X	X	X	X	X	X
Enmeshment	X	X	X			X	X	X		X
Entitlement							X			
Insufficient/ Self Control	X		X			X	X	X		X
Mistrust/ Abuse	X	X	X	X	X	X	X	X		X
Subjugation		X		X	X					
Social Isolation		X	X	X		X		X		X
Self Sacrifice	X					X	X	X		X
Emotional Inhibition	X	X	X	X	X	X	X	X	X	
Failure	X	X	X	X		X	X	X		
Unrelenting Standards	X	X		X	X	X	X	X	X	X
Vulnerability to Harm					X	X	X	X	X	X
Approval Seeking	X	X	X	X	X	X		X	X	X
Negativity										
Punitiveness				X	X					

### *Memo Writing*

Memo writing is the process of writing notes throughout the data analysis process.

Memo writing may support analytical thinking, insights and learning on the part of the researcher (Bogdan & Biklen, 1998). For example, while reading each transcript, this researcher made notes as specific statements appeared within the transcript that could



possibly be associated to maladaptive schema. This led to better organization of themes that occurred throughout each transcript and across transcripts. Writing notes in the margins of the transcript allowed this researcher to identify themes and capture thoughts as they occurred.

### *Audit Process*

Another strategy in the final analysis of a qualitative study is the use of an auditor to increase the dependability, confirmability, and credibility of the process. Because prior experience could lead to drawing conclusions too quickly, this researcher used an auditor to draw new perspective. “Preliminary analyses, like cognac, need to be distilled twice” (Miles & Huberman, 1994, p. 126) and the use of an auditor may help with this process. Lincoln and Guba (1985) describe a five stage process. The first stage for the researcher is to select the auditor and describe the study, how the data was collected, and the procedure for data analysis. An auditor was selected who is a counseling colleague with some previous experience in disordered eating and was willing to apply a critical eye in the coding of maladaptive schema. Background information on the auditor is attached as Appendix Q.

The second stage is to determine audibility (Lincoln and Guba’s 1985). In order to accomplish this, the selected auditor was provided with a copy of the dissertation proposal, the research questions, and Young’s et al. (2003) categories and definitions of maladaptive schema. The auditor familiarized herself with the data collected. Clean copies of each of the transcripts were provided and a formal agreement was reached regarding what should be accomplished by the audit. The auditor was also asked to provide a written report of her findings which is attached as Appendix R. The auditor

agreed to provide the service at no charge with an agreement that the favor would be returned at some later time.

Stage three is the determination of trustworthiness and requires the assessment of confirmability, dependability and credibility. This was accomplished by the researcher and auditor reviewing the transcripts and making a comparison of each of their findings. In reviewing the data the auditor followed the same procedures as the researcher. The auditor reviewed and confirmed the audit trail and determined that the results were due to the data provided and not a result of researcher bias. Credibility was established by determining that the transcripts were an accurate depiction of the interviews. The fourth and final state of the process is closure. In this stage the auditor and researcher discussed, processed, and noted any feedback and the auditor submitted her final report (see Appendix R).

#### *Establishing Trustworthiness*

It is important not to try to fit qualitative research into a quantitative design model. However, that does not mean that qualitative research should ignore the tenets of validity (Tyler, 2002) or recognizing that there may be threats to the research. An effort was made to not allow these threats to influence the outcomes. Lincoln and Guba (1985) found that the terms of validity and reliability that fit well in quantitative analysis do not work in qualitative studies and recommend that qualitative researchers consider credibility, transferability, dependability and confirmability. All of which were considered throughout the course of this research. Lincoln and Guba suggest several activities which can help to establish credibility to the research including prolonged engagement, member checking, and triangulation.

It is also important to consider research bias as a part of credibility. Prolonged engagement is the investment of sufficient time to build trust (Lincoln and Guba, 1985). For the purposes of this study prolonged engagement included meeting with the participants prior to the interview process to explain in detail the purpose of the study, review the consent form and answer any questions and concerns the participants might have regarding the study. An effort was made to make the participant comfortable prior to the interview process in order to gain their trust and willingness to participate at a high level during the interview process. During the interview process each participant was allowed to talk at their own pace and provide information in whatever order they were comfortable. Establishing a trusting relationship in advance helped to create willingness on the part of the participant and allowed the researcher to capture detailed personal and sometimes emotional information in support of the study.

The researcher counts on member checking to assure that the intended meaning of the transcribed information is accurate and the participants can provide a critical review of the collected data which helps to triangulate the researcher's observations and interpretations (Stake, 1995). On occasion a participant may find something within the transcript that is considered objectionable and, therefore, it is important to make the effort to work with the participant to clear up any type of misunderstanding or information that they believe may have been misstated. The participant may provide alternative language or re-interpret information provided earlier (Stake). For the purposes of this study, the participants were asked to examine the transcription of their audio taped interview for accuracy and palatability. This session was also recorded in case the participant wanted to add, delete or change information presented earlier. Only one participant added further

information to her transcribed interview. That information was then added by the researcher and she reviewed the transcription a second time without making changes. Seven of the participants reviewed the materials without making changes, deletions, or additions, and two participants opted not to read the transcription and approved its use as is. This may be considered a limitation of the study and will be discussed more fully in a later chapter.

Triangulation occurs through the use of different modes such as interviews, questionnaires, observation, or testing (Lincoln and Guba, 1985). For this study triangulation was accomplished through the use of interviews, interviewer's notes, and asking the participants to keep a food journal prior to the interview process. During the course of the interview the researcher found that information being presented triggered new questions or a more detailed discussion. As these moments occurred she made notes to ask further questions or clarify information. The food journal helped to provide an understanding of eating behaviors (see Appendix E). Each participant was asked to chart when and what they ate and for what reason (e.g., hunger, emotional issues, anger, fear). The food journals were returned at the second meeting and were discussed as part of the recorded interviews. However, two participants failed to return the journals. This may be a limitation of the study which will be discussed in a later chapter.

Researcher bias can be seen as a threat to credibility in a qualitative study. Researchers may have a tendency to overweight facts they believe in and to ignore data not going in the direction of their reasoning and to see confirming data far easier than nonconfirming data (Nisbett & Ross, 1980 as cited in Miles & Huberman, 1994). Researcher bias may occur when data is selected by the researcher that seems to

correspond with the researcher's beliefs or preconceptions regarding the study (Tyler, 2002). In order to avoid bias, this researcher prepared a list of carefully thought out questions to be asked as part of the interview process and used self-awareness during the interview process to allow the participant to lead the conversation. The researcher asked clarifying question when it was deemed appropriate. However the prepared questions were followed in each interview. Also, the use of an auditor helped to ensure that the data collected was analyzed properly avoiding researcher bias.

Transferability is the degree to which similarities exist between contexts that allow findings to be transferred from one situation to another (Murphy et al., 1998 as cited in Plack, 2005). Creswell (1994) suggested that the use of thick descriptions can provide a solid framework in which to make comparisons which allows transferability to occur. It is the responsibility of the researcher to provide detailed descriptions so that the reader can judge the transferability of the data (Robson, 1993, as cited in Plack). This removes the onus of transferability from the researcher to whoever may attempt to generalize the information from one context to another (Plack). The goal of the researcher was to provide thick rich data and explanations which would allow for transferability of the findings to other contexts.

Dependability comes into play during the analysis of the data. Dependability in a qualitative study replaces the quantitative concept of reliability (Tyler, 2002). In order to raise the dependability of this study three techniques were used. First, audio tapes were made of each interview with a participant, and each audio tape was transcribed verbatim. Second, the tapes were listened to all the way through for a second time to check for accuracy to ensure that the words spoken were, in fact, the participants and not those of

the researcher. Third, an auditor was used to examine both the process of inquiry as described earlier in this chapter. Using an auditor helped to determine the acceptability of the process and confirmed the dependability of the study.

Confirmability is the qualitative equivalent to objectivity in a quantitative approach (Tyler, 2002), and the audit is the technique used to establish confirmability. The auditor reviewed each transcript independently from the researcher. The auditor examined the audit trail by reviewing the transcripts, the data reduction matrix and the themes, categories and relationships produced and established the confirmability of the study in a written report (Appendix Q).

#### *Summary*

Chapter 3 provided a detailed explanation of the methodology that was used in this study including descriptions of the participants, the research procedure that was followed and how the data was analyzed. Chapter 4 will provide the results of the study.

## Chapter 4

### Results

Chapter Three presented the methodological procedures followed during this collective case study. The study concluded with 10 participants, four in the category of obesity due to compulsive overeating, three participants who met the DSM IV- TR (American Psychiatric Association, 2000) diagnosis for Bulimia Nervosa and three participants who met the DSM IV- TR (American Psychiatric Association, 2000) diagnosis for Anorexia Nervosa. Each of the participants was interviewed and the transcripts were analyzed in order to further explore maladaptive schema associated with anorexia nervosa, bulimia nervosa, and compulsive overeating resulting in obesity to better understand recovery and relapse in disordered eating. The research issues explored were: first, to identify the maladaptive schemas which may be associated with anorexia nervosa, bulimia nervosa, and compulsive overeating resulting in obesity in adult females; and second, to identify which of these maladaptive schemas are held in common by these disorders. Exploration into the identification and effect of maladaptive schema associated with disordered eating may further develop and improve treatment, increasing the opportunity for recovery, and decreasing the rate of relapse. The data analysis was described in Chapter Three along with a discussion of the concepts of credibility, transferability, dependability, and confirmability of the data and research design.

Chapter Four begins by presenting the results of each case study. These case studies are presented independently of each other. The cases are grouped according to eating disorder and presented with other cases within the same type of disorder. Each participant's story is told using her own words. Background information and the details associated with each identified maladaptive schema, are also presented to provide a better understanding of the participant's life events which have led to a specific maladaptive thought. Quotes from the participants are used to show the association to a specific maladaptive schema. These quotes are presented in the first person in order to identify that these are the words used by the participant. This is considered a common practice in qualitative research. Presenting the quotes in the first person allows the reader to be less distanced from the participant (Seidman, 1991). As each participant tells her story, discussing her thoughts and feelings regarding family and her specific eating disorder maladaptive schema are identified and noted. The common themes from each disorder that developed during data analysis are introduced. The data is sorted by eating disorder and the common themes that appear within each eating disorder. Then the data is cross analyzed to find themes that are common to all three disordered eating categories.

The categories used are Young's et al., (2003) 18 defined maladaptive schema. Each participant made comments that fit into one or more of these maladaptive schema. The 18 categories are: (1) abandonment/instability, (2) defectiveness/shame, (3) dependence/ incompetence, (4) emotional deprivation, (5) enmeshment/undeveloped self, (6) entitlement/grandiosity, (7) insufficient self-control/self-discipline, (8) mistrust/abuse, (9) subjugation, (10) social isolation/alienation, (11) self-sacrifice, (12) emotional inhibition, (13) failure, (14) vulnerability to harm or illness, (15) approval-



seeking/recognition-seeking, (16) unrelenting standards/hyper-criticalness, (17) negativity/pessimism, and (18) punitiveness.

### Case Studies

In this section each participant's case study is presented. Each participant tells her story in her own words. Each category of maladaptive schema that applied as the story unfolded is identified and discussed within the case study presentation. The order of presentation is four case studies representing compulsive overeating resulting in obesity; three case studies representing bulimia nervosa; and three case studies representing anorexia nervosa.

#### Obesity Associated with Compulsive Overeating

Four women volunteered to participate in this category. Three of the four currently meet the Body Mass Index definition of obesity based on weight and height. The fourth participant currently meets the Body Mass Index definition for overweight based on weight and height but admitted that while she currently is overweight her weight in the past has been in the obese category. Because she successfully lost weight and was able to reach a normal weight range but has been unable to stay within that range she was accepted as a participant. It was believed by the researcher that this participant would reveal maladaptive schema which could explain her inability to keep her weight within a normal range. All four women admitted to being compulsive overeaters. They all indicated that they use food as a source of comfort during times of stress, anxiety, and sadness. As each participant tells her story it can clearly be seen that each has unresolved trauma which has resulted in maladaptive schema.

*Cathy*

Cathy is a 33 year old Caucasian female who volunteered for this study after hearing about it from her former therapist. She is a single mother of three children. Her weight at the time of the interview was 170 pounds. For her height of 5 feet, 5 inches this is considered overweight based on the Body Mass Index (BMI). She stated that her heaviest weight has been 222 pounds. This weight falls within the BMI range for obese. Over the course of the past two years she reported her lowest weight was 145 pounds, which is considered within normal range. She indicated that she recently finalized a second divorce and during that time her emotional eating was out of control. She attributes her weight gain to her emotional turmoil during the separation and divorce. She indicated she has returned to her Weight Watchers food plan, and has begun exercising again in an effort to get her weight back to 145 pounds. She failed to return her food journal. For the purposes of this study Cathy was placed in the category of obese due to her admitted compulsive emotional overeating, her inability to maintain her weight loss and that for at least two years her weight was in the obese range.

Cathy reported that she was molested by her father until the age of 13. She stated her father was “the love of her mother’s life” and her mother was devastated and confused about having to lose her husband in order to protect her children. Cathy stated that things were quite confusing and frightening for her during that time. Her mother had a hard time staying away from her father and at one time Cathy feared they would have to move back in with him. The father was also a drug addict and the mother was constantly trying to rescue him. The mother eventually did give up her efforts to reconcile the family. Many of the events around Cathy’s incestuous relationship with her father are

played out through her own discussions in this interview regarding her personal need to try to keep her current family together. “I wanted the mom and the dad to wake up with the babies because that is all I ever wanted as a kid.” Throughout the course of her interview Cathy made statements that fit into 12 of Young’s et al., (2003) 18 maladaptive schemas.

As an adult Cathy continues to believe that she should have a relationship with her father and that he chooses not to be a part of her life, “I think he draws himself away from everything and falls out of our lives.” Her perception is that he has abandoned her even though she believes she has forgiven him for his behavior when she was a child. Another area of abandonment revolves around her first marriage. Cathy became pregnant at the age of 16 and married the father of her child. However, this marriage did not last long. She indicated that he was not home much of the time and she was alone to care for a small child. In her words: “I went through a divorce with my first husband. He was just running around all the time.” This left her again feeling abandoned and alone. By the age of 19 she was divorced and caring for her son on her own.

Cathy also made several statements related to defectiveness and shame. The first is a description of her father who she perceived as defective. In describing him she stated:

It is almost to the point where he had demons. I felt like as a child and even grown up today that he has demons. Or a devil has just taken over his body because he is not a good person when he is on drugs and drinking.

When she was offered the list of words and phrases and asked if any of the words helped her to better described her father she stated: “defective, I see the word right there. There are some other ones but defective is definitely the word.”

Cathy made several comments suggesting her thoughts regarding her own defectiveness and shame. As she stated: “and on the bad part just low self esteem and it is just putting yourself down a lot. ...I am not good enough.” She indicated that her father use to verbally abuse her mother often and Cathy believes she internalized his comments and applied them to herself. As she stated: “my dad was so verbally abusive and he would put her down. So I think seeing that I then internally was putting that in my own mind.” Cathy indicated that she tends to talk to herself when she is trying to resolve problems and that many times this happens when she is driving her car. Her concern was what other people must think of her when they see her. She stated: “sometimes I feel like I am driving down the road with no Bluetooth in my ear or anything just talking and hoping no one is looking at me like I am crazy” suggesting her concerns for others seeing her as defective. She also mentioned talking with her therapist regarding her defective feelings toward herself: “...and through just talking through why I would feel bad about myself.”

Cathy talked a lot about her second divorce and her defective thoughts regarding her success as a wife and mother.

I could have done this better. ...I felt like I am not a good mom because my kids are all apart and I wasn't a great wife. ... I cry a lot and put myself down inside. ...So I know there is something inside saying you're self destructive.

She has struggled to see herself as others do, showing her thoughts of defectiveness. She indicated that she had been discussing her weight issues with her mother who attempted to console her. Cathy's thought was “that is beautiful but that is not helping me at all because I don't see that in myself.” She also commented on her success at work as “I

would say an outsider looking in they would say Cathy is very successful. Cathy says this is luck. And why are they picking me for all these?”

Cathy talked about her compulsive overeating. She admitted that when she is feeling emotional she tends to gravitate toward food to find a source of relief or comfort. Her most recent experience revolved around her separation and divorce from her second husband. She went through periods of questioning her ability to be a good wife and mother, and during that time she would find herself compulsively eating in an effort to make herself feel better. Later she would regret her use of food to find relief. She recalled her own feelings of defectiveness and shame relating to this divorce when she stated:

I was sitting there crying and I am just shoveling piles in my mouth and all of the sudden I looked down and realized, oh my gosh, almost the whole bag was gone, and I opened the bag. And I said Cathy what is wrong with you? What is seriously wrong with you?

Cathy indicated that at one point she gained weight and felt that part of the reason was because there was no one telling her not to. This is a sign of her dependence upon others to provide her with direction and guidance. She indicated that during her second marriage she found that her husband would love her no matter what: “at that point I thought he loves me no matter what and so I can continue to do this because I don’t have anybody telling me, I wish this or I wish that like my mom or dad.” She also talked about her recent divorce and her dependence on her ex-husband to help her make the decision to follow through with the divorce. She filed the paperwork at least two years earlier and then moved the hearing date several times because she was not clear about what she really wanted. She indicated:

This is the second time I have been married and I am failing. What is wrong with me? And so finally my husband said you need to do something and we finally came to the decision to move forward and we got it done.

This statement not only shows her need for someone else to help her make decisions it again points out her defective thoughts about herself. She also comments about her need for support in other areas. When she is attempting to watch what she eats she is dependent upon friends to tell her what she should not be eating and expecting friends to push her to work out on a regular basis. She is motivated but struggles to do any of this without support from others. She indicated:

It is always good to have someone to do it with. Right now my friend is joining me in the gym and we are putting together our plans of what we are going to eat and really paying attention to that. So I think her and I together can make it work because she lost a lot of weight too when we did it together. I would surround myself with people and say look if I do this you got to say something to me. My best friend would say I am going to slap you if you don't knock it off. We had this understanding. She never had to hit me. I got it.

Cathy expressed a sense of emotional deprivation when she talked about her mother. After Cathy told her mother that she was being molested by her father, her mother went through her own personal confusion. During that time Cathy believed her mother focused more on trying to fix her father and the family than she did trying to support her children. The result of that in Cathy's perception is that now her mother focuses most of her attention on her children and emotionally deprives her grandchildren. She perceives her mother as feeling guilty for what she put her children through when they were young and, therefore, she over focuses on trying to make up for that now. Cathy believes her mother should be focusing all her love and affection on her grandchildren and ignoring her children. She stated:

She loves her children, puts them first over anybody. It is so much to a point where she forgets her grandchildren. ...I think she does that only because she is trying to make it up to us not realizing that what we really want is the love for our children. That would make me happy.

She also commented that her relationship with her brother seems to lack the emotional attachment that she would like. "He says he doesn't care about people's feelings. He is very factual and does not want to hear that fluff stuff. He likes to pick on me, he likes to push my buttons and get me all riled up."

Cathy expressed some feelings of enmeshment regarding her relationship with her daughter and youngest son. She believes that she was too young to appreciate her oldest son when he was a baby because she was still growing up herself. She now admits that she is over involved with her daughter as she stated: "I am living through my daughter and doing those things with her probably more than I should."

Cathy expressed statements indicating some maladaptive thoughts in the area of insufficient self control. Related to her use of food for comfort she stated:

I like comfort food. It is what makes me feel good. It works for a minute. Then you are uncomfortable as you're going oh I feel horrible. ...I think I don't care I was so desperate to do something without realizing that the real issue was within me. ...I cried every day, I ate, I ate late, super late because I would go to bed late. Sometimes two or three in the morning so I would be eating and that is not a good time to eat certainly, but that was the comfort. It is a glass of milk and some cookies or pie sitting there watching television.

Most of Cathy's issues with mistrust and abuse stem from her father sexually molesting her as a child. Later her first husband had several extra marital relationships and this again provided her with feelings of mistrust. She described her father as "manipulative in getting his own way twisting it toward where it worked out to his benefit." She talked about her second husband and how she had so much confidence in his ability to love and

care for her daughter. “There is never a doubt when my daughter sits on his lap. And that wasn’t the case for me. I would question what is happening here,” showing an inability to trust her own father. She indicated that at times it is tough for her to watch her daughter and second husband together because it is the relationship she has always wanted with her own father.

Cathy considers herself a master at suppressing her own preferences, decisions, and desires in order to make sure she fits socially into everyone else’s life. The tone in her voice indicates she takes great pride in this ability. It would not be surprising to learn that very few people know her as well as they may think they do. She is very chameleon like in her behavior.

I have seen people all my life who say that is a mean person. I have never wanted to be that person that someone speaks at the dinner table about. Have I not liked people? Absolutely but they would never know it dealing with them because I just have always believed that. Personality wise I can walk up to a group of people and just chit chat about whatever and pick up very quickly what interests them and then have a conversation around that and I may not know anything about it.

While Cathy’s tone sounds somewhat accomplished and grandiose when evaluating her words it appeared that this is her way of suppressing her own values, thoughts, and opinions in order to fit in.

Cathy made several comments that fit into the category of emotional inhibition.

She stated:

This is what makes me feel good. Like the comfort food. ...All I know is that I ate and it made me feel good. ...I would be eating and that is not a good time to eat certainly but that was the comfort. I would comfort myself going through that very serious depression. ...I don’t know if it is taking away the pain of the outside and the hurt of the heart and say all right if my stomach is hurting like crazy then it takes everything else away.



Cathy was asked if there was any specific event that caused her to eat more than other times and her response was “probably just any type of low moment.” She was also asked what she thought she gained by eating and she indicated “just feeling good at that moment.”

Cathy struggles with a sense of failure even though she has had several successes in her life. She has been very successful at work, having moved up into a management level at a very quick rate. She struggles to understand what it is her bosses see in her and considers that, for the most part, her advancement has been pure luck. She has impressed her employer so much that she has been placed in a management role that normally requires at least a Bachelor’s Degree. Cathy has completed a two year college degree but never completed her Bachelor’s Degree. She states that she sees her promotions as errors on the part of her company and that eventually someone will figure out that they have made a mistake believing in her ability. “I would say an outsider looking in would say Cathy is very successful. Cathy says it is luck.” She also struggles with being divorced twice and feeling like she is a failure when it comes to marriage by stating:

When I got divorced my thoughts were I am just not good enough. What it says about me is that I failed. This is the second time I am married and I am failing at it. I put it all on myself. Maybe this is your fault. Everything points to you.

Cathy puts herself down suggesting that not only was she unable to be successful in a marriage, but that she must also be a bad mother because her kids are required to spend time with each parent separately. She lamented:

I felt like I am not a good mom because my kids are all apart and I wasn’t a great wife because you know this and that. You pick apart all the things you do in the whole marriage and you think I could have done this better.

While she is seeing herself as a failure at the same time she may be hypercritical expecting that she should have done better. She talked often during the interview about wanting to be able to provide that family atmosphere with “the mother and the father and the children all together under one roof” and tends to over criticize her part in not being able to make this second marriage work. She states of her ex-husband: “He is a great father. I could not ask for any person better. Sometimes it makes me angry at him, because I wanted that, I wanted that life.”

Cathy made several comments that fit in the category of approval seeking. She continuously worried about what people may think of her. Cathy always presents herself with a smile and full of energy. It would probably surprise many people to find out that she does not consider them friends even though she appears to be friends with everyone. She stated: “If I die I want it to be fun, happy. I want everyone to have a party and say man that girl was the coolest person in the world, or the neatest person, most interesting or something.” She also commented several times about how important it was to her to be seen as successful by other people yet doubts her own success showing a need to have others validate her.

I want people to see me as successful. So I really, really care what people think about me. Almost too much. ...Even today I care about what people think about me in the sense of my reputation. ...And I like being around people so being in the group settings and bragging and saying yeah I did it too and look what we can do together.

Cathy is also concerned with how her children see her. She indicated that her sadness, crying, and much of the compulsive eating happen when her children are not at home or are asleep: “I don’t want them to see mom is a basket case or whatever it may be.”

Cathy's comments fell into 12 of Young's et al., (2003) maladaptive schema. The majority of her comments fell within four distinct areas; defectiveness/shame, dependence/incompetence, emotional inhibition, approval seeking, and failure. Cathy continues to see herself as defective and a failure. She attempts to mask those feelings with food. This becomes a vicious cycle for her because she is aware that she is eating in an attempt to make herself feel better, yet admits that in the end it only makes her feel worse. She failed to return her food journal. This may be a sign that she continues to struggle with her emotional eating. Writing down her food choices and emotions that go along with eating may have been too visual and more than she was willing to see at the time of this interview. Her continued struggle with losing and regaining weight indicates that she will continue to compulsively eat and that some of her maladaptive schema do interfere with her weight loss success.

### *Joan*

Joan is a 25 year old single female of Middle Eastern and Caucasian decent. She is 5 feet and 4 inches tall and currently weighs 216 pounds which places her in the obese range based on the Body Mass Index. When asked how much she weighed, she stated she thought between 200 and 220, but that she found it depressing to weigh herself. The scale indicated she weighed 216 pounds. She asked not to be told what her actual weight was. Joan volunteered for the study after hearing a presentation regarding the research in a class she was taking at the university. Through the course of the interview Joan made statements which fit 11 of Young's et al., (2003) maladaptive schema categories.

Joan was raised by a single mother. She stated that when her mother became pregnant that she barely knew Joan's father. He was from a Middle Eastern country and

apparently worked as a bartender in the town where her mother lived. They dated and she became pregnant. She decided to keep the baby but not to marry the father. Joan has never met her biological father. She recalled that her mother dated often while Joan was young, suggesting that it was her mother's mission to find a father for Joan. Joan expressed her feelings of abandonment regarding her mother's dating by stating: "What she didn't realize was that she was pushing me away by not spending time with me. I felt rejected because she was working so hard at trying to keep them happy that I wasn't getting any attention."

Joan stated that her mother never encouraged her to seek out her biological father. Joan believed that her mother feared that because of her father's ethnicity that he might steal her when she was young. Her mother feared that he would return to his country with Joan. Because of her fear Joan's mother moved out of the town where he lived after Joan was born and did not make any attempt to stay in contact or let him know where they were living. While Joan has never known her father she did comment "I didn't realize how much it bothered me that he wasn't around until I started counseling." Her mother has stated in the past that Joan's father could have found her if he truly wanted to. This also plays into Joan's feelings of being abandoned and unwanted by her father.

While Joan's responses fell in 11 different categories, one area of major concern were the statements she made about herself and her appearance which fell in the category of defectiveness and shame. Her first simple comment regarding how weighing herself makes her feel depressed is one example of her thoughts regarding being ashamed of her appearance and, as long as she does not know how high her weight is, she can deny the problem. She also stated "I have issues with my weight and feeling bad about myself."

She also commented on several occasions regarding how she perceived herself as looking different than other girls, as a child, due to her ethnicity. She stated:

It wasn't like I couldn't be a kid, but I knew I was different than other kids. ...I didn't realize how much of a self esteem issue I have because of my ethnicity. ...I remember having low self esteem when I was a kid. ...It probably started when I was in kindergarten or first grade that I started having doubts about my self esteem and about the way I looked because all the girls in my school were straight...not curvy and I have always been curvy. ...And so I always felt different from the other girls. And I remember even girls making fun of me when I was younger and calling me fat and saying things like that. ...My back was curved and my stomach poked out a little bit...and I remember always not having confidence in myself because of that.

Joan also commented about how her happiness was tied to the idea that she was not thin when she stated:

My whole life I thought that if I am skinny I will be so happy. And then it was like, well if I just didn't have braces, and I was skinny I will be so happy. If I could get rid of all those things at the same time then things would be great.

At some point Joan was able to loose some weight and the braces on her teeth were removed, but she still worried about how defective she might be. She indicated:

I remember being more paranoid about my self esteem because I thought well I finally look pretty on the outside. If guys don't pay attention to me now its got to be something I am doing wrong with me instead because if you are overweight you can say oh if a guy doesn't like me it is because I am fat and that is fine. I don't care. And it is not as personal. But if you feel like you look really pretty on the outside and guys still don't want to give you that attention it is like wait a second that doesn't make sense. ...So I think it does impact your self esteem a lot if you can't meet those expectations then there must be something wrong with you. And you are not as pretty as everybody else.

Joan mentioned an embarrassing situation that has caused her some concern over the years. She was at a family picnic where watermelon was being served. She wanted to be able to take some of the watermelon home to eat later in the evening. She asked her mother if that would be okay, and her step-grandmother responded in front of the entire

family “I don’t know why you would eat it you are just going to pee all over the bed.”

Later in the day when Joan discussed her embarrassment with a cousin, the cousin reinforced her feelings of defectiveness by stating “I don’t know why you’re upset about it. It is your fault.”

Joan’s issues with defectiveness and shame continue to be a problem for her now as she struggles with her feelings regarding her ability to succeed in school. Although she is an A student and has been successful each semester she commented:

When I get half way through the semester I get so depressed and hopeless and I want to give up every time...and I feel that I am not good at it. ...but I always feel like everyone is doing better than me. ...That you are never good enough. That you will never be powerful. You don’t mean as much as people who are like that.

Joan made comments specifically about her relationship with her mother when she was young that appear to fall in the category of emotional deprivation. Along with her mother’s need to find her a father, she also worked full time and on the weekends was apparently tired and did not spend the time with Joan that she would have liked:

I did have a lot of babysitters when I was little. And my mom was, she worked full time. She would come home and on Sunday she would sleep all day. And I remember watching TV because that would keep me busy. I remember waking up my mom a lot. Hey mom can I eat the Doritos? And she would say no you can have a bowl of cereal. And I would be like please, please, can I eat the Doritos? And I remember eating a lot. I would have a little carpet picnic and eat lots of food. And I don’t really know how much it was it may have been like three or four bowls of cereal over five hours.

Joan expressed some confusion regarding her father, due to some mixed messages from her mother. Her mother told her that they hid from Joan’s father because of her mother’s fears that he would take Joan away. At the same time her mother has commented that, if her father really wanted to find them, he always has known where they are. Because of this Joan expressed a concern that fit in emotional deprivation

regarding her father when she stated: “so I think it really impacted me a lot not having my dad around.”

Joan’s strongest area of maladaptive schema is her enmeshment with her mother. Her mother has alienated herself from other family members including Joan’s biological father. Joan commented early in the interview: “my mom has always needed my help. She constantly asked for my help. I didn’t really have a choice.” She also stated:

Probably if she has told me once she has told me a million times that I am the most important thing in the world to her. And that she doesn’t want anything to ever happen to me and that nobody is going to ever hurt me no matter what.

Joan also commented on her sense of responsibility toward her mother.

When I was younger it seemed like she always mentioned it... You can try to cheer the person up and say oh mom you are not fat or you are pretty or I love you. Or you start to take it out on yourself and say well if my mom thinks that then maybe that is what I should do. You start to think it is normal and you start to do it to yourself. And I realize I do that to myself.

The concern for her safety Joan explains is more her mother’s fear that, if her biological father found her, he might try to take her away to the Middle East where she would never be seen again. Joan also believes everything her mother has told her about her father without question. She stated:

Whenever I asked her a question she would always tell me the truth no matter how difficult it was for her. Or she would tell me I will tell you in a few years. But I remember that being so different from my other friend’s parents that I really could talk to my mom about anything.

Joan’s mother has also struggled with weight issues. As young as 13, when her mother would diet, Joan would join her in eating the same foods, or going to the gym to exercise. “...I remember eating that and drinking diet coke for lunch because that is what my mom drank and that is what we had at home.” The most interesting comments

regarding food and enmeshment came when Joan stated: “we find happiness in food. Why don’t other people get excited about food the way we do. We don’t get it.” When asked to clarify who she meant when she used the word “we” she indicated “me and my mom.” Joan also made statements regarding her mother’s relationship with her grandmother indicating “my grandmother is someone we have both avoided. We don’t want to talk to her anymore to tell the truth.” She also stated that “we have gotten to the point where we kind of like our privacy and we are happy with who we are” again referring to her relationship with her mother.

Joan at one time recently thought she might like to find her father. When she discussed the idea with her mother she stated:

I remember us talking about it for about three hours straight crying. And it was exhausting trying to have a conversation and trying to understand her point of view because in her mind she had tried to protect me during this whole, during my whole life and it was like I was throwing that in her face if I wanted to meet him anyway.

Joan opted not to find her father after their conversation. However, many of her reasons fall within the next category of maladaptive schema, mistrust/abuse. She stated:

I was almost convinced...to actually try to meet him. Just to kind of meet him once just to see what he was like. But I was kind of scared because what if he is not what I expect. What if he is not a nice person? And then all of those fears that I have been associating with someone that is not a good person would come true. And then I would start to internalize that and say well if he is like that and he is half of me what does that make me? I was unsure about that. And I was unsure what if he doesn’t want me around?

She also associated her lack of trust in men to her lack of a relationship with her father when she stated:

I have a lot of trust issues with guys because my dad wasn’t around. And because the only guys I saw that were around my mom I thought the only reason they were around her was because they wanted something. I thought they just wanted her



for sex. I don't really understand the relationship and because I had never had a really positive male relationship it didn't make sense to me. And I still struggle with it. Trying to understand how there are good guys out there but so many of them are bad. It is just a complicated situation.

Joan's mother has instilled a strong sense of mistrust. Joan commented:

My mom always tried to be really careful with me and would say you need to always be aware of your surroundings and those types of things. ...I remember you have to be aware of your surroundings and you need to be careful. And I remember her also saying something about if someone is looking at you, look them in the eye because that means they know you are not someone who is shy.

She states that her mother told her "I had to teach you to be afraid. People were constantly telling her how pretty I was and she didn't want anyone to take me." While it appears her mother's fear was more related to her father taking her away, Joan has translated that into mistrust of men in general. She commented "I think that then when people start noticing me especially guys in Wal-Mart I thought it was for dirty reasons. I thought maybe that guy is going to attack me later and I would be all paranoid."

Joan's issues with subjugation also coincide with her relationship with her mother. Her mother has been the authority figure in her life. She has made all the rules, and been very over protective of Joan due to her personal fears. As this has played out for Joan, she has simply complied with her mother's wishes, even admitting that as an adult she struggles to stand up to her mother. Joan justifies her mother's action as follows:

But at the same time she also told me don't tell people where your dad is from. And I think in her mind she was trying to protect me because the town she grew up in was very prejudice. And I think in her mind she didn't want me to face the same prejudices that she may have faced or others may have faced. And so she was trying to protect me but I didn't really understand that when I was younger and it was so confusing for me because I was like, well how is it that I am not suppose to be ashamed of who I am but I am not suppose to tell anybody where my dad is from but he is not bad. I never got it. It didn't make sense to me.

Because she would always say your dad is not a bad person but I don't want him to find us and take you away.

This behavior also helped Joan feel very socially isolated however other things played into her social isolation as well. She stated "I think that I felt different from everybody. All the other girls were skinny and they could shop in the skinny girls sections. I remember having to shop in the women's section."

Joan also made comments regarding emotional inhibition. She attempts to control her emotions with food. She commented "We relate food to happiness" again expressing enmeshment with her mother. She also commented that "I do think I eat my emotions." She went on to explain:

When I was little I think it was more boredom than anything. Now I think it is emotions I mean when I get upset. ...food brightens my day. ...If I am having a bad day and I find out there is free food on campus...my day just got better, and if I am really upset and eat certain foods I usually feel better. ...I do know that if I have a bad day at work or I am really stressed out or I am in a really bad mood I will eat. Or a lot of times when I am home and see something good on TV or I am bored I eat. ...I think that when you eat you get those feelings of happiness and you feel so much better.

Joan made one comment regarding her issue with failure to achieve and it centered around her inability to be successful on a diet or food plan. She tried entering her calorie intake into a program she found on a computer website. However she commented:

I would think that I was doing really good and it would say I went over my limit all the time. And I was like, but I haven't really eaten that much. Like it just didn't seem to be very realistic and a lot of the things I would eat weren't on the data base that I was trying to check from. And the exercises I did wouldn't be in the data base either so it was really frustrating and I felt like I wasn't making very much progress so I stopped using it.

Joan also comments on her unrelenting standards for herself. During her adolescence when she was trying very hard to fit in with her peers she started doing pushups and stated: “I would do pushups and sit-ups for 30 minutes every night. I would test myself all the time to make sure my abs were tight. I remember being preoccupied with that.”

Finally, there are Joan’s issues of approval seeking. This area of maladaptive schema also appears to be significant in her life. The biggest area of concern for her appears to go back to her issues with her ethnicity.

I have always been interested in other cultures...I really thought I was trying to find one to identify with. I wish I could marry an Italian or American Indian or some other culture that I look like that I can envelop myself in and be absorbed by so I don’t feel so outed or that there is something wrong with me because I am part of a culture that nobody likes.

She also comments about her need to fit in when she and her mother joined a gym to go work out. She stated:

I think I loved it because you are in the club now. Because everyone is working out and talking about their gym and I could say I go to the gym. And it was just *fun to be one of those people.*

She commented further regarding her need to fit in:

...you are suppose to find a happy median in accepting who you are no matter what size you are and having confidence. And it is really hard to have confidence when you don’t like the way you look or you are worried about how other people perceive you and those types of things. I was always the bigger person in the group. And that was hard because you don’t want to be different. You want to be accepted and you want to be able to buy the clothes that everyone else is wearing and that was hard.

She continues to find it a struggle to understand where she fits in whether it is at school, work, or at church.

While Joan made comments throughout her interview that fit into 11 of Young's et al., (2003) maladaptive schema, four areas appeared to stand out as the strongest areas of concern. These may play a role in her inability to lose and/or maintain a stable, healthy weight. Her thoughts about her appearance elicited strong statements regarding her defectiveness yet she is not ready to know how much she really weighs. Not wanting to know what she weighs suggests that she is not ready to do the work necessary to lose the weight using a nutritional food plan and working on issues that trigger her compulsive eating. The second largest area of concern is her enmeshment with her mother. Her thoughts and beliefs appear to be tied very strongly to her mother's thoughts and beliefs. This does not allow her to express herself as an individual. Other categories where Joan made strong statements were in the area of mistrust/abuse, approval seeking and emotional inhibition. These areas of maladaptive schema stem from early childhood memories and continue to cause problems for her based on her inability to lose and maintain a healthy weight.

### *Laura*

Laura is a 32 year old Black female. She is married with two children. Laura's current weight is 274 pounds. Her height is 5 feet 6 inches tall. For her height she does fall in the obese range according to the Body Mass Index. She stated she recently lost about 20 pounds and believes that her highest weight was three months ago at 295 pounds. Her current weight loss plan includes trying to make better food choices. However, her food journal suggests that she is struggling to stay on that plan. She admits that she eats when she is bored, emotional, feeling down, frustrated, and anxious. At one time she was able to get her weight down to 140 pounds through consistent exercise. She

stated that she thought that was the best weight for her height. She stopped exercising and stopped smoking and her weight has gone up continuously over the course of the last 3 years. Laura volunteered for this study after she heard a presentation regarding the research in a class she was taking at the university. During the interview process Laura made statements that fit into 11 of Young's et al., (2003) 18 maladaptive schema.

Many of Laura's feelings regarding defectiveness and shame stem from the relationship with the gentleman she refers to as her father, as well as, several comments she made regarding an abusive ex-boyfriend. "I felt unwanted, inferior, criticized, rejected, blamed, and insecure by both my father and my former boyfriend." These are all descriptive words in the category of defectiveness and shame. She also stated some feelings of shame regarding her weight gain. She indicated:

I didn't want to cook. I was in school. We were always on the go...it was easier to go buy food than to cook. I tire easily. I am tired most of the time. I take so much stuff just to stay up. I am so disappointed with myself. ...I do regret it because I can't spend time with my kids like I want.

Laura is determined to complete her bachelor's degree. Unfortunately her thoughts regarding her weight also show her thoughts regarding her defectiveness as she stated: "but you know I feel like if I am this size when I finish school I will be discriminated against trying to get a job." She also commented regarding her personal disappointment and shame regarding what she perceived as a lack of accomplishment.

I feel disappointed in myself that I am at this age and I have not achieved what it was I set out to achieve by a certain age. ...And so I am really disappointed with myself. I haven't believed in myself in anything and I never have completed anything but high school and that was because I had to.

When asked about her strengths Laura commented: “I don’t know if I have any true strengths. I think I just mentally wasn’t a strong person” showing how strong her thoughts about her own defectiveness are and how it controls her thinking.

Laura made comments regarding family and her relationship with her husband that fell in the category of enmeshment. “If something happens to one of us it happens to both of us. We are not separate.” She also indicated that prior to meeting her husband she had been exercising regularly and had gotten her weight down to 140 pounds. However, when she started dating him she stated “my world revolved around him and there was no more going out with the girls because they were single and so it was no more going to the gym.” She struggles to see herself as separate from her husband. Laura stated she met her husband while she lived in another part of the state and was attending school. When she met him, she had broken up with her previous boyfriend and was struggling to make ends meet. The new boyfriend provided an extra income which lessened her economic struggle.

It does not appear that Laura has had much in the way of emotional support for most of her life. Between her father and first boyfriend, she made a number of statements which fell in the area of emotional deprivation. She questions who her real father is, but she has never gotten a paternity test. She was told at a young age that she was to call her mother’s second husband father. She stated:

She [Mom] was sleeping with two men. She was married. But my birth certificate says that my sister’s father is my father. Because she was still married I had his last name up until I was eight. And then she moved in with my current father. When they would go off for the weekends they would send the whole family over to stay with her former husband. And then when they moved into a bigger home in a different neighborhood, they said I couldn’t go anymore with the other kids to see their father.

While this may also fall in the category of abuse it clearly supports the definition for emotional deprivation. Her feelings about watching her brothers and sisters play outside with their father were met with a lack of empathy or compassion as she states: “I felt a lack of affection and lack of understanding that I wasn’t listened to.”

Laura made one comment that appears to fit in the category of insufficient self control. She indicated that much of her lack of self control revolved around her emotions and food. She stated:

When you get bored you don’t have anything to do and you just knick knack all day long. I mean I would open up the pack and eat it all. I find it hard to just fight off just eating something.

The feelings that Laura used to describe how she felt on the days that she did not follow her plan to eat healthy included the words bored and disgusted. Comments she made on the food journal suggest anxiety, frustration, and a lack of self control.

Laura from an early age identified herself as having lived in an unstable environment with an abusive father. Prior to her birth, her mother was having an affair with another man and she became pregnant. It has never been clear who Laura’s father really is. The mother divorced the man she was married to and eventually married the man that Laura has been forced to call her father. When discussing her father she stated:

They made me say he is my dad all my life. My dad...growing up he was horrible. He was an alcoholic on the weekends...and when he drank he was very abusive both physically and mentally. If he was angry he wanted everyone in the house to be angry. I would try to hide in my room and he would literally come back there and tell me to come out of my room and sit out in the front and be around him while he was angry. When I first started gaining weight he said he would pay me a thousand dollars to loose it because I wasn’t attractive anymore.

Mistrust and abuse was a big area of concern for Laura. She was emotionally abused by the man she refers to as her father: “they made me say he was my dad;” and physically and emotionally abuse by her first boyfriend. Laura alluded to possible sexual abuse by this father figure, but refused to discuss this in any type of detail. She did comment that:

He was pretty much just as abusive as my boyfriend. ...And he called me names. He would call me a slut and whore and tell me I was doing this and that and I am telling him I am not. ...At one point I felt like I gained weight so he wouldn't look at me anymore. So that I would not be appealing to him anymore.

Laura was asked whether or not her father still becomes abusive when he drinks and she stated: “Yes, I get away from him then.” Laura also commented on the abusiveness she encountered when the other man she had thought was her father would come to visit his children: “He would come to visit and I would stand in the window and cry because I wasn't allowed to go outside. And if I did go outside I would get beat and what have you.” Laura also mentioned some incidents regarding her father which continue to leave her with a lack of trust or security around him. As mentioned earlier Laura talked about her fear of abuse when her father drank. As an adult she still avoids him when he has been drinking. She stated:

When he drinks I stay away from him because he becomes abusive. He is no longer physically abusive but he is mentally abusive to whoever is around. When I was pregnant with my daughter, he would try to get abusive with me again.

Adding to her feelings of mistrust and abuse, Laura's first boyfriend whom she dated from 14 to 21 years of age was also abusive to her. When she described her first boyfriend she stated:

He was one of those people that would say things that only your enemy would say like, he would call me names. He called me ugly, slut, and the “B” word,



whatever. Anything that would come out of his mouth. He called me fat. If I gained a little weight he would say things like you are unattractive and this and that. And he was horrible. ...When he moved up there with me and that was the worst time of my life. That is when I had enough because it was constant non-stop with him. There was no escape. He would do things like not come home and then blame me for when he did get there. I was like how was it my fault.

When asked what kept her in the relationship that long her response suggests that he may have feed her self esteem. She indicated that when she met him in high school he was the first boy who had ever really noticed her. She claimed in the beginning he was attentive and treated her nicely. She was caught up in the attention he paid to her and found it hard to leave. Once their relationship was established he began to change. She remarked "It was like he would lose interest and when he did he would publicly embarrass me. We were out at a function and he poured a 64 ounce orange soda on my head."

Laura indicated that she dealt with his abuse by avoiding her feelings creating a maladaptive schema in the category of emotional inhibition. In reference to this particular incident, she stated "I tried to act like it didn't make me feel. I pretend around other people that I wasn't affected by it, but it hurt my esteem too much." Getting out of the relationship came after she miscarried their child seven months into the pregnancy at which point she indicated she became numb and no longer was able to feel anything for him. She indicated:

I just had enough. I couldn't cry anymore. I couldn't even force myself to cry anymore. No words would come out. I had had enough. I had gotten to my breaking point and that was enough for me.

Laura commented that she does not like to show her feelings: "So I try not to get into those feelings that will lead me to depression or things of that nature. I don't want to be depressed. I am not beneficial to anyone if I am unhappy." She indicated that food tends

to be what she turns to when attempting to inhibit her emotions. When this researcher asked if she found herself searching for a food item and not being able to identify what it is she wants because it isn't really food, she commented: "No it is not food, but right now my financial situation, with the economy being the way it is...I don't have the means to do what I am in the mood to do" indicating that she settles on food because she needs something to inhibit her emotions.

Laura commented that she believed she had no one that she could talk to regarding the abusive relationship with her boyfriend showing her thoughts of being socially isolated: "I was kind of there by myself so it was either talk to girlfriends or to my mom" But she did neither.

I would tell my mom some things but then I realized in that relationship that you can't involve family in everything about your relationship because when you forgive him your parents still remember. So I learned from that not to involve them in that.

However it is important to realize that she considered herself as socially isolated prior to her abusive relationship with her boyfriend. She indicated "I have been a loner most of my whole life" and this may have made it easier for her to continue that behavior once she was in the abusive relationship. She pointed out that her family belief was:

They just tell you that you don't tell other people your business. What happens in the home stays home and that Black women have to be stronger than that. You don't go to anyone else to help you with your problem.

Laura does not see herself as successful. She stated "I feel disappointed with myself that I am at this age and I have not achieved what I set out to achieve" identifying herself as a failure. When she finally made the decision to return to school, she remembered being extremely unsure about her ability to succeed. She stated "when I

enrolled, can I really do this? I haven't believed in myself in anything, and I have never completed anything but high school and that was because I had to."

Laura also made statements that showed that she tends to seek approval from others. At one time when she was between relationships she joined a gym with several other women and worked out regularly commenting "we were single and we wanted to still look good." She also talked about her relationship with the abusive boyfriend in terms of approval seeking behavior:

When I was pudgy in middle school and no one looked at me but then I went to high school and everyone saw me. But he paid the most attention to me. He was the first person who wanted to know who I was. He was the first person to ever really open up and talk to me and want to know me.

She also made the statement "I was always a pleaser." She recognizes this about herself and is currently working to make changes in this area. However her outlook on life can be very pessimistic stating "I just can't catch a break." She also was very pessimistic regarding her future.

While Laura made statements that fit into 11 categories her strongest statements and areas of concern fell into defectiveness/shame, emotional inhibition, mistrust/abuse, and social isolation. Laura's strongest areas of concern appear to revolve around her unresolved issues with her father. By the end of her interview it became clear that she still holds resentment for the way he treated her as a child. She also struggles with her feelings of defectiveness/shame, which also appear to be related to childhood and early adult memories.

*Margaret*

Margaret is a 35 year old single Black female. She is 5 feet 5 inches tall and currently weights 229 pounds. According the Body Mass Index this places her in the obese range for her height. Margaret heard about this research study from a friend at the university and volunteered her participation. Margaret stated that her lowest and most comfortable weight is 165 pounds. She stated: "I have let myself down that I didn't keep some kind of agreement with myself and I am trying to wrestle with that" suggesting a sense of failure regarding her inability to maintain that weight. Margaret identified with 10 of Young's, et al., (2003) 18 maladaptive schema.

Margaret lived in a single parent household throughout most of her formative years. Her mother was married twice, however, each marriage ended in divorce. Based on Margaret's interview, she spent a good amount of time alone starting at the age of seven because her mother was either working or going out in the evenings. Margaret's thoughts provide a sense of her feelings of abandonment:

My mother was 25 when she got divorced and she was still pretty young and cute and she wanted to go out. So I wouldn't say she left me alone every night but she used to leave me alone a lot. She would come home from work and check to see if I had a bath and everything and then she would get ready and she would say remember your bedtime is 9:00 p.m., and you need to go to bed.

She also talked about her first memory of feeling very alone at around age seven when she stated:

After my parents got divorced we lived in our little apartment. My mom had to work and I was a latch key kid and I remember it was a Christmas holiday. It was like the week before Christmas and we didn't have to go to school but my mom still had to work and so I am in the apartment. And I just remember feeling for the first time in my life feeling profoundly alone.

Margaret does not outright express abandonment, but clearly it appears she was left alone on a regular basis which by today's standards would be considered abandonment based on child welfare standards.

Margaret identified one very strong memory that fits in the category of defectiveness and shame. She talked about her father being extremely abusive to her mother. Her mother was so afraid of what her husband might do that she tried to teach Margaret at the age of five how to call on the telephone for help. She recalled:

It just happened that the next time he beat her it was so severe that I just froze. I was just standing there with the phone in my hand...I remember the beatings. I remember how he use to choke her. I remember that incident with the phone being one of the most shameful things of my life.

Margaret made no other statements that fit into this category, but it was clear that this is a strong area of shame that she still struggles with.

Margaret's statement regarding mistrust and abuse was simple and clear. She watched her father abuse her mother until she was four or five years old and carries very strong memories of that time in her life. It is easy to see that the memory is strong and still an area of concern when she stated:

I do very much resent how things transpired in my parent's marriage because it has been very hard for me to really feel safe around people and trust them to get close with them. To connect with them. I have blanket trust issues. But maybe that is why I am not married because, I don't know what. Because my dad is a pretty charming guy and nice, but how can I make sure I don't end up with the same kind of situation my mother was in.

Margaret's memories of her father's abuse of her mother were not her only memories which would lead to her thoughts of mistrust. She also reported that her mother mentally abused her stepfather. Margaret found that extremely painful to watch and on most occasions felt that it was truly undeserved. She stated

My mother has a bit of an irrational temper. Like she will just start and go at it and it is a bit much. My mother would call him all kinds of names. She would talk about his mother and he would never push back on that.

These collaborative events provide an understanding of her own statement that she clearly understands her issues of mistrusting people.

Margaret, by her own admission, struggles with subjugation. She struggles to speak up even when she knows she has been wronged. She will withhold her own preferences and avoid making decisions and has spent much of her life suppressing her anger.

Because it is not like I say oh well, I don't like that and how can I change it. I just go I don't like that and I shrug and try to focus on something else. And that is pretty unsatisfactory.

A prime example of this was her suppression of her emotions in middle school when she was being taunted on a daily basis on the school bus. She was the only African American student on the bus and found very little support from other students, the bus driver or her mother. She stated that this carries over in her life still. In her own words:

I will find myself grouching to myself about some issue where I should have spoken up or something and/or taken it on and it is not really something I can do anything about and I will be like – oh my gosh – I will be thinking about it over some cookies and so I think sometimes thank God I don't like alcohol because I think I could really have a problem.

However, she indicated that she learned the skills to be more assertive in a college course but struggles to apply these skills across the board. One positive statement she made was in reference to standing up to her mother:

I kind of learned that my mother is not a mind reader and so I would have to express myself. The compliant child thing wouldn't work forever so I had to speak up for myself.

This is still a work in progress for Margaret.

Other issues of subjugation come with her admission of being a compliant child when she remarked “I was an incredibly compliant kid. My mother wasn’t home but she said to be in bed by 8:30 or 9:00 and I would be in bed by 8:30 or 9:00.” Margaret stated that it was not until she was 14 or 15 years old that she figured out that she probably did not have to follow all her mother’s rules and would not get into trouble. She indicated:

She used to tell me I couldn’t watch TV until my homework was done. I was 14 or 15 when I realized that I could watch TV until about half an hour before she got home and then turn it off and the TV would be cold and that she probably wouldn’t even think to check to see if the TV had been on. So I was really compliant.

At times, Margaret’s mother would leave her with neighbors when she was going out for long periods of time. She stated that many times she didn’t know these neighbors well and felt extremely uncomfortable in their homes. Margaret again stated her compliant nature when in the home of others.

I didn’t want to get in trouble for messing with their stuff so again being the compliant person I would just like bring a book or I would pray they had some magazines and I would read magazines. I would just sit there and read a magazine and watch TV.

Margaret also discussed how her mother expected her to “shake down” her father for money when she went to visit and how she felt obligated to go:

He never hit me but I didn’t know what was going on. He still drank a bit. And I would just go and we would do stuff and I was expected to try and shake him down for stuff anyway, so I had to go and I had to kind of make an effort to at least try because I knew when I got home that my mother was going to say “did you tell your daddy you have a class trip to go on?” “Did your daddy give you some money?” Yeah, I really felt obliged to go. I can’t say I really enjoyed visiting my father. It was like just get this over with.

Young’s, et al., (2003) definition of subjugation of emotions suggests that suppressing emotions may manifest in maladaptive symptoms such as substance abuse.

Margaret's comment regarding believing that, if she liked alcohol, she might have used that to suppress her feelings shows her ability to misuse substances in an attempt to suppress feelings. In Margaret's case she suppressed her feelings with food. She stated:

I feel comfort. Oh food feels good in your stomach and it tastes good and it takes you out of whatever painful thing you were thinking about especially if you have to make or go get it or wait for someone to bring it to you.

These remarks also tie in well with Margaret's comments regarding emotional inhibition. Her strongest memory of using food to suppress her emotions was at age seven years old. She was left home alone during a Christmas break from school. Her mother had to work and Margaret was expected to stay at home alone and entertain herself. She stated her feelings of loneliness and how she responded to them:

We had some cereal and little snack packs of chips and some soda and some snack cakes...I ate just about all of it. I ate most of the chips....And I ate about half of a box of Twinkies and I must have drank three or four sodas....So I remember that it was one of the first instances where I did connect food with an emotion. And you know it was loneliness and that was my solution. I just ate.

When asked if she still believes she emotionally eats, she stated "when I am frustrated, angry, or sad I eat."

Margaret also talked about experience with racial discrimination as she attended a nearly all white middle school. She was the only African American child riding the school bus and had numerous situations where she was taunted by other children on the bus. She stated:

There was a period in junior high where there were just a lot of racial incidents that kept happening on the school bus and I would get home and be pretty upset about it and I would eat. I would have a full meal. If there were leftovers I would eat those and then I would look for something else and then I would eat dinner to try and cover up for the other.



Margaret has carried this behavior into her adulthood and it continues to cause problems for her. When asked by this researcher if she would consider herself a stress eater, she stated “yes.” She commented that she does not know how to handle her emotions and therefore “I guess I just cook up a couple dozen cookies. ...And whenever I have stressful or hurtful times I tend to overeat and I tend to eat quite a bit of crap.” When asked if she eats all the cookies as well she responded “Yeah.”

Margaret also commented on her feelings of isolation and alienation particularly during her middle and high school education. She stated:

I may not have been overweight when I look at it now. I went to a predominately white school and I developed early and secondly I have very different characteristics. My butt was rounder, my thighs were bigger. I looked probably more womanly than the other 13 year old girls. ...I think also my experience with being usually the only minority person or African American in a lot of school settings was very isolating. ...Or something would come up to remind me of my outside status and that would upset me very much because there was nothing I could really do about it.

Margaret’s experiences as being one of few African Americans in her school truly provided her with a sense of isolation.

Margaret is very proud of her academic success however, she made one comment regarding her inability to maintain a lower weight which could be considered a failure to achieve. She stated “I have been struggling with this for a while...I feel like I let myself down that I didn’t keep some kind of agreement with myself.” It is likely that if she is unable to successfully lose weight and keep her weight down, it will manifest into a stronger maladaptive schema and will affect her future attempts to have some control over her weight gain.

Margaret also made comments that suggest she has some thoughts that fall in the category of unrelenting standards. She showed some signs of being hypercritical of others when she commented:

I would like to think I am not a judgmental person but I see somebody come in with French tips I make a snap judgment. And the snap judgment I make on them is not one I want people to make about me....I know how people are suppose to be and I am very attuned to that. I like, order, I like propriety, I like decency. The fact that it has not always been a value of the people around me is painful because I feel like an outlier. And sometimes I question...why don't I just lower my standards? And I can't because I have seen the result of it.

Margaret made one fairly strong comment which fit in the category of approval seeking when she talked about believing that she looked different than the other girls in her predominantly white middle school. She stated "I developed early and secondly I had very different characteristics....But I always thought that if I lost weight I would be like this...and I would fit in better." As an adult, Margaret suggests that she is not concerned with how she looks. However she may again be suppressing these types of feelings with food.

Margaret gave one example of punitive behavior regarding her relationship with her father. She stated that they had an argument when she was about 19 years old and she stated: "I decided I was sick of all this...I decided I don't have to see him anymore and I am not going to. I never called him or saw him after that." She actually did not speak to or hear from her father until she was 35 years old. She stated that he had a stroke and was not expected to live. Her stepmother called to let her know and Margaret made a decision to reconnect with him. However, for about 16 years she made no effort to make him a part of her life. She expresses no regret and actually suggested that reconnecting has brought new information into her life that she was not entirely prepared

to handle. She discovered that she had two half brothers that were about her age which created another issue of trust regarding her father.

Margaret made comments that fell within 10 of Young's et al., (2003) maladaptive categories. The categories where Margaret made the most comments included abandonment, defectiveness/shame, mistrust/abuse, subjugation, feeling socially isolated, and emotional inhibition. Margaret admits that she continues to struggle with her ability to be assertive and express her thoughts and feelings to others. She continues to see herself as that compliant child who could sit quietly for hours waiting on her mother to come and pick her up. She indicated that she can become passive aggressive rather than confronting the issues, just as she did when she realized she could watch television as long as she turned it off before her mother got home. She continues to have strong feelings of mistrust, particularly regarding relationships. She indicated that she struggles to have a relationship "because my dad is a pretty charming guy and nice, but how can I make sure I don't end up in the same kind of situation my mother was in?" She also admitted that it was easier for her to deal with the emotional and physical abuse she endured at school with food, emotionally inhibiting how she truly felt about the way she was being treated by her classmates. Margaret lost weight several years ago because she was bordering on several serious medical concerns. Her doctor has again warned her of these health concerns, yet she continues to struggle to keep her weight within a normal range. Based on the maladaptive schema that were identified through her interview, it is likely that not having dealt with the issues involved may be contributing to her inability to keep her weight within normal range, even though she knows it makes her feel better physically and removes several health risks.

The four participants in the category of compulsive overeater resulting in obesity made comments in 14 of Young's et al., (2003) maladaptive schema however all four of the participants in this category shared comments in five categories. Each of the four participants made comments indicating thoughts and feelings in the areas of defectiveness/shame, mistrust/abuse, emotional inhibition, failure, and approval seeking behaviors. Some of the participants made more comments than others in each of those categories which would suggest that individually some categories triggered more maladaptive schema than others. It is important to note that all four participants discussed the use of food to inhibit emotions each indicating they found some type of comfort in food and eating. Addressing these maladaptive schemas in the treatment of compulsive overeating resulting in obesity may provide better results in maintaining weight loss.

#### Bulimia Nervosa

Three women volunteered for this study, each indicating they are in recovery from bulimia nervosa. Each admitted to binge eating and purging at least two times a week for more than three months which is considered the essential features of bulimia nervosa according to the Diagnostic and Statistical Manual for Mental Disorders (DSM-IV-TR; American Psychiatric Association, 2000). Each indicated that they would eat larger amounts of food, experiencing a sense of lack of control during a discrete period of time. All three women admitted to self-induced vomiting after a binge. All three women indicated they are currently in recovery. The least is two years and the longest is 15 years. As each tells her story, it is clear that they are still struggling with some maladaptive schema for which each has found a different way to cope. Donna works a

12 step program and shows the strongest signs of recovery. Carla appeared to use food as comfort and currently, based on the body mass index, is obese. Jade admits to continuing to binge on specific foods but denies vomiting. Each of their stories identified maladaptive schema which still may be disruptive to their recovery process.

*Donna*

Donna is a 25 year old Caucasian female. She is single, but engaged to be married. This will be her first marriage. She has no children. Donna stated that her bingeing and purging behaviors began at 16 years of age and continued until she was 23 years old. Her story is complicated by the fact that she is also a recovering drug addict. Her bulimia started at age 16; however, she started using marijuana at 14 years of age. She stated that when she could no longer get access to drugs she switched to bingeing and purging in an effort to continue to inhibit her emotions. She stated “I spent four months in a teen crisis shelter...and I didn’t know how to deal with what was going on any other way and I started bingeing and purging.” She indicated that she started her recovery from drug abuse but failed to consider her eating disorder in her early recovery. Later she did start to apply a 12 step program to her eating disorder as well. As she stated:

I would have periods of abstinence and I would work the 12 step program and apply it to my bulimia and then I would have relapses where I would binge and purge again. ...It was six months here and six months there in the last year I was doing it, and it became premeditated. Everyone of them. And I would spend lots of money on what I was putting in and throwing up.

Donna’s father is a recovering alcoholic who has been in recovery for 20 years. She believes her mother had difficulties with anorexia, although there was no clear diagnosis. Her perception of her mother now is that she may be an active alcoholic. Donna stated she has never received professional treatment for her bulimia, although she

indicated that she applies her 12 step recovery program to both her addiction and bulimia. Through conversation Donna made comments that fit 10 of Young's, et al., (2003) 18 maladaptive schema.

Donna believes that when her father became sober this was the first time she felt abandoned. In her words:

He was too obsessed with this failing marriage so he didn't really have time for the kids until they got divorced and then he knew we were the only family he had left and had a change of heart and then we were all friends again. But he didn't really have a lot of time to think about us kids because he was trying to hold on to the marriage.

Donna indicated that at one point neither one of her parents was able to manage her behavior which left her feeling abandoned.

My mother sent me to live with my father. I was 15 and I stayed there for four months and that didn't work. ...My dad sent me back to my mom's. ... I was back at my mom's for a month ...and my mom put me in the teen crisis shelter.

Donna admitted that she desperately wanted her mother's attention "I wanted her attention more than everyone else because everyone else will just give it to me and she made me beg for it." Her approval seeking behaviors lead her to running away from home. When her mother made no effort to bring her home, she again felt abandoned.

Donna went to stay at a friend's house. She stated:

My mother said you do whatever you want. You think you are grown up you do what you want and just stay there. And then six hours later the cops came and picked me up because she changed her mind. So I went to juvey and they called my mother and said we can't hold her because she is a run away. That is not an offense. And my mom said I am not coming to get her. They said then we consider that child abandonment and they turned me over to child protective services.

When asked which of her parents she would consider to be more unstable Donna stated "It depended on how many cases of alcohol they had at the time. My father has the

standing record today for being pretty stable. My mother has the record for being somewhat stable for prolonged periods of time.” While much of the cause of Donna’s issues related to her own behavior in the end her perception that her parents abandoned her seemed clear.

Donna made numerous comments regarding her thoughts of defectiveness and shame associated with her eating disorder and addiction in general. She stated “I have lots of obsessive-compulsive and self centered behaviors in my life. ...It started out with food and trying to feel loved. ...I have not had a day go by that I have not rejected some part of my body. She made comments about her own frustration with herself and her use of food to attempt to make herself feel better:

I didn’t think there was any hope for me. So I started eating potato chips and then threw them up. ...Because I would give up and I don’t think there is any hope for me. There is no reason to try and help myself because I will always be just this screwed up. ... I don’t know how to love myself.

In her recovery Donna has begun to work on her feelings of defectiveness and shame and made several comments that show how she works her program:

I have to practice at being somebody that I want to be and I think it was six months ago that I finally started to feel really successful at this. Practicing being someone that I wanted to be and I started to feel a lot of these feelings of esteem. ...I use to loath myself but now I see myself as more of a quirky – you know traits I still need to work on to be of better service to other people. ...recently it is just I know what I think and that is okay and I will just have to learn more politeness. I have already been learning more politeness and this is actually okay that I can incorporate this into my confidence and my idea of myself. ...I started out with this hatred for myself and now it has just changed.

Donna is working hard on her recovery and is making progress particularly in forgiving herself and building her self esteem. This provides her with less of a sense of being defective.

Donna made comments regarding emotional deprivation that appear to stem from her relationship with her mother. Donna believes now that her mother was doing the best she could but when Donna was growing up she believed:

She did not have the ability to talk things out which is what I really would have benefited from. You know you don't have to eat because you are bored, or you don't have to eat a lot. We can do other things that make us feel good than just eating and stuff like that but she just didn't talk about her problems. She would just try to control. And when she could not control me she would ignore me. ...She would not speak to me. And I would beg for her attention and be all up in her face and she would completely ignore me.

Donna admitted that her inability to deal with her issues with her mother led to insufficient self control on her part and admitted "I didn't know how to deal with what was going on any other way and I started bingeing and purging." She talked about her bingeing and purging behaviors and her lack of control over stopping herself once she started. She stated:

I was very active and it wasn't enough food and that is one of the things I say to myself. I really loved to do it and I find it difficult to control myself at times and so I think it is both things. I would like to tell myself I was eating too little and my body revolted and I have to put more food in but it is also that I have less control over myself as I would like. ...Well when I made the decision to use it was like a compulsion. It was like I wanted to use a four letter word but screw it. You know. It is kind of a familiar thing in my stream of consciousness where it goes. I don't care anymore I am just going to do it.

When asked what she thought she gained from bingeing and purging she indicated:

"control of my feelings, avoiding reality, not taking personal responsibility for my life, myself, my feelings, everything." Her issues of self control played a big role in her inability to give up her binge/purge behaviors when she entered a recovery program for her drug addiction. In effect she simply traded one addictive behavior for another.



One of Donna's critical maladaptive schema is mistrust/abuse. This is the maladaptive schema where the majority of her statements appear. Many of her issues with mistrust/abuse also stem from her relationship with her mother. At age two years her mother apparently was caught physically abusing her. "My dad found out that my mom had been beating me up when I was two." Donna does not remember the incident but her father told her about it. Donna states that she was surprised by what her father told her. "I think he told me too soon. I wasn't on my fourth step yet and it messed me up in the head for a while." Once her parents divorced, her mother remarried and her stepfather was also an abusive person. She was 13 years old and this became the start of her abusiveness to herself. "My stepfather started hitting my younger sister and I still didn't use but when he started hitting me that is when I started to use." Donna started smoking pot and used for two years. When she no longer had access to drugs, she began bingeing and purging.

In reference to mistrust, when asked to describe her mother, she stated "liar is the word that comes to mind." She further indicated:

I think she can twist and change the truth in her own mind. She is not an honest woman. I would trust her with my physical well being to a point. Because if I go on a trip with her and it is just her and me and she is drinking and upset, then I don't want to be in that type of situation. ...Because why would you want to reason with a crazy person?

Donna also noted, when her mother joined a recovery program for her own eating disorder, she "would portion control my food because she believed I showed signs of over eating" showing her mother's continued over control and abuse.

Due to Donna's behavior at home she found that her parents were constantly trying to maintain some type of control over her. Her perspective on their need to control

fits in the maladaptive category of subjugation. “Every time I did something wrong they would take my life away. They would take the little jar that is me and turn it upside down in an effort to control me and I would work to feel nothing.” She believed that her stepfather was most responsible for attempting to control her behavior.

My right to control myself had been removed. He was manipulative...he was definitely controlling...and that type of person goes and tries to rob that person of their self control.

Donna admits that she “worked to feel nothing” based on what her parents would do to try and place some controls around her. At some point the bingeing and purging apparently was not enough, and she started cutting in order to control or release feelings. She was in a treatment center at the time and interestingly reported the cutting to the therapist, but did not report that she was also bingeing and purging her meals. Prior to being placed in a treatment facility, Donna had run away from her mother’s home on more than one occasion. When her parents became frustrated Donna ended up in a teen crisis shelter. Donna’s comments described her need to inhibit her emotions in order to survive:

When your parents are kicking you out it is like this resignation would be a lot of how I would feel. I would get this numb I would describe kind of like a PTSD type response. I had no feeling. The underlying feeling I was trying to suppress was having to deal with my body and accepting my body and myself.

Donna also expressed thoughts which indicate her unrelenting standards for herself. Early in the interview, when asked to describe herself, one comment she made was “I have lots of obsessive compulsive and self centered behaviors in my life.” At another point in the interview she talked about an effort on her part to control her calorie intake. She stated: “I would eat more than the 1350 calories and that rigid black and

white thinking I would not think that 1400 was a successful diet day.” She was then asked what would happen if she went over the 1350 calories in a day, and her response was simple and matter of fact “I would throw up.” She also stated: “So I would eat something and then realize it was a mistake and I would have to make myself throw it up.”

One of Donna’s critical areas of maladaptive thinking involves her need to have her mother’s approval. From the time she was a small child, she recalls trying to gain her mother’s approval: “I wanted her attention more than everyone else because everyone else will just give it to me and she made me beg for it.” Her mother’s own addictive behavior got in the way of Donna’s success. She commented early that her need to feel loved revolved around food. She believes that her mother saw her as having a tendency to be over weight and therefore controlled her food intake and what she was allowed to eat. She stated: “my mom was controlling my food ...I would goad her at times to tell me I was the right size. ...And I would find opportunities to ask her to tell me that I was the right size.” Donna’s need to gain approval from her mother extended into other relationships in her life. She commented: “I think that people like me if I do this then I will be loved, if I do that I will be okay. If I do this then I will be appreciated in society.”

Donna also made one very strong punitive statement regarding her mother. When she finally got to a point where she realized that she may never be able to have a positive relationship with her mother, she came to the conclusion that she would need to exclude her from her life entirely. “I never thought my mother was giving me approval so I rejected her as a punishment and as a way of dealing with the rejection of myself from her.”

Donna made comments that fit into 10 of Young's et al., (2003) categories of maladaptive schema. She is now in recovery for her drug addiction, as well as her bulimia. She works a 12 step program for both. She works the steps of the program with her sponsor and recognizes that she is always just one drug or one binge away from relapse. She also applies this program to her bulimia. She recognizes that she has a life long struggle and appears to be working hard to change the things she can while accepting those things she cannot change. This has served her well and she made clear statements that allowed this researcher to see that she is working through her maladaptive schema in this process. Particularly in the area of defectiveness and shame, she appears to have a better understanding of who she is. She stated that she tends to be over confrontational in her style and that she is trying to stop confronting people so much.

She commented:

Yes I have always hated myself for that and then recently it is just you know what I know what I think and that is okay and I will just have to learn more politeness. I have already been learning about politeness and this is actually okay that I can incorporate this into my confidence and my idea of myself.

She also stated: "I used to loath myself ...now I see myself as more of quirky, you know traits I still need to work on to be of better service to other people." This is still a work in progress for Donna as she stated: "I need to find some type of way to shut off the self critical thoughts."

*Jade*

Jade is a 27 year old single Hispanic student who fits the DSM IV-TR (American Psychiatric Association, 2000) diagnosis of bulimia nervosa. She indicated she started bingeing and purging at the age of 16 and stopped two years ago. Jade was referred to the

study by a counselor. Jade attended group meetings and 12 step programs off and on for approximately 5 years seeking help for her bulimic behavior. Jade was born in the United States; however, her parents entered the country illegally. Shortly after her birth, they returned to Mexico. She lived in Mexico until the age of nine with her mother, father, and brother at which time her parents gained legal access into the United States. She returned to the U.S. with her parents at age nine. Her older brother had to stay in Mexico because they could not get his paperwork in order. Jade indicated that she struggled to fit in either as an American or a Hispanic.

I was not good enough for either. The older I got the more my mom pointed out that I was getting too involved in the American life style and I was denying my roots. I knew that wasn't true, but the more I tried to be Hispanic the less successful I was.

This is a clear sign of her feelings regarding her defectiveness and shame. Her parents were migrant workers which required that they moved often and she struggled with friendships. This left her feeling lonely and socially isolated. She also believes that she was constantly compared to a cousin who was the same age, but was always smaller in stature. She felt unaccepted by family and friends, again leaving her to feel defective "Somehow in my mind I always thought she was better than me."

Her bulimia originally appeared to stem from her approval seeking behavior to find a way to fit in. "If I can't get accepted any other way then if I stay little then that will be the way to get accepted." While she no longer purges, she admits that she still uses food as an emotional crutch and occasionally binge eats. She stated her favorite binge food currently is cereal. She appeared to believe this is a healthy alternative to

what she used in the past as binge foods. Jade made comments that fit into 12 of Young's et al., (2003) maladaptive schema categories.

Jade's parents returned to the United States when she was nine years old. She stated that she believed while growing up in Mexico she had a relatively normal childhood. She had friends, attended school, and remembers this as being one of the happier times in her life. However, once her parents were able to secure green cards and return to the U.S., Jade began to see a change. Both parents worked as migrant workers throughout the southeast. Jade's perception is that because of their work they had very little time to spend with her. Because she could not speak the language she felt alone, and expressed throughout the interview her feelings of abandonment. "I mean I literally grew up on my own." She also stated "my parents said we would move back to Mexico after I graduated. Once we did, they decided not to stay and so I was left alone. For those nine months I was pretty much living on my own." She had looked forward to returning to Mexico, however, the end result was a sense of loneliness and abandonment as the rest of her family returned to the United States. She stated "I was in Mexico by myself so I was dealing with being lonely. I was so lonely. I just didn't know how to cope with it any other way." Her coping mechanism was bingeing and purging in an effort to relieve her emotions.

One area of maladaptive schema which appears to have had a big impact on Jade's eating disorder is defectiveness and shame. She provides several examples throughout her childhood that fall within this category. Jade struggled with thoughts about not fitting in. She indicated that when she tried to fit into American culture, her mother complained that she was giving up her Hispanic heritage. Yet at the same time,

when she tried to embrace her Hispanic side she did not believe she was ever able to do it well enough to please her family. She stated:

And so growing up it was a lot you don't fit in, as far as being Hispanic or being American. I was like not good enough for either one. I felt that anyway. The older I got the more my mother pointed out that I was getting too involved in the American life style and then that I was denying my roots. And I knew that wasn't true but the more I tried to be Hispanic the less successful I was.

Jade believed that the comparisons the families made between her and her cousin suggested that she was not good enough. This again pointed to her feelings of defectiveness:

I was not a very popular kid. Not only that, but when I was growing up, I was compared to a cousin. ... We were the same age but she was a very petite person. Like really, really tiny. So the comparisons were always that I was a little heavier than her. .... And somewhere in my mind I thought she was always better than me in that way.

Jade also commented on her feelings of shame and guilt after a binge and purge episode:

I felt like oh my God I can't believe I got rid of all that. I did so good. And then there is like a high that you get. Because you are relieved but it is like well I just got rid of something that was not suppose to be there. And then it lasts for a good five or ten minutes until the guilt comes. ... And if there was any stress going on in my mind I think that it has to do with concerns like being able to control the thoughts that go in. It is like you wake up with problems that are going around the house or feelings of inadequacy that I am not good enough so I am just going to torture myself. ... and then the guilt is on the back burner oh this is going to make you fat. So not only do I not feel good this is only going to make you fat.

Jade also made several general comments about her thoughts of defectiveness and shame including "I feel so inadequate and I still wake up some days and think you have done nothing with your life. You are not successful and that is why no one wants you. You are this, and you are ugly." She also commented on her bingeing and purging behaviors and the fact that she knew what she was doing was not appropriate or healthy.

She stated: “there was always a lot of guilt afterward because I knew it was wrong. ...I felt very shameful.”

A good sign of recovery is Jade’s ability to start to express to others her thoughts about her perceived defects. She did tell her mother about her eating disorder after she had stopped binging and purging. She realized:

I guess expectations of me being the excellent daughter has always been there and sometimes it is just like, you know what I am just human. I need help and other things too. I am their only daughter and you know what it is just like sometimes I know it is like I told my mom you are thinking that I have it all put together but I don’t have it all put together. I am struggling with lots of things and I need for you to understand that I am just as human as anybody else.

An excellent beginning to accepting herself and allowing her mother to see who she really is.

Jade admits that she has a problem with decision making which likely stems from her having to make decisions while living on her own in Mexico at 17 years of age. At that time in her life she indicated “I had no clue and again I had no control over anything whatsoever.” She appears to carry her fear of decision making even now as she stated: “I feared decision making and that even applies now. I am still struggling with that, and giving in to other’s wishes. I didn’t have them myself I just had to do what everybody else told me.”

Jade also made two statements that fit into the category of emotional deprivation. In particular she believes that her father was unable to provide her with a sense of care and belonging. She described her father as very distant.

Emotions don’t count so he doesn’t have a lot of emotions. He just goes through the process of living. ...He is a caring person but I don’t know how to say this he lives in his own world. So it is like, it is about him.



She expressed a lack of support from both parents throughout her life adding to her sense of loneliness and feeling emotionally deprived as she stated: “I did wish that I had someone I could rely on like my dad to protect me or care for me, or whatever.”

Jade expressed a belief that her mother had anorexia nervosa; however, she was never diagnosed. Jade believed her mother depended on her for support “she leaned on me.” Her enmeshment with her mother was identified when Jade indicated that one of her fears was not being able to have a life of her own due to her mother’s dependence on her. After consulting the list of words and phrases offered to her she described her relationship with her mother as: “fear of over involvement in other’s lives and I would say my mom would be it, no life of my own. ...I felt it was my responsibility to make her feel better.” Jade has a sense of responsibility toward her mother where she believes that it is her job to fix her: “because I still take blame for, well not blame but I will try to fix my mother. She is such a caring person yet at the same time she is so fragile that I want to fix her.” While her relationship with her mother shows signs of enmeshment at the same time she expressed her mistrust as to how her mother might perceive her help.

Yet at the same time she has this powerful character and personality that is manipulative at the same time that if you get too close to her she will make your life miserable. ...So it is like how do I approach my mother so that I can help her but yet that she doesn’t affect me so much that I become miserable in the process.

Jade also expressed feelings of mistrust regarding the move back to Mexico. “My parents always told me we would go back to Mexico and so I thought in my mind that I always wanted to go back and it seemed like a lot of broken promises because we never did.” Eventually the family returned to Mexico. However her mother and father decided not to stay there and returned to the United States leaving Jade in Mexico to take care of

herself. During this time her feelings of isolation were overwhelming and her binging and purging increased. She commented: “I didn’t feel like I could trust anybody to go tell anybody. Not even my mom at that point anymore.” Jade also expressed that her father’s lack of emotional support left her feeling that she could not trust him to ask for help. She stated that she believes her father has her on a pedestal and that she is unclear what would happen if he found out she was not who he believed her to be. As she stated: “...so I am not going there with my dad. I can’t even ask him for help.”

While living in Mexico on her own, Jade’s eating disorder became more out of control, yet it provided her with a sense of control for her emotions, particularly her feelings of loneliness and isolation from family. She stated “it was so easy to hide and lie about it.” Jade also expressed that coming to this country as a young child also carried a strong sense of isolation for her.

But here it is like you come here, you don’t know the language, you have to learn a new language, you can’t communicate, you have to move around a lot you never have friends, your parents work all the time. ... You can’t talk to anyone because you don’t know the language.

Jade also appears to be very self sacrificing. Included in her enmeshment with her mother is Jade’s sense of responsibility for her mother and that if she didn’t take care of her no one else would. She stated:

My dad was working all the time and so it all came down to me. I was forced to grow up real quick when I was little. ...I had to protect her, I had to make her feel good, I had to keep her happy. And for a kid that is kind of hard.

Jade still carries this need to place others before her own needs as she explained: “My coping mechanism is, stop feeling sorry for yourself and see what you can do for someone else that feels worse than you do.” While this may be a sign of recovery, at the

same time Jade's need to help others keeps her from working on her own issues. This may be leaving her open to relapse.

Jade's issues with emotional inhibition contributed largely to her eating disorder.

As she stated:

It was one of those things you do to try and compensate the feeling and you over eat so much in such a short period of time then the guilt that I over ate too much and then the fact that I don't want to get fat because I am only accepted when I am little you have to get rid of it right away.

At times in her life when she became overly stressed she stated:

I would eat, and eat, and eat and then just get rid of it again. There was a lot of stress because I didn't know what I was going to do. ... Like this eating is going to make me feel better, and um, it was just a coping mechanism because I was so stressed out that I would eat and then just keep eating and eating and eating and by the time you realize it you have eaten so much and then you don't feel good.

During her time in Mexico she found herself trying to cope with her feelings of loneliness again by bingeing and purging as she stated:

So I was in Mexico by myself so I was dealing with being lonely. I was very lonely. I just didn't know how to cope with it any other way. ... And again the coping mechanism came in that way. I just can't control anything and so I will eat and purge and I will stay skinny. While you're eating it just kind of relaxes you.

Jade believes that her family perceives her as being independent and very successful. However, she does not see herself in the same way. She stated that she has "a lot of fear always making the wrong decision for a lot of things." While she will try to provide herself with encouragement that she can succeed she stated: "again that little voice will come out and says no you can't do it." Another area of failure for Jade includes her issues of enmeshment with her mother and her efforts to help her as she

stated: “when I can’t do it I feel like a failure because I’m still not there for my mother the way I wish I could be.”

Going along with her fear of failure, Jade expressed unrelenting standards for her ability to be successful. She stated “I have been a perfectionist. ...I have always been an over achiever, I always want to accomplish more than I think I can. ...Sometimes I don’t think I am doing enough.” She also indicated that some of her approval seeking behaviors will end up in her setting up unrelenting standards for herself. “It is like if nobody likes me, then I am going to torture myself so that I can be skinny.” She also talked about how her need to be the perfect daughter influences her perfectionism:

I think again I always try to keep the faith that I was the perfect kid who never did anything wrong. And as an adult I still want to keep the thing that I never make a mistake. The perfectionism is like oh I am so perfect. ...I still hear the mom voice and dad voice because my dad always thought I was super smart.

Jade has started to realize in her recovery that these unrelenting standards do not help her eating disorder, and she is working to make changes. She stated:

There is a little voice somewhere in the back of my head that is just an over achiever and it is like you are not going to get stuck in that. ...I have been trying to present as this little robot that’s perfect and I am not.

It appears that many of Jade’s bingeing and purging behaviors stem from her perception of not fitting in. This appears to start with her moving to the United States at the age of nine years old and not being able to speak the language. Even after learning English she continued to struggle with seeing herself as a part of something, particularly when her mother is critical of her Americanization. This seems to culminate in her belief that she is being compared to a cousin of the same age who is smaller in stature than

Jade. Her expressions regarding approval seeking appear to culminate in her need to fit in and be accepted particularly by family:

If I can't be accepted any other way then at least if I stay little that will be the way to be accepted. .. I immediately got noticed when I lost weight. ...and in my mind again as I got older I was like well, if I can stay this little everyone is going to like me more. ...There is so much of a desire to be accepted and I felt that by losing a little bit of weight that I would be accepted and then it becomes sort of like a circle. Because people say you look good, so then you want to continue to do it. And it isn't so much that you want to do it but you do it more, and more, and more and it becomes a pattern. ...I am only accepted when I am little you have to get rid of that food right away. ...it was always in the back of my mind that I had to be skinny. ...That it would make me accepted.

Jade also stated that this continues to be an area of concern for her, stating "I still do struggle with trying to please others."

While Jade made comments that fit into 12 of Young's et al., (2003) 18 maladaptive schema two areas that appear to have the strongest statements are the areas of defectiveness/shame and approval seeking. Jade's struggle to fit in continues to be a source of concern and could lead to relapse, if not considered as part of her treatment program. Jade has sought out 12 step recovery programs for support. She has attended meetings but not worked the steps, which are considered key to a successful recovery. Because she admits to occasional binge behavior without purging and justified this with the food she chooses for those binges, she should be considered vulnerable to relapse. She failed to return her food journal. Reviewing the journal might have provided more information regarding the binge behavior and what thoughts and feelings continued to be linked to those binges.

*Carla*

Carla is a 40 year old married Caucasian female. She is a graduate student at the university where she heard about this study in class and volunteered her participation.

Carla stated that she started bingeing and purging during high school.

I could tell the calorie count of everything and what one quarter of the calorie content of anything was. I would get up before school and exercise. I played volleyball and we would practice after school and then I would go home and exercise some more. ...And low and behold my cousin taught me how to throw up and then I went through a stage where even if I ate a little bit I didn't have to try and throw up. I would just get sick.

Carla stated that this went on for about five or six years. She stated: "at times I would get it under control and then I would get bad again and back and forth for a while." She did not seek treatment for her bulimia. At 24 years of age she joined the Army and then did a stint with the National Guard. She stated she stopped bingeing and purging because she was convinced that it would get her discharged. She stated she has not binged and purged in about 16 years, however, admitted that she still binge eats when her emotions are out of control which could indicate that she is not fully in recovery. Carla made statements in 10 of Young's et al., (2003) categories of maladaptive schema.

Carla stated that her mother has been an alcoholic for as long as she can remember. She stated that her mother was promiscuous and Carla was the product of a one night stand. She did not find out who her father was until she was in her 30's. Her mother did marry when Carla was about five years old. She was raised by her stepfather until she graduated from high school. Her issues of abandonment are related to her mother's behavior when Carla was in her early teens. She stated "my mother moved to Florida and actually left me with my step-dad until I graduated high school." She later in

the conversation without the use of the words and phrases list described her mother as “unreliable, and unpredictable.” Both words fall in the category of abandonment on Young’s, et al., (2003) definitions of maladaptive schema. She stated that throughout her early adult life she continued to struggle with “some things from my childhood and the feeling of my mother abandoning me.”

Carla appears to have a good self concept and therefore made minimal statements that would fall in the category of defectiveness and shame. One area of concern for Carla has been the affect of family on her marriage. The turmoil surrounding her husband’s previous marriage and daughter, as well as the turmoil that Carla’s mother brought to their lives, at times would affect her relationship with her husband and their ability to be close to each other. Because of the turmoil their sexual relationship has always suffered and as she stated: “so then I feel unattractive.”

When she married she also gained an 11 year old step-daughter. Her husband had been given custody of the child by the court. The step-daughter immediately came to live with them. Carla stated there was a lot of turmoil regarding her step-daughter, her husband and his ex-wife and this caused some difficulties for them. After the step-daughter graduated high school she decided to go live with her mother in another state. Carla sometimes questions her parenting skills. She stated that she has learned things about parenting through her education that she wished she had known then and “when I think about it I feel guilty” indicating her guilt regarding her ability to parent affectively.

One of Carla’s major areas of maladaptive schema is emotional deprivation. She stated that even when she was living with her mother and step-father her relationship with her mother was not strong. She recalled spending an enormous amount of time at her

maternal grandmother's home. She described her maternal grandmother as being affectionate to her and perhaps the reason she has "turned out as well as I have." However, according to what one aunt has said, her grandmother was not a great parent to her own children. She stated her grandmother found her own father after he hanged himself in the barn when she was 13 years old. After her grandmother married and had five children, her own husband died leaving her to raise her children on her own. Carla's perception of this relationship identified generational emotional deprivation as she recalled:

I didn't know my biological father so there were kind of three generations and I really think that had a lot to do with my mother's inability to be a parent and my grandmother's inability to be a good parent as well.

Carla also described her stepfather as not a good parent. She indicated that he spanked her a couple of times and raised some welts, but she does not see him as being physically abusive to her. She did indicate however that he had a bad temper and generally yelled and threw things or punched a wall. She stated: "he wasn't really like a parent either. He was more like a person that kept the lights on." When asked for a description of him she stated: "definitely a lack of warmth and affection" identifying emotional deprivation.

Carla had not been in contact with her mother for several years prior to becoming engaged to be married. At her husband's insistence she contacted her mother regarding the wedding. Since that time their relationship has not been positive. Carla stills struggles with her mother's inability to express warmth and affection toward her. She commented:

I notice that even when I got into school she says that she is proud of me and I think that she is not proud of me but more like my daughter is a graduate student type thing, not really me. And I would tell her like real things and she is not even



listening. She doesn't even hear what I say. I would be saying something really intense and she would be like – yeah, I ordered these new whatever that I saw in a magazine and I hope they work out.

Carla stated that her relationship with her mother is not good. The mother has moved in and lived with her and her husband at least three separate times since they have been married over 12 years. Carla states that she “recently got rid of her for the last time I hope” indicating that her mother has finally moved into a trailer park and is living on her own. Carla's relationship with her mother has been a struggle, and while her mother was not a good parent, Carla's sense of family obligation falls within Young's, et al., (2003) category of enmeshment. She stated:

I have been the parent in the relationship for a lot of years. And I have always, out of a sense of obligation, liked to help but it really doesn't make any sense because I really don't feel like she is the parent. She is just a DNA donor is how I look at it. ...But we bailed her out and moved her in with us.

Carla appeared to have a strong sense of obligation to family which culminates into enmeshment with her mother. After her mother received her first driving under the influence citation, she continued to drink while living with Carla and her husband. They became concerned that if she continued to drive she was likely to get hurt or hurt someone else. They called a friend in the Sheriff's department, described her mother's vehicle, where she was likely to be headed, and that she needed to be pulled over. Carla stated: “Kind of that tough love thing and I kept thinking I shouldn't have to do this.” Her mother was arrested a second time and again Carla bailed her out and took her home. Carla stated that the relationship between her husband and her mother deteriorated over time and “for years I played the mediator between the two of them.”

Carla appeared to constantly sacrifice herself in her relationships with family and eventually realized that she is giving more of herself than she is receiving back from those she supports. At that point she becomes frustrated and starts to have thoughts of entitlement. This appears to become an issue particularly with her husband as she stated:

At the point where I was ready to leave him I said look I opened your business store, I struggled with two electric bills, two phone bills, I mean I did everything. I mean I managed the store and the household and I raised your daughter. I said I gave you 10 years now I am going to school. It is going to be harder for me to go to school if I leave you so like it or not you are going to be stuck with me until I finish school.

Carla stated that since she has started school they have made an effort to work on their relationship and some things have improved stating “we have good spots and bad spots.”

Carla’s mistrust and abuse stems from unresolved issues regarding being sexually molested as a child. She stated: “I was sexually abused and I had some control issues there and I think I put on weight to keep men from wanting to look at me.” Carla stated that her mother married her stepfather when she was five years of age and: “it was multiple people primarily an older step-brother, a cousin; my step-sister did a couple of things.” This continued until she was 13 years of age. Once the older siblings moved out of the house Carla stopped trying to gain weight and her symptoms of bulimia nervosa began. Carla also commented that she liked going to her maternal grandmother’s house because the step-siblings were not invited and she found it to be a safe place. In her words: “it was safe there because none of the other kids were there and nobody would hurt me there.” Carla talked some about how the sexual abuse has affected her thoughts regarding her physical appearance when she stated: “just feeling attractive was kind of

scary. I wanted it but I was afraid of it due to the sexual abuse” identifying her lack of trust regarding relationships.

Carla also feels some mistrust and emotional abuse when she talks about her relationship with her stepdaughter. Carla stated that she raised her stepdaughter from the age of 11 years old. When she turned 18, the step-daughter dismissed Carla by moving back to live with her own drug addicted mother. This hurt Carla tremendously. She believes she gave so much of her time to this young woman and then was rejected for her efforts. She stated:

She calls her father every once in a while but she still won't talk to me, because it is all my fault. ...It still hurts if I think about it and I still get angry sometimes when I think about it.

When asked what Carla saw as her own strengths her comment appeared to fit in the area of mistrust. She stated: “I have been through so much that it is fairly easy for me to not rely on anybody in any situation.” While she sees this as a strength, it appears to stem from her issues of mistrust.

Carla grew up not knowing who her biological father was. Based on the few things she was able to find out from her mother, she believed she was the product of a one night stand. Prior to getting married Carla decided she wanted to find her father. She asked her mother for information and she provided her with a name. Carla set out to find this man and her stepfather offered to help. When her mother found out the stepfather was helping she told Carla she had lied about the name and that she really didn't know who her father was. This provided Carla with many concerns regarding her ability to trust her mother, as she states “I never know if she is telling me the truth or not.”

Carla appeared to be very self sacrificing and over accommodating, particularly with family. She struggles to set boundaries and is easily taken advantage of. One of Young's, et al., (2003) areas of maladaptive schema is self sacrifice defined as excessive focus on voluntarily meeting the needs of others. This appears to be one of Carla's strongest areas of concern which she confirmed when she stated: "I feel like I have sacrificed my whole life for other people." When she agreed to marry her husband she was aware that she would also be gaining a stepdaughter. Within a few weeks of the marriage she began to feel like perhaps she had made a mistake but she stayed anyway telling her husband: "I am not going to leave you until your daughter graduates from high school because I know what that will do to a kid." Carla commented, "I am very responsible when I make a commitment and really just for her I felt like I had made that commitment and I owed her that because it is not her fault who her parents were." She was more than willing to take on the responsibility. However, the stepdaughter went through some rough times prior to coming to live with Carla and her husband. Due to that they struggled to have a positive relationship with her. Carla was very hurt when her stepdaughter decided to move to another state at the age of 18 to live with her birth mother, but willingly allowed her to return after two years and live with them again.

She was out there for a couple of years and then she called and said I want to come home and go back to school. She was engaged so we said that is fine and so we got her back, her fiancé, and her little dog which I ended up being stuck with. I said you can come back home and live at home but they were both lazy, sloppy, and dirty.

Carla provided another example of her over enmeshment and self sacrificing when she talked about her youngest half-brother. At the time he was still living at home with Carla's stepfather, his biological father was in another state. She indicated that the

half-brother called her one day very distraught and threatening to commit suicide. Carla stated:

He told me he wanted to kill himself and he told me how he was going to do it and it freaked me out and so I begged him I will come see you, just promise me you won't do anything till I get home. So I took a leave of absence from both of my jobs and I drove home and told my step-dad. ...I just can't walk away and not do anything.

While she could have easily picked up the phone and called other relatives who lived near the half-brother, or her stepfather and report her concerns she was compelled to drop everything to run to his aid showing her need to sacrifice self for others.

Carla made statements that showed her emotional inhibition. When talking about her mother and the issues that they have been through, she commented: "It is just that I don't have feelings for her." She stated their relationship now is one of her mother calling if she needs something and Carla providing what she can. She indicated that she had an argument at one time with one of her aunts regarding her responsibility to her mother. The aunt suggested that Carla needed to be doing more and that Carla had a responsibility to let her mother live with her for as long as she needed or to give her money to move out. Carla's thoughts toward her aunt were: "are you kidding me, we barely make ends meet. I am a student. How dare you complain about taking care of my grandmother and then tell me I owe my mother anything." When given praise by the interviewer she commented: "well I didn't say it to her but it is what I was thinking. I wasn't that strong," showing her inability to truly express her emotions openly. Carla also commented on her marriage and indicated that she believes she and her husband may use food to replace emotions and sex. "I really sometimes think that maybe we will have

a dish of ice cream at night or we will bond over food, popcorn, and a movie instead of actually physically bonding.” When asked directly by the researcher if she was replacing sex with food, Carla responded: “I think sometimes I am.”

Carla made some comments connected to her marriage and her step-daughter that fit in the category of failure to achieve. She stated regarding her stepdaughter “I feel guilty because looking back I have learned some things and I think there were so many things I could have done better with her.” Regarding her marriage she commented: “three weeks after the wedding I thought I made the biggest mistake of my life.” Carla also talked about her unrelenting standards in relationship to her marriage and her bulimia. Regarding her husband she stated: “I am too much of a perfectionist. I expected too much from him as far as how I think our relationship should be and how I think the house should be. I have real control issues.” She also commented on her bulimia nervosa indicating:

Once I started to loose weight it was like an addictive quality that I wanted to lose more weight. ...I went through a stage where even if I ate a little bit I didn't even have to try to throw up. I would just get sick. And that was scary that I didn't have control of it.

Throughout the course of her interview Carla made comments that fit into 10 of Young's, et al., (2003) 18 categories of maladaptive schema. Those areas with the largest number of statements may be the areas that should be targeted for treatment purposes as categories needing improvement. For Carla there were four categories which stood out as possible areas of concern: self sacrifice, emotional deprivation, mistrust/abuse, and her unrelenting standards. The mistrust/abuse is related to unresolved issues regarding her lack of trust regarding her mother. Another area of concern is her ability to self sacrifice,

putting everyone else's needs before her own. While Carla stated that her bulimia has been under control for many years, it is likely that lack of resolution in these areas is keeping her from being able to maintain a stable healthy weight.

Of Young's et al., (2003) categories of maladaptive schema the participants who fell in the category of bulimia nervosa made comments in 16 of those categories. They shared comments in six of the sixteen categories including abandonment, defectiveness/shame, emotional deprivation, mistrust/abuse, emotional inhibition, and unrelenting standards. The number of comments in each of those categories varied, but because each of the participants did make comments in those categories, a treatment plan could include addressing these maladaptive schema in a group setting. This could lead to a reduction in the relapse rate for bulimia nervosa.

#### Anorexia Nervosa

Three women volunteered as participants who fit the DSM-IV-TR (American Psychiatric Association, 2000) criteria for anorexia nervosa. Each of the participants at one time maintained a body weight that would be considered less than 85% of what would be expected for a female of the same height and age. Each admitted to a fear of weight gain or being fat and a denial of the seriousness of their weight prior to recovery. Each of the women indicated that she is in recovery. One participant, Jillian, continues to struggle and has relapsed several times in the past three years. Her weight continues to fluctuate between 115 and less than 100 pounds. However, over the course of the past year she has successfully kept her weight above 100 pounds. Monica has been in recovery for six years, but still counts calories and watches her weight. She has successfully maintained her weight between 105-110 pounds over the past six years.

Andrea has been in recovery for 18 years. Currently her weight is in the overweight range based on the Body Mass Index. She admits that she now finds comfort in food. She eats and then feels guilty and then she tends to not eat the next day which would suggest that the behavior and thought processes that accompanied her anorexia are still playing a role in her recovery. Each participant's story is described below.

*Jillian*

Jillian is a 24 year old female diagnosed with Anorexia Nervosa. She has recently married and has no children. Jillian was referred to this study by a counselor. Jillian stated that she started restricting at around the age 12 years and was diagnosed with anorexia at the age of 15 years. The diagnosis came during her first hospitalization. Her parents became concerned when she appeared to be grossly under-weight. Upon admission to the hospital she weighed about 80 pounds. She stated she was only treated for physical issues such as dehydration and malnutrition during her hospital stay, and she was forced to eat and gain some weight. Once she gained a few pounds and appeared to be eating, she was released by the hospital back to her parents care and referred to counseling. She has been hospitalized on four occasions. The second time she was hospitalized she was very ill. However, she failed to see the relationship between her eating disorder and that her body was most likely reacting to lack of nutrition. She stated during her second hospitalization she was at her lowest weight of 77 pounds. She had a problem with her liver and she was only treated for the physical ailments. Her eating disorder was not addressed. The third time she was admitted to the hospital it was after an attempted suicide. She drank about an ounce of Cool Aide mixed with bleach. The fourth time was again due to her body reacting to the abuse of her eating behaviors. She



stated that her electrolytes and potassium were at critically low levels. She was again only treated for the physical issues and released. After being released from the hospital the fourth time, she sought counseling on her own.

She has had three different counselors working specifically with her on her eating disorder. She stated that the first time was after her first hospitalization. She was not ready or willing to change her behavior and the counselor ended up confronting her with that. The counselor asked her to come back to treatment when she was ready to really work. The second time she sought counseling she was 21 years of age and this time she stated she was asking for help. She believes she made progress with the second counselor and continued to see her for approximately two years. She stated that she seemed to come to a point where she was no longer progressing and actually back sliding. She and the counselor agreed it was time for her to find another approach. She is now working with the third counselor and stated that it is early but she feels like she is making progress once again. She currently weighs 115 pounds which is within normal range for her height according to the Body Mass Index. Jillian stated she does not believe she is anorexic anymore. However, her sample food journal suggests that while she does not completely restrict her food intake, she has extreme limits and barely eats enough calories per day to sustain her weight. Jillian identified with 12 of Young's et al., (2003) 18 maladaptive schemas as reviewed below.

Jillian sees herself as defective and made several statements in this regard. When asked to describe herself the first response was:

I despise myself. A color that comes to mind is very black, very angry black. I hate the way I look because of the way I have put on the weight. ...I find it very hard to say nice things about myself.

She also stated that she was not very social in school and still struggles with friendships. “I didn’t like being around people because I always felt fat and unacceptable.” She also mentioned having feelings of shame for some of her behaviors. “Old habits die hard and I was into a lot of stuff that I wish I had never gotten involved in.”

Jillian described her father as extremely controlling. He sold his business when Jillian was 12 and became a stay-at-home dad. He took control of the entire household. He cooked, cleaned and did all the grocery shopping. He also managed the family’s finances. He controlled his family by not allowing them to make decisions or purchase any type of items without his approval. For an example, all the family vehicles are in his name only. Each of his children is purchasing one of the vehicles from him, rather than getting a loan on their own or co-signed with a family member. If there is a problem with the vehicle he is the only person who can determine where the car can be taken for repairs. The timing of Jillian’s eating disorder starting at the age of 12, and his need to control all aspects of the family’s lives, is likely to be a contributing factor. When asked how anorexia helped her cope with her father’s controlling behavior she stated:

It helped me have control over my life. He could threaten to take anything away from me but I could care less because this was one thing he could not control. I can’t control what was going on with them but I could control what was going on with me.

Jillian’s inability to control so much in her life continues to be a problem for her. It feeds into her feelings of dependence and incompetence. She displayed this in the following remarks:

My father’s overbearing affects my decision making. It affects how I feel about myself a lot due to the things that have been said by him. I fear decision making.

I need to give into other's wishes, allow my partners to make all the important decisions.

During Jillian's last hospitalization her father and her fiancé decided that she needed to move out of her parent's home and move in with her fiancé. She stated:

I knew nothing about moving until the day I was getting released. My fiancé told me on the telephone that he and dad had a chat. I was freaking out and had a panic attack in the hospital. It is weird because I know I can make my own decisions but I almost feel like I don't know how.

While she tends to show resentment for this decision, she was compliant and continues to allow her husband to do most of the decision making.

Jillian also made statements regarding emotional deprivation in reference to her father. When provided with the list of words and phrases to help her describe her father, she stated "a lack of warmth, and lack of understanding" indicating his inability to provide her with emotional support. This also leads to her statements regarding emotional inhibition. She indicated that she would attempt to hide her feelings from her father because she anticipated that his response would most likely be angry and he would say hurtful things to her. At around the age of 18 years, Jillian began to find it more difficult to hide her restricted eating habits and was forced to eat. In order to maintain control she began to purge her food. When forced to sit down to a family meal she would eat and then excuse herself to vomit the meal back out. Eventually this became another way for her to control her emotions. She stated: "I think I continued to binge, purge, binge, purge cause I didn't want to deal with the emotions that were coming on so I began relying more on food to feel better."

She also stated that when her favorite aunt died of cancer she was unable to express any emotions regarding her loss. "I didn't cry for years about that. I used my

eating disorder to control my emotions.” She also commented about emotional inhibition during her middle school years “I think a lot I was just numb.” This behavior has been carried into adulthood and she now inhibits her emotions by bingeing and purging.

Jillian’s relationship appears to border on enmeshment when she describes her mother. “Mom and I have a really good relationship. We talk every day. I still share everything with her.” At one time her parents considered separating and Jillian recalls:

I don’t know what happened if anything but it did start a slew of mistrust between my parents and I would consistently hear from my mom what my dad was doing and consistently hear from my dad what my mom was doing and it was constantly back and forth. I was like the person that could hear everybody’s garbage because no one else would listen or they didn’t feel comfortable talking to anybody else.

She also commented that in every relationship she has ever been in she tends to take on the personality of the person she is with. She stated:

I have a lack of separate identity. With him he listened to country music so I listened to country music. ...I don’t think I have changed the lacking separate identity. I am working on it. I kind of lose it and then I get stuck into it and then I start feeling miserable, and I am like why am I feeling and I figure out oh I am acting like what the other person is acting like and I gotta get out of there.

She struggles to find and express her own personality within any relationship whether it is one with her parents or friends.

Jillian also expressed statements that make it clear that she has a problem with being able to exercise sufficient self control. She is easily directed by impulsive behavior.

I start saying I gotta do this I gotta do this and immediately it starts and it is right there and there is no stopping me. A couple of instances I have dissociated during the day and ended up in places where I have no idea how I got there. It is kind of out of my control, something I can’t control and it is like some days I am good about it where I will follow my little routine, whatever. And some days I don’t know it just gets to me.

Jillian expressed very clearly that she has issues of mistrust and abuse, particularly surrounding her relationship with her father. While her father was not physically abusive, comments she made regarding him would support emotional abuse. “My dad is unstable and unpredictable. ...The time I spend with him now is all in protected settings that I control.” Now that she is moved out and married she still finds a need to spend time with her father, but she does it by going grocery shopping with him. This establishes a time limit and he will be concentrating on what he needs to buy and not be able to focus on a conversation with her. She also commented on a relationship with her first serious boyfriend in terms of mistrust when she stated:

My first boyfriend ...was my first everything and he kind of took advantage of my naiveness. He took advantage of me in lots of ways. The way he was treating me I did not feel was matching what he was saying.

She continued her statements of mistrust by stating “I won’t ask advice from certain people because I know I will get what I don’t really want to hear, or get a what you should do answer.”

Jillian also expressed feeling socially isolated. She commented that she sees herself as different from other people. Neither she nor her parents seem to fit into any group or community according to her comments. She stated “my parents are different from other people. Not a part of any community.” When discussing her personal issues of social isolation she stated: “I still lack a lot of social stuff. I don’t like to go out and do things. I like to hide and am very uncomfortable in the way my body looks right now.”

Jillian commented several times throughout the interview regarding her perception of her own failure. When asked if any of the words from the list applied to

her she indicated: “Not standing up for myself, inadequate, failure, stupid” without hesitation. During a post-interview when asked if she believed that this was still an adequate description of herself she stated: “failure still stands out.” Jillian commented that she struggles to complete things. When asked to elaborate she mentioned that she started taking piano lessons and quit and then started playing soft ball and quit. Her perception of quitting these things is that she failed, rather than perhaps they were not what she wanted to do after she tried and made a decision to stop. When asked if she has been told by someone that she was a failure for quitting she mentioned her father.

Jillian also displays unrelenting standards for herself and can be hypercritical regarding her outcomes. She described herself stating “I am driven. Yes very driven and compulsive. When I set my mind to something I do get it done. Sometimes I will sacrifice everything physically and mentally whatever and I end up in a mess.” During middle school she joined the cross country running team. Her coach challenged the students to run more than he did over the summer. Jillian stated:

You are looking good. You are running really fast and I was pushed to even do better than that. And so of course I wanted to succeed and thought losing a few pounds although I had lost a few running so the more I ran the more I lost. So at first it was a total runner’s high. I was number one on the team. Compliments still were coming because I continued to lose weight and that summer after cross country and track my coach challenged me to run more than he did. I took that way to the max, over 500 miles that summer and that is when I ended up in the hospital.

Jillian also found herself placing excessive emphasis on gaining approval particularly at school, as she commented: “I was driven more by wanting to be accepted. I went to a small school and I had trouble with relationships and stuff, not really fitting

in.” She also indicated that when she started running she started to receive compliments on looking good and being the best runner on the team. This encouraged her to run more.

Out of the 12 categories of maladaptive schema that were coded for Jillian seven categories stood out. For example she only made one comment that clearly fit in the category of self sacrificing behavior “I put others before myself” and numerous statements in the area of mistrust/abuse. The four categories which held the highest number of statements included insufficient self control, mistrust/abuse, emotional inhibition, and unrelenting standards. While she did not make as many statements in the categories of defectiveness/shame, dependence/incompetence, and enmeshment the statements she did make tended to be very strong and self critical and may be affecting her ability to stay in recovery.

### *Monica*

Monica is a 29 year old Caucasian female who was diagnosed with anorexia nervosa at 17 years of age. Currently she is married with no children. She learned about the study from classmates and volunteered to participate. She states she was never hospitalized for her disorder, however, she originally met with a psychologist at a children’s hospital in her home town. She saw him for 10 sessions and all she remembers of those sessions was sitting in an unpleasant office and crying. After the 10 sessions the doctor told her mother that Monica was wasting his time as she did not want to talk about her issues and he quit seeing her. She was then seen by another doctor and also saw a dietician at the same time. The dietician indicated to her that she was storing fat by eating potatoes, one of the few items she would eat, and therefore, Monica stopped eating

potatoes. A third attempt at counseling included the entire family which Monica stated was not helpful either and treatment attempts stopped.

Monica managed to maintain her weight slightly above 100 pounds during the rest of her senior year in high school. When she graduated and went to college in another town she again stopped eating and her weight returned to below normal range. She saw her local doctor who referred her to a dietician. Monica stated this dietician was the most helpful person regarding her eating disorder, “she was the one who really kind of helped me get my food worked out.” However, her weight did dip below normal during her sophomore year when she was pledging to a sorority. During her sophomore summer she went to a summer program which she states changed her life. While the program was not associated with her eating disorder she stated that it provided her with the guidance that she needed to make better decisions in her life. She stated she has been in continuous recovery for nine years. Even with her continued recovery, Monica made statements that fit into six of Young’s et al., (2003) 18 maladaptive schema. Some of her comments relate to her past thoughts and behaviors. However, some continue to be areas of concern and could lead to relapse if not addressed.

Monica’s expressions of maladaptive schema stem in part from her relationship with her mother. She stated that her mother was always quick to judge and very demanding as to how things should be done. This effected Monica’s thoughts regarding her own defectiveness. She described her mother and their relationship as:

Hello, she is a control freak. I would get into trouble for putting a spoon in the wrong drawer. And we probably did it multiple times. But putting it in the wrong drawer would piss her off. She just believed this is where things go and you don’t put them anywhere else. If I didn’t read the recipe right then I didn’t know how to cook.



Monica still struggles with defectiveness. When she eats something she believes she should not, she feels guilty. As she stated: “If I had eaten a little bit of fat I might still feel guilty about it” which relates also to her own issues of perfectionism which will be discussed later.

Monica still struggles with feelings of incompetence and dependence when it comes to making decisions. She stated:

I find that I have a hard time making decisions without her. Not that I have to consult her but I have to consult somebody. So I feel like okay I can't make that decision. A \$3.00 shirt sometimes can be hard and I think this is ridiculous I shouldn't have to call my mom to buy a \$3.00 shirt. Just buy the frickin shirt.

Monica indicated that her thoughts of incompetence still carry over into her work now as she works in an eating disorders facility. As she stated: “because being in an eating disorder facility I don't feel equipped to do what I am doing quite yet and so I still have a lot of anxiety about am I doing this the right way?” She often questions her skills and wonders if she has done the right thing:

The problem is I felt horrible for doing it like that. And I ended up talking to one of the therapists about it because I felt so bad I had done that. That was so triggering. And the I am like, I don't know what the heck I am doing.

Monica describes her relationship with her father as “our relationship is good but it is not what I want with him sometimes. He would never call me,” suggesting a feeling of emotional deprivation regarding her father. She also describes her mother as not showing much affection. She stated: “we didn't know how to stand up to her. Because she is a rooster. The you are all wrong type.”

Monica also discusses feelings of emotional inhibition in an effort to avoid disapproval by others and also to hide her own feelings of inadequacy and shame. When

she was attempting to control her feelings, she would move back into her anorexic behaviors and control her eating. She stated:

Sophomore year I dropped back down because I did rush and something terrible, they didn't let my best friend in. And had I been the person then that I am now I would just have said forget you guys but I dropped back down to 95 pounds. ...Controlled my weight. Ah controlled my emotions. Probably by not eating I probably controlled not my school work, but it was just another way it controlled everything. It was one of the things I was disciplined about. But probably more so my emotions were in control. Oh yeah people fed the disease. ...It was pretty much an identity thing for me.

One of Monica's strongest maladaptive schemas is her thoughts surrounding unrelenting standards/hypercriticalness, which she tends to believe she learned from her mother who she described as: "...Dominant, controlling, but not in a freakish but kind of in a she knows best way. She is anal, clean, neat, orderly." She stated about herself:

I am already a perfectionist and very controlling. ...I am a perfectionist. I am very organized, can be detail oriented. ...Because of my mom I am the way I am. The things that piss me off or create anxiety for me I have realized just recently, or frustrate me, actually frustrate her.

She related her eating disorder very clearly to her unrelenting standards when she stated:

I didn't know how to not I was just stuck on the calories and my thought process was almost like this obsession to not go over a certain amount of calories...to be a certain size. ...But part of my thinking about perfectionism and controlling was that this thing was something I could control in my life because I didn't know at that time how to cope. ...I was obsessed with calories. ...But I remember looking at the calories and being obsessed about it. I wrote down how many calories were one point. ...It is more of a way to control something and a way to cope. It was very much a way to ah, I can control this. ...I had great discipline. I could be skinny.

Monica stated that she continues to struggle with her unrelenting standards. "I do the check book now. I can't let it go." She commented that recently she and her husband needed to buy a new vacuum cleaner and her response to that was: "Let's investigate 10 vacuums and then decide which one to buy. You don't want to spend money on crappy

stuff.” She indicated that she is making improvements even though it continues to be a struggle: “I want to do the best job and the best job to me is that you have all the information. I have loosened my grip on some things just because I had to. If I didn’t, I wouldn’t.”

Monica is the first to admit that she carried some approval seeking thoughts in association with her eating disorder as she states: “Oh yeah, people fed the disease.”

During her sorority rush her sophomore year in college she again dropped her weight back down to be noticed and believing it would bring her acceptance:

I dropped weight...and I slipped back into counting calories and I kept it under 100 pounds. ...And I remember people making comments... if I just had your discipline if I just had your body. ...it was pretty much an identity thing for me. It wasn’t about body image it was about the fact that oh look they think I am really in control.

When asked if she sees herself as a people pleaser, Monica stated: “It depends on who the person is. Professionally yes” indicating her growth and recovery over the years but that there continues to be a struggle with approval seeking.

Monica states she has been in constant recovery for approximately 10 years. She relates her commitment to her religion as key to living a recovery life style. While she admits that she still counts points, she does consistently appear to address areas that could cause her difficulty. Based on her food journal, she appears to eat appropriate amounts of food to sustain a healthy weight. She admits that even when she splurges and eats more sugar than would seem appropriate she does not find a need to punish herself by not eating the next meal or the next day. She indicates because she works in a treatment center she believes she needs to set a good example for her patients and this helps to keep her honest in her own personal recovery. She indicated that she continues to work on the

areas that cause her difficulty including her perfectionism, and thoughts of dependence/incompetence.

*Andrea*

Andrea is a 41 year old married Caucasian female. She has no children. She heard about the study from a classmate. Andrea indicated that shortly after graduating from high school she went through about six months where she refused to eat any food whatsoever. When her parents became concerned and took her to a doctor, he indicated that she was underweight for her height and age and susceptible to having an eating disorder, although he did not name it. Based on Andrea's recollection it would appear that her body weight was less than 85% of what would be expected for her height and age. The doctor recommended that her parents force her to eat and that they track her daily intake. She did not return to the doctor or receive any type of treatment. She associated the start of her eating disorder with her graduation from high school and having to move. She stated "I graduated from high school and moved right away. Being away from my boyfriend, and being forced to be somewhere that I didn't want to be, I just stopped eating completely. I really just didn't eat." Eventually her parents allowed her to return to her hometown. However she indicated for a variety of reasons she continued to not eat and not gain weight. She stated "I had nothing, I had lost all my goals, I had lost everything." She stated that this behavior continued for four years. Andrea identified eight of Young's et al., (2003) 18 maladaptive schemas.

One of Andrea's major areas of maladaptive schema is abandonment/ instability. She made 11 comments that fit into this category. Andrea made a comment regarding a lack of boundaries in her life. When asked by this researcher where that came from, she

indicated: “a fear of losing a family member. Him not loving me, not caring about me. ...and just that sense of rejection. Always a feeling of rejection.” Andrea was adopted by her parents when she was eight months old. Her parents were open about her adoption with her and at an early age she felt confident that she was loved and wanted. However, during middle school a friend began teasing her and this made her insecure. She stated:

I was in seventh grade and a family friend that went to school with us his parents were friends of my parents, made jokes about me being adopted and that I wasn't loved and I was given up and I was found in a dumpster. ...It had a profound effect on me that I wasn't loved. I started questioning my place in the world and trying to understand why anybody would want to give you up and not understanding.

Andrea stated that she thought about trying to find her birth mother during her adolescents. However she did not stating: “I was too scared to search. ...Not knowing what to expect. Not knowing how I would react to them or how they would react to me and the fear of being rejected because that would be horrifying.” When Andrea turned 30 years old, she decided that she wanted to attempt to find her birth parent. Her birth mother was found by a mediator through the courts. However the mother refused to meet Andrea. The process of locating her was long and difficult, and when the birth mother refused to meet her she commented “I was hurt because I really felt rejected” indicating her feeling of abandonment one more time. She stated:

So that is where a lot of this whole rejection came into play. Abandonment and not loved and trying to find my place. That one incident in middle school caused me to; it had a profound effect on me. That kid telling me I wasn't wanted.

Her concerns regarding abandonment also played a role in her inability to set boundaries around her oldest brother and his calls from prison. Andrea indicated that she was the closest in vicinity to her brother when he went to prison. He would call her

collect to talk at odd hours of the night and she would always take his calls. She stated: “because I didn’t want to lose them. I didn’t want them to not love me. So I had to be there for him at all costs. At all costs.”

Andrea also commented about her thoughts of abandonment regarding her high school boyfriend. He received a scholarship to a school in another state. Andrea stated “I couldn’t understand why he would want to go away to school and not be here with me.” Andrea admits that abandonment is an area in which she continues to have problems. Her mother has been ill lately and at times was too tired when Andrea called and would not come to the phone. Andrea stated: “so I feel like she, when I call her up and she doesn’t want to talk to me I feel like she is rejecting me.” Andrea is quick to indicate she knows she is not being rejected, but at the same time, she struggles to not first consider this as being abandoned by her mother before more realistic thoughts come to mind. This is an example of how maladaptive schema from childhood can continue to play a role in behavior and thinking as an adult. The one comment Andrea made in the category of emotional deprivation helps to explain her thoughts of rejection. In reference to her parents she commented: “they were always proud of me but never wanted to tell me that.”

Andrea made one maladaptive comment in reference to her adoption which fit into the category of defectiveness and shame. When she was struggling with comments made to her in middle school regarding her adoption. She stated: “I started questioning my place in the world and trying to understand why anybody would want to give you up. Then I started believing that she didn’t love me, I wasn’t good enough.”

Andrea talks about her relationship with her boyfriend in high school in terms of what appears as a much enmeshed relationship. She admitted that she was obsessed with their relationship. She stated:

I was that girlfriend that I had to be with him 24/7. ...My world revolved around him. I would give up anything and everything to make sure that I could be with him. I had nothing for myself. Everything was around him.

She indicated that even after her parents gave in and let her move back to her home town, she continued to not eat. By the time she moved home her boyfriend was leaving for college, leaving her alone. As she stated: "I continued because he wasn't here. And I had nothing for myself. Everything was around him and everything was around my parents."

A moderate area of concern for Andrea is mistrust/abuse. She made several comments that fell within this maladaptive schema. When talking about her father she indicated: "he was very abusive growing up. To my mom he was physically and verbally. He was verbally and emotionally to me." She indicated her father would lock her mother and her brothers out of the house in an abusive rage, and keep Andrea inside the house with him because he knew the affect it would have on his wife. She stated "he knew that would get to her." One thing that Andrea thought she had learned from her parents relationship was that she would not allow herself to be that dependent on another person.

I refused to live like that, I refused. The biggest impact was that I would go get my education and I wouldn't have to rely on anybody to take care of me. I would be able to support myself no matter what and that was the most important thing to me.

However, once she started dating her boyfriend in high school she completely forgot her resolve for several years while she gave up her own life in order to constantly be available for him. This behavior played into her eating disorder. Once she figured out what she was doing and re-established her own goals she was able to get back on track regarding her ability to be an independent person. She also commented regarding her relationship with her brothers in terms of mistrust and abuse stating: “they were also mean to me. But then they were very controlling of me. They were pushy, demanding you do this.” She also talked about her lack of trust stating:

I don't trust too many people because somewhere along the line they are going to hurt me. They are going to reject me. What my dad did to my mom. What he put me through. I don't trust my dad, even today. I don't trust him. I don't trust he will always be that way.

Thus her mistrust particularly related to her father and her brothers continues to be a problem for her.

Andrea made a number of comments that fit in the category of self sacrifice. She has a tendency to meet the needs of others before considering her own in order to maintain connected to other people in her life. Her oldest brother spent time in prison for passing bad checks. At the time he was in prison her parents lived about 3,000 miles away and her middle brother was in the military. Andrea believed that she needed to make herself available to her brother at all costs. She stated: “I was the person he dumped on. I was the person he called at five in the morning every time he was allowed to use the telephone I was that person.” The interviewer asked if she had a problem with setting boundaries around her brother and she responded “Oh absolutely. I had no boundaries. I sacrificed my education to try and be there for my family.”



Andrea also talked about self sacrifice in the process of searching for her birth mother. Through the entire process she was constantly concerned about hurting other people in her life. She first indicated that she was uncertain about finding her birth mother without having her parents blessing. She indicated "...one of my biggest fears is that my parents would be hurt. The last thing I wanted to do was to hurt them." The search for her mother was not an easy task and took some unfortunate turns. Her mother was located by a court appointed mediator. When she was located, the birth mother was uncertain about whether or not she wanted to meet Andrea. The process was long and eventually disappointing for Andrea as her birth mother eventually decided that she did not want to meet her. Andrea's response to her disappointment was very self sacrificing.

At first, I was very understanding because I was really trying to put myself in her place because that is the only way I am going to get through this without having a heart attack. And I kept thinking how she must feel. What she might think what she might want. ...So I was trying to think about it from her perspective.

At some point in the process her birth mother agreed to accept a letter from Andrea, but not meet her. Andrea agonized over the letter because as she stated: "I didn't want her to feel too much of the emptiness because I didn't want to scare her away" again thinking first about her birth mothers feelings and needs over her own.

Andrea also commented about her self sacrificing behaviors in relationship to her family. When her brother was released from prison he immediately got into more trouble with the law and he disappeared for 13 years. During the first several years Andrea again sacrificed her needs for the needs of her family as she stated: "I sacrificed my education to try and be there for my family. I had nothing, I had lost all my goals, I had lost everything. Everything was around everyone else." Andrea continues to struggle with

self sacrificing behaviors and setting boundaries. This may play a role in her current admitted binge eating behaviors.

Andrea stated very clearly “I need to be perfect” showing her unrelenting standards. She believes that a part of this is associated with her father and his issues with perfection. She recalled that she learned from her two older brother’s mistakes and the abusive punishment they received. As they were punished for a mistake, she learned to not make the same mistake. Her unrelenting standards also showed up in her search for her mother. When she was told that her birth mother was willing to receive a letter from her she stated: “So I had to in my mind create the perfect letter.” She goes on to say:

And so it took me probably three days to write the letter. And I literally wrote, and wrote, and rewrote and I threw away and it had to be the perfect paper, it had to be the perfect pen, the handwriting had to be perfect.

She also commented that her birth mother asked the mediator for Andrea’s phone number and address but then indicated that she would not be contacting her. Andrea obsessed about her birth mother’s decision, stating:

For the next two years every time the phone rang I became obsessed with who was calling. If I was available I always answered it. I was obsessed with who was calling. If it was a number I didn’t know I answered it. If they hung up on me I would go online and research trying to find them. I went as far as to find where they lived, how far that would be from me. Was it possible that it could have been who it was? It was insane. It was awful. Every birthday I just knew she was going to call.

One of her statements regarding her father’s abusiveness also plays in her comments regarding unrelenting standards. She stated that she feared her father’s abusive nature and as her brothers were punished she learned from that.

I was always very careful. ...I did not want to have to go through what they went through. Because I think my dad was abusive to them physically now that I look

back at it as an adult. Because I was scared to do anything wrong. So I tried to be the model child.

Her mistrust is also seen in her decision regarding relationships. Because her father was physically abusive to her mother, Andrea vowed to never date or be involved with someone who might be like him. She stated: “I was determined to never be involved with anybody like him. I would not date anybody who would drink to excess or ever get intoxicated.

Andrea also made two comments associated with approval seeking thoughts. When asked about her painstaking efforts to write the perfect letter to her birth mother, she commented “because she was going to judge me based on this.” The letter was critical in that she really wanted her birth mother to like and accept her. She also commented about her eating disorder and the need to seek approval. She indicated that even after being allowed to move back to her home town she continued to avoid eating in order to control her weight because she still had no control over her boyfriend’s behavior. She stated:

I continued to battle with eating because it was still that he is trying to live his life and do what he wanted to do and he still wasn’t taking care of me the way I wanted him to. If I gained weight he would not want me.

Andrea shows good signs of recovery. However, it is clear that there are some maladaptive schema that continue to cause concern for her. She is aware of her irrational thinking and recognizes when it gets in the way of her ability to move forward. She continues to ask for support through therapy when she realizes that she is becoming overwhelmed. She admits that she continues to use food to relieve stress and anxiety. When she feels like she has eaten too much, she will skip a meal or not eat for a day to

make up for the poor eating behaviors. She suggests that while she is in recovery she struggles to maintain a healthy weight as food can now tend to be used for comfort, only to punish herself later by skipping meals.

Of the 18 categories of maladaptive schema (Young, et al., 2003) the participants in the category of anorexia nervosa made comments that fit into 13 categories. They shared statements in four categories including defectiveness/shame, emotional deprivation, unrelenting standards, and approval seeking. The number of statements in each of those categories varies from participant to participant. However, the category that seemed to gather the most statements was unrelenting standards. This may have to do with the strong need to find a way to control something in their lives. Addressing these maladaptive schema, as a standard part of a treatment program, may help to reduce the rate of relapse for anorexia nervosa.

Comments were made by at least one participant in each of the three categories of disordered eating which related to 16 of Young's et al., (2003) 18 categories of maladaptive schema. This provides some confirmation to earlier research which suggested the need to consider addressing more than just body, weight, and nutrition when treating individuals with anorexia nervosa, bulimia nervosa, and compulsive overeating resulting in obesity.

### Summary

Chapter Four presents the results of each independent case study. The case studies are grouped by eating disorder which includes four participants in the category of compulsive overeating resulting in obesity, three participants in the category of bulimia nervosa, and finally three participants in the category of anorexia nervosa. Each of the

participant's stories is told in her own words with background information and details that are associated with each of the identified maladaptive schema that helped to provide a clear understanding of each participant's life events associated with a specific maladaptive schema.

In the category of compulsive overeating resulting in obesity, four women volunteered as participants to this study. Each told her story in her own words and the results indicated that these four women held five of Young's et al., (2003) maladaptive schema in common. These included defectiveness/shame, mistrust/abuse, emotional inhibition, failure, and approval seeking. The first participant, Cathy, admitted that she attempts to mask her emotions by eating food. She is aware that she is eating the food in an attempt to make herself feel better and understands that when she finishes she feels guilty about her behavior. Joan has strong thoughts regarding her weight and feeling defective regarding her appearance, but is not ready to hear how much she really weighs. This is a sign that she is not entirely ready to change the behavior necessary to stop being a compulsive overeater and lose weight. Her enmeshment with her mother is a serious concern. It would appear that, unless her mother was willing to do something about her own weight issues, Joan would not consider changing her own behaviors. Joan admitted that she and her mother are emotional eaters conceding that she tends to compulsively eat when she is bored, unhappy, and feeling stressed.

Laura continues to have unresolved issues surrounding the man she has called her father and his abuse both mental and physical to her. Because of this relationship and an abusive relationship with a boyfriend years ago, she continues to find herself as defective and a failure. She continues to use food in an effort to make herself feel better. The final

participant in this category, Margaret, also clearly admits that food is an emotional crutch. She started trying to mask feelings of loneliness, abuse, and mistrust from about the age of seven, and continues to use food today when she is feeling a need to inhibit her emotions and to mask her frustration when she is nonassertive.

Three women volunteered to participate who were in various stages of recovery from bulimia nervosa. Each admitted to purposely bingeing and purging for at least two years. Recovery for the three women ranged between two and 15 years where at least no purging activities have occurred. Donna has been in recovery for two years and has not binged or purged. She maintains a normal weight. She is working a twelve step program for her recovery and appears to have the strongest recovery of the three participants. She still struggles with approval seeking behaviors having never received the approval of her mother. Seeking approval continues to carry over into her current relationships and a need to be accepted. It was clear to this researcher that Donna is able to apply a 12 step program to her eating disorder and has had some success at working through some of her maladaptive schema particularly in the area of defectiveness/shame as she has a much better understanding of who she is and that she must work to “shut off the self critical thoughts.”

Jade’s strongest areas of maladaptive schema lie in the categories of defectiveness/shame and approval seeking. She continues to struggle with finding a way to fit in. She admits that she still will occasionally binge on food without purging. She justifies this behavior by suggesting that she binges on cereal which she considers a healthy alternative. She continues to appear vulnerable to relapse, since she has not entirely gotten the binge behavior under control. Carla continues to struggle with self

sacrificing behaviors as well as feeling emotionally deprived in her close family relationships. She also made strong statements in the categories of mistrust/abuse and unrelenting standards. Her mistrust also relates back to being sexually abuse as a child and feeling abandoned by her mother as a teenager. This makes it difficult for her to trust new people in her life. She no longer binges or purges food, however, her weight is closely bordering on obesity at this time. She denies overeating, but admits that in the past that keeping her weight up did help her feel safe and unattractive to men. While her bulimia appears to be under control, Carla is unable to maintain a healthy weight which would indicate that she continues to struggle with maladaptive schema. Resolving some of these issues may help her to maintain a healthy life style.

Three women volunteered to participate in the category of anorexia nervosa. Each participant at some time in their lives maintained a body weight that was less than 85% of what would be expected of a female of the same height and age. All three participants expressed a fear of gaining weight or being fat and each admitted to not understanding the seriousness of their low weight prior to recovery. All three women indicated a belief that they are currently in recovery from anorexia nervosa. However, each continues to attempt to control weight by counting points, overeating and then restricting, or switching to bingeing and purging rather than restricting. Despite this behavior, two participants maintain their weight at the low end of normal range. The third struggles with being overweight according to the body mass index. Six maladaptive schema stood out in the conversation with Jillian. While she did not make numerous comments in the areas of defectiveness/shame and incompetence, the comments she did make seem to drive her decision making and anxiety related to her eating disorder. She

also made numerous comments in the area of mistrust/abuse, emotional inhibition, insufficient self control and unrelenting standards. These areas still appear to cause her problems. Until she is able to address many of the issues related to these categories, she is likely to be susceptible to relapse.

Monica has successfully remained in recovery for about 10 years. However she continues to count points related to calories. She has maintained a healthy weight within a normal range for her height and age but tends to be at the low end of the range. She admits that she still struggles with maladaptive schema associated with unrelenting standards, approval seeking and dependence incompetence. According to her food journal she does eat reasonable portions of all types of food. She indicated that even when she does splurge on sugar, she does not see a need to punish herself. She does, however, work in an eating disorders clinic and therefore admits that she wants to try and set a good example for her patients. She continues to work on her unrelenting standards and issues regarding dependence incompetence.

Andrea, the third participant, has not restricted for about 20 years. She now appears to struggle with overeating when she is attempting to inhibit emotions. She admits that when she does overeat she may skip the next meal or not eat the rest of the day in order to make up for her overeating. She struggles with a lack of boundaries, a fear of rejection or abandonment, and mistrust/abuse. She is aware of, and takes responsibility for her irrational thoughts and asks for support when she needs it. She continues to struggle with the use of food for comfort. Working through some of her maladaptive schema may help to put some of these behaviors to rest.



Young et al., (2003) developed 18 categories of maladaptive schema 16 of which were identified by one or more of the participants. This suggests the need to consider addressing more than just body shape, weight, and eating when treating individuals with anorexia nervosa, bulimia nervosa, and compulsive overeating resulting in obesity. All ten participants held defectiveness/shame in common. From a treatment perspective it would be possible to address this maladaptive schema as part of the group process which is commonly used in the treatment of eating disorders. Bulimia nervosa and anorexia nervosa participants all made comments in the categories of emotional inhibition and unrelenting standards. These two maladaptive schemas could be addressed as part of the standard treatment for the two disorders either in group or individual treatment. Bulimia nervosa and compulsive overeaters resulting in obesity held mistrust/abuse and emotional inhibition in common, which would allow these maladaptive schema to be addressed in a mixed group setting.

Chapter Four presented the results of the data collected from the participant interviews. Coding of the data resulted in a wide range of information regarding maladaptive schema associated with three types of disordered eating; anorexia nervosa, bulimia nervosa, and compulsive overeating resulting in obesity. Chapter Five will provide conclusions drawn from the data analysis, propose suggestions for future research, and discuss recommendations for use in the field of counseling particularly associated with counseling for eating disorders.

## Chapter Five

### Summary and Conclusions

Chapter Four presented the reduction and interpretation of data from 10 qualitative interviews into a useable format. The 10 participants provided extensive information regarding the existence of maladaptive schema associated with three types of disordered eating. Four participants identified as compulsive overeaters resulting in obesity made statements which fit into 15 of Young's et al., (2003) maladaptive schema while three participants diagnosed with bulimia nervosa identified with 16 of Young's, et al., maladaptive schema. The three participants included in the group with anorexia nervosa identified with 13 of Young's, et al., maladaptive schema. Each of the case studies was presented independently from the others with a short discussion regarding the overall findings in each specific category of disordered eating. Chapter Four concluded with a summary of each category of disordered eating and the maladaptive schema identified in that category.

Chapter Five presents a summary of the information that directed this study which includes a statement of the problem, the methodology followed for conducting the research, the findings associated with each case study, and the relationship to each of the maladaptive schema identified in each category of disordered eating. It will also present the conclusions derived from these findings followed by the implications these findings may have on the future treatment of disordered eating. Each of the research questions

will be reviewed and answers will be proposed and supported by the findings of the research and the supportive literature. Suggestions will be presented as to how this research may be used in the counseling profession. Finally, limitations identified in this study will be discussed along with the suggestions for future research.

### Summary

Previous chapters in this study created the structure and protocols to be followed for this research project. The goal of the study was to identify maladaptive schema associated with disordered eating, specifically related to compulsive overeating resulting in obesity, anorexia nervosa and bulimia nervosa. The data collected was rich and thick with content and provided excellent material for analysis. This summary of the previous chapters will paraphrase the key elements and findings of this study and will help to set the stage for a comprehensive interpretation.

### *Statement of the Problem*

Treatment models using cognitive behavioral therapy to treat disordered eating have suggested that those diagnosed with an eating disorder tend to judge themselves in terms of their body shape, weight, and eating habits, and lack the ability to control these three specific types of maladaptive schema (Fairburn, et al., 2003). However, the recovery rate for those treated for an eating disorder that only addresses the three issues identified above is less than 50% (Argas, 1997). It is also reported that the relapse rate for anorexia nervosa is 35% and the rate of relapse for bulimia nervosa is 36% of those who actually complete treatment (Keele, et. al., 2005). A number of quantitative studies have provided evidence that other maladaptive schema may contribute to bulimic behaviors (Leung, et al., 2000; Meyer, et al., 2000; Spranger, et al., 2001; Waller, et al.,

2002; Waller & Thomas, 2000 & Waller & Watson, 2000). Fewer studies have addressed this issue in relationship to anorexia nervosa or compulsive overeating resulting in obesity. However, the few studies found indicated similar findings (Waller, 2002; van Hanswijck de Jonge et al., 2003). If 50% of those seeking treatment for disordered eating fail to reach the recovery phase using the cognitive behavioral model that addresses only eating habits, weight, and body shape, and 36% of those individuals who are reported to reach recovery using the same model later relapse, then identifying and addressing other contributing maladaptive schema may help to increase the rate of long term recovery. Young, et al., (2003) indicated that schemas that develop from toxic childhood experiences may be the core of many chronic Axis I disorders. While there is no DSM-VI-TR (American Psychiatric Association, 2000), diagnosis for obesity, anorexia nervosa and bulimia nervosa do fall in the Axis I category, and therefore, may also be impacted by such toxic childhood experiences as described by Young, et al. This study further explored and identified other maladaptive schema associated with anorexia nervosa, bulimia nervosa and compulsive overeating resulting in obesity that may be interfering in the long term recovery process.

### *Methodology*

This research is a collective case study which used a natural setting and allowed the participants to express thoughts and emotions that surrounded their disordered eating in their own voices. Young, et al., (2003) defined maladaptive schema as self defeating emotional and cognitive patterns that repeat throughout life and may develop in response to distorted life events. Young, et al., identified 18 categories of maladaptive schema including abandonment/instability, defectiveness/shame, dependence/incompetence,

emotional deprivation, enmeshment/undeveloped self, entitlement/grandiosity, insufficient self-control/self discipline, mistrust/abuse, subjugation, social isolation/alienation, self-sacrifice, emotional inhibition, failure, vulnerability to harm or illness, approval seeking/recognition-seeking, unrelenting standards/hyper-criticalness, negativity/pessimism, and punitiveness. This collective case study provides evidence that persons diagnosed with disordered eating have carried early life events into adulthood and that these events have created maladaptive schema which may be interfering in their recovery process.

The ten participants involved in this study were each interviewed three times. The first interview was used to explain the study, answer questions, provide a journal for tracking food, and to have the consent to participate in the study signed by each participant. The second and third interviews were audio taped and transcribed verbatim. The 10 participants ranged in age from 24 to 41 years, and they voluntarily agreed to participate in the study. Each transcript was repeatedly read in an effort to analyze all the data. An auditor was also used to provide a second pair of eyes, as well as identification and confirmation of the findings to provide trustworthiness to the study. The data was organized according to the three disordered eating diagnoses which were the focus of this study; compulsive overeating resulting in obesity, bulimia nervosa, and anorexia nervosa.

### *Findings*

Since the purpose of this study was to identify maladaptive schema associated with disordered eating related to compulsive overeating resulting in obesity, anorexia nervosa, and bulimia nervosa, the results are presented and the data is grouped according to each disordered eating category. Within each category of disordered eating there is a

discussion of the maladaptive schema which the participants in that category held in common, as well as unique variations based on specific participants. There is also a discussion of the commonalities across all three types of disordered eating.

The total findings in this research are a reflection on the experiences of ten women from a rural area of Florida known as Polk County. The participants were either students attending classes at a regional campus of a larger university system, or living in one of the small municipalities located within the county. Polk County has a total population of approximately 583,403 as of 2007 (Quickfacts.gov, 2010). Lakeland is the largest city with a population of approximately 93,428 (Polk County Website, 2009). While these participants' stories and experiences may be similar to other populations, they also could be very different. Further research using a larger and more diverse population would be required in order to address issues of generalization for this study. This will be discussed in more detail in the section regarding further research suggestions later in this chapter.

Lastly, the findings in this study have been analyzed for thematic content and independently reviewed by an auditor. The auditor did initially code the data independently from this researcher and arrived at her own conclusions and themes. The auditor is a fellow licensed mental health counselor who has a strong interest in the treatment of eating disorders. The auditor and researcher came to a point of consensus and the themes and their labels based on Young's, et al., (2003) maladaptive schema categories. The data presented here is the product of this collaborative effort between the researcher and auditor.

### Compulsive Overeating resulting in Obesity

Four women ranging in age from 25 to 35 years volunteered to participate and qualified for the criteria of compulsive overeating resulting in obesity. For the purposes of this study, compulsive overeating resulting in obesity is defined as the condition of elevated fat masses in the body which have been caused by the use of food and eating to compensate for emotions rather than actually eating due to physical feelings of hunger. None of the four women reported having a medical condition such as thyroid disease or any other disease that would result in being identified as obese, due to a medical condition which would have disqualified them from this study. In total the four women in this category identified with 15 of Young's, et al., (2003) categories of maladaptive schema. There were three categories none of the women identified with; entitlement, self sacrifice, and vulnerability to harm. Not all the women identified with all 15 categories. Cathy made comments that fell within 12 of the maladaptive categories, while Laura made statements that fit into 11 categories. Joan made comments that fit into 11 and Margaret identified 10 categories of maladaptive schema. All four women made statements that fit into the categories of defectiveness/shame, mistrust/abuse, emotional inhibition, failure, and approval seeking.

All four women identified defectiveness/shame as an area that still creates problems in the lives. According to Young, et al., (2003) this category is defined as the feeling that one is defective, bad, unwanted or inferior to others. Each of the four women made statements regarding a belief that in some way they were defective or felt shame regarding a specific incident from the past which continues to cause concern and feelings of shame in the present. Joan stated: "I have issues with my weight and feeling bad about

myself.” Laura indicated “I felt unwanted, inferior, criticized, rejected, blamed, and insecure,” while Cathy simply stated: “I am not good enough” showing her thoughts about her defectiveness. Margaret expressed her feelings of shame while referencing one specific incident where she saw her father physically abuse her mother. Her comment was: “I was just standing there with the phone in my hand. I remember that incident with the phone being one of the most shameful things of my life.” This was her only comment in this category, however, it was considered significant because of her self-described feelings of shame. While she indicated that she now understands that a child of four or five years of age would not likely react any differently under the circumstances, she still admits that her father’s treatment of her mother plays into other areas of maladaptive schema particularly mistrust.

Young, et al., (2003) defined mistrust/abuse as the expectation that one will be hurt, abused, humiliated, manipulated, or taken advantage of. Each of these women expressed thoughts that fell within this category. As Margaret stated:

I have blanket trust issues period. But maybe that is why I am not married. Because my dad is a pretty charming guy and nice, but how can I make sure I don’t end up with the same kind of situation my mother was in? I do very much resent how things transpired in my parent’s marriage because it has been very hard for me to really feel safe around other people and trust them to get close with them. To connect with them.

Cathy commented that her father was “manipulative in getting things his way. Twisting it toward where it worked out to his benefit.” Margaret and Cathy were sexually molested by a family member which they each admitted plays into their lack of trust. Cathy’s comments regarding her abuse relate to her thoughts and concerns for her own children. She identified her former husband as a great father and someone her children



will never have to doubt. As she stated: “He loves them so much and there is never a doubt when my daughter sits on his lap. And that wasn’t the case for me. I would question what is happening here.”

Joan’s issues of mistrust and abuse stem from never knowing or meeting her biological father. As she stated: “I was unsure about that and I was also unsure what if he doesn’t want me to be around?” This appeared to lead her to a mistrust of men in general as she stated: “I have a lot of trust issues with guys because my dad wasn’t around. And because the only guys I saw around my mom I thought the only reason they were around her was because they wanted something. I thought they just wanted her for sex.”

Laura was mentally and physically abused by both her father and a boyfriend and alluded to sexual abuse, but did not want to discuss it as a part of this interview. She commented about her boyfriend:

He was one of those people that would say things that only your enemy would say like he would call me names. He called me ugly, slut and the “B” word, whatever. Anything that would come out of his mouth. He called me fat. If I gained a little weight he would say things like you are unattractive and this and that. He was horrible. ... We were out at a function and he poured a 64oz orange soda on my head.

She commented regarding her father: “He called me names. He would call me a slut and whore and told me that I was doing this and that and I am telling him I am not.” As an adult she still avoids him when he has been drinking. She continued by stating:

When he drinks I stay away from him because he becomes abusive. He is no longer physically abusive but he is mentally abusive to whoever is around. When I was pregnant with my daughter he would try to get abusive with me again. Each of these four women made strong statements regarding abuses that took place in childhood that they have now carried into their adult life in the form of mistrust.

Each of the women also made comments that fit in the maladaptive schema of emotional inhibition admitting to using food to cover up feelings. As defined by Young, et al., (2003) emotional inhibition is a withholding of action, feelings or communication for fear of being disapproved by others. Each of the women indicated that in order to withhold feelings or push down feelings they would eat food. As Cathy stated: "I would be eating...I would comfort myself going through that very serious depression." When asked what she thought she gained from eating she stated: "just feeling good at that moment." As Joan stated:

Food brightens my day. If I am having a bad day and I find out there is free food on campus I am like, free food, yes! My day just got better. But that is something that is really important to me and makes me feel better. If I am really upset and eat certain foods I usually feel better.

Laura commented: "I tried to act like it didn't make me feel. I pretended around other people that I wasn't affected but it just hurt my esteem too much", when discussing how she felt about having orange soda poured over her head by her boyfriend. When Margaret was asked what food provided her she stated:

I feel comforted. Oh food feels good in your stomach and it tastes great and it takes you out of whatever painful thing you were thinking about especially if you have to make or go get or wait for someone to bring it to you.

Three of the four women discussed the use of food to inhibit emotions, while Laura made comments on her food journal that would suggest she also used food in an effort to feel better. One comment on the journal was "I felt I shouldn't be eating but I did anyway."

All four women also made statements regarding a sense of failure. Young, et al., (2003) defines this maladaptive schema as believing that one has failed or will fail or is simply inadequate in comparison to one's peers. Each of the women expressed thoughts

indicating that they perceive themselves, or they believe that others perceive them as failures. Cathy, who works in a major company and has moved into a position of supervision without meeting the educational requirements, believes her success is just luck. She also perceives that her parenting skills are a failure.

I felt like I am not a good mom because my kids are all apart and I wasn't a great wife because you know this and that. You pick apart all the things you do in the whole marriage and you think I could have done better.

Joan sees her inability to lose weight or stick to an eating plan as failing on her part. She continues to be in denial about how much of a problem she has with eating and does not take clear responsibility for her actions. She stated regarding a calorie counting program she attempted to use:

I was doing really good and it would say I went over my limit all the time. And I was like but I haven't really eaten that much. Like it just didn't seem to be very realistic and a lot of the things I would eat weren't on the data base that I was trying to check from. And the exercises I did wouldn't be in the data base either so it was really frustrating and I felt like I wasn't making very much progress so I stopped using it.

Joan struggled in this case to see that perhaps the option was to choose things that were in the data base rather than the reverse. It would appear as though Joan was setting herself up for failure.

The final category that all four women commented in was approval seeking. This is defined by Young, et al., (2003) as having an extreme emphasis on trying to gain approval or attention from others. It is a need to fit in at the expense of not developing a true sense of self. Each of these women discussed clearly a need to seek approval from others. Cathy indicated: "I want people to see me as successful. So it is like I really, really care about what people think of me. Almost too much." Joan attributed her

approval seeking behavior to being half Caucasian and half of Middle Eastern decent. As she stated:

I wish I could marry an Italian or American Indian or some other culture that I look like that I can envelop myself in and be absorbed by so I don't feel so outed or that there is something wrong with me because I am a part of a culture that nobody likes.

Laura expressed her thoughts regarding seeking approval very simply with the words "I was always a people pleaser."

These four participant's comments in the categories of defectiveness /shame, mistrust/abuse, emotional inhibition, failure and approval seeking indicate a possible common link among women who are admitted compulsive overeaters which has resulted in obesity and continue to struggle with obesity.

Several other categories of maladaptive schema were identified in the review of each transcript, but were not held in common by all four participants. Three women in this category were the product of divorced parents and each felt that at least one parent had not been available to them when needed. Their comments fit the category of abandonment which is described by Young, et al., (2003) as perceiving that certain people most important in their lives are either unstable or unreliable for support or connection. This leaves one to feel like significant others are unable to provide emotional support, connection, or strength that can be depended upon. For example Joan stated:

When I was young she [mom] was always dating a lot. What she didn't realize was that she was pushing me away by not spending time with me. ...I felt rejected because she was working so hard at trying to keep them happy that I wasn't getting any attention.

Margaret stated: “So I wouldn’t say she [mom] left me alone every night but she used to leave me alone a lot.” Cathy stated: “I want the mom and the dad to wake up with the babies because that is all I ever wanted as a kid.”

Young, et al., (2003) described emotional deprivation as one expecting to receive a normal degree of emotional support from other people, but that this expectation is never truly met. This may come from a lack of nurturance, lack of empathy and/or a lack of feeling protected. Three of the four women made comments that appeared to fit in the category of emotional deprivation. Cathy commented regarding her brother that: “he says he doesn’t care about people’s feelings. ...He likes to pick on me, he likes to push my buttons and get me all riled up.” Regarding her relationship with her mother, Joan stated:

My Mom worked full time. She would come home and on Sunday she would sleep all day and I remember watching TV because that would keep me busy. I remember waking my mom up a lot. Hey mom can I eat the Doritos? And she would say no you can have a bowl of cereal. And I would be like please, please can I eat the Doritos? And I remember eating a lot. I would have a little carpet picnic and eating lots of food. And I don’t really know how much it was. It may have been three or four bowls of cereal over five hours.

Laura may have made the most profound statements regarding emotional deprivation in relationship to her family dynamics and her confusion regarding who her father is when she stated:

They made me say he is my dad all my life. My dad...growing up he was horrible. He was an alcoholic on the weekends...and when he drank he was very abusive both physically and mentally. If he was angry he wanted everyone in the house to be angry. I would try to hide in my room and he would literally come back there and tell me to come out of my room and sit in the front and be around him while he was angry. ...When I first started gaining weight he said he would pay me a thousand dollars to lose it because I wasn’t attractive anymore.

All three of the same women also made comments regarding enmeshment in a relationship. Young, et al., (2003) described enmeshment as being excessively emotionally involved or close to one or more significant others at the expense of one's personal individuation or social development to the fullest extent possible. Joan appeared to have the strongest area of enmeshment. Many of the comments she made seemed to include not only her thoughts on a subject, but also her mother's. She made numerous comments using the plural form "we" in response to many questions. For example she stated: "I think we have gotten to the point where we kind of like our privacy and we are happy where we are." When asked what she meant when she stated this in the plural she responded with: "me and my mom." Cathy commented on her relationship with her daughter: "So kind of I live through her and doing those things with her you know probably doing a little bit more than I should." Laura's comments regarding enmeshment appear to stem from her relationship with her husband. She stated: "if something happens to one of us, it happens to both of us. We are not separate. ...My world revolved around him" indicating her thinking that she cannot be happy without the support of her husband.

Three women also made statements regarding unrelenting standards/hypercriticalness. According to Young, et al., (2003) unrelenting standards is the belief that one must strive for very high standards in order to avoid being criticized by others. This usually results in extreme feelings of pressure and hypercriticalness toward self and others. Cathy mentioned several times during her interview that she wanted "the mother and the father and the children all together under the same roof" and criticizes herself for not being able to provide that atmosphere. She commented regarding her ex-

husband: “He is a great father. I could not ask for any person better. Sometimes it makes me angry at him, because I wanted that, I wanted that for my life.”

Joan commented about her abuse of exercise indicating an unrelenting standard of what she should do more in order to look the way she wanted. She stated: “When I got older I started exercising. I would do pushups and sit-ups for 30 minutes a night. I would test myself all the time to make sure my abs were tight. ...I remember being preoccupied with that.” Margaret seemed to make the most compelling statements regarding unrelenting standards and hypercriticalness when she stated:

I would like to think that I am not a judgmental person but I see somebody come in with French tips I make a snap judgment. And the snap judgment I make on them is not one I want people to make about me.

Margaret appears to set her moral and ethical values a little on the high side which causes her to be hypercritical of others. As she states:

I know how people are suppose to be and I am very a tuned to that. I like order, priority, I like decency. The fact that it has not always been a value of the people around me is painful because I feel like an outlier. And sometimes I question...why don't I just lower my standards? And I can't because I have seen the result of it.

Because three of the four participants made comments in the areas of abandonment, emotional deprivation, enmeshment, subjugation, social isolation, and, unrelenting standards, these categories of maladaptive schema should be considered important to the process of recovery from compulsive overeating resulting in obesity. While in each category one of the four participants did not appear to make a specific comment that fit into one of these categories, it is possible that with further investigation or through a group process that some memory would be triggered and reported that was

not realized as part of the taped interview used in this study. This may be a limitation of the study which will be discussed later in this chapter.

Cathy and Laura each made comments that fell in the categories of dependence/incompetence and insufficient self control. Dependence/ incompetence is defined by Young, et al., (2003) as a belief that one is unable to handle everyday life responsibilities without a considerable amount of help from others. Cathy commented about her decision making process in divorcing her husband. She apparently made the decision to separate and filed the paperwork with the court, but then for the next two years she kept changing and postponing the court hearing date. She stated: “And so finally my husband said you need to do something and we finally came to the decision to move forward and we got it done.” Laura’s comments revolved around her inability to take care of herself and be alone. She stated that when she met her husband that: “he came into the picture and had an extra income and so I wasn’t struggling as much anymore.” Each of these women struggles to find their strengths. They are each successful in their own right, Laura continuing with her education against the odds, and Cathy’s ability to successfully climb the corporate ladder. However neither perceives that they have completed these tasks on their own. Cathy suggested it is just luck and appeared to depend on others for a boost, while Laura appeared to depend on her husband, as well as other family members, to make decisions.

Insufficient self control is defined by Young, et al., (2003) as an inability to maintain self control and frustration tolerance in order to achieve one’s goals or to control one’s impulses and emotions. Cathy commented:



I cried every day, I ate, I ate late, super late because I went to bed late. Two or three in the morning so I would be eating and that is not a good time to eat certainly, but that was comfort. ...I think I don't care I was so desperate to do something without realizing that the real issue was within me.

Laura stated: "When you get bored you don't have anything to do and you just knick knack all day long. I mean I would open up the pack and eat it all. I find it hard to just fight off just eating something." Each of these women indicated a need to use food for emotional comfort. Each cannot fight the impulse to use food in this way even though they are aware that it is contributing to their weight problems. They use the food to avoid pain and sometimes conflict at the expense of their own personal fulfillment which fits into Young's definition for insufficient self control.

#### *Conclusion Regarding Compulsive Overeaters Resulting In Obesity*

The results of the current study confirm and contribute information to the body of evidence regarding the effects of maladaptive schema in the category of compulsive overeaters resulting in obesity. According to Bryne, et. al. (2003), compulsive overeaters eat in order to regulate mood, and avoid negative feelings. Bryne, et al., conducted a qualitative study to explore the concept that psychological factors were involved in the inability for women with a history of obesity to be successful with weight loss and maintenance. It was found that 90% of those in the regainer group reported that they were likely to use food during adverse times to reduce stress and anxiety. The result of that study suggested that issues of obesity were not exclusively due to biological problems and that psychological factors also play a role. The current study helps to confirm that psychological factors particularly in the form of maladaptive schema contribute to the lack of success for compulsive overeaters resulting in obesity to lose and

maintain a weight loss. Based on the results of the interviews conducted as a part of the current study, it is apparent that all four women used food to avoid negative feelings, and to control or regulate mood.

vanHanswijck de Jonge, et al. (2003), conducted a quantitative study using the short form of the Young Maladaptive Schema Questionnaire and found significant results in the categories of defectiveness/shame, social isolation, vulnerability to harm, subjugation, emotional deprivation, abandonment, and unrelenting standards in obese participants who had been sexually abused. Using an interviewing process the current study reported evidence in agreement with vanHanswijck de Jong, et al. In the current study two of the participants indicated that they had been sexually abused, while a third alluded to being sexually abused but was unwilling to discuss that as a part of her interview process. Regardless of sexual abuse, all four participants did make comments that fell in the category of defectiveness/shame, and three made comments related to abandonment, social isolation, subjugation, emotional deprivation, and unrelenting standards. It was also found in the current study that all four participants made statements that fit the category of emotional inhibition, failure and approval seeking. At least two made comments regarding dependence/incompetence, insufficient self control, and one made a comment in the category of punitiveness. The only maladaptive schemas that none of the four participants appeared to identify were feelings of vulnerability to harm and negativity.

Each of the participants expressed thoughts and feelings that were identified in 15 of Young's (2003) categories of maladaptive schema. Through the review and coding process Cathy's comments fell into 12 categories particularly in four distinct areas:

defectiveness/shame, emotional inhibition, approval seeking, and her thoughts associated with failure. Cathy attempted to mask her feelings regarding failure as a mother and wife, and her defectiveness issues through her compulsive eating. She is aware that she is eating in an effort to make herself feel better and also realized that in the end it made her feel worse. None-the-less she struggles to stop this behavior which showed how strong her maladaptive schema are, particularly in these categories. The fact that she failed to return her food journal suggested that writing down her food intake and identifying the reasons for eating may have been too visual for her, and more than she was willing to identify as a part of her interview process.

Five areas of maladaptive schema stood out in the 11 categories in which Joan commented. Two areas in particular may strongly influence her inability to identify problems, or lose and maintain a weight loss in a normal range based on the body mass index. Joan's enmeshment with her mother clearly presented issues with her personal development. While she did not make comments that fit in the category of dependence/incompetence, it is clear that she continues to depend upon her mother for a major part of her belief system. This enmeshment will continue to inhibit her ability to express her individuality. The other area of major concern is defectiveness/shame. Her thoughts regarding her appearance provided strong statements which fit in the category of defectiveness and shame. Her refusal to know how much she weighed at the time of the interview suggested that she is not ready to stick to a nutritional food plan or work on issues that trigger her compulsive eating.

Laura made comments in 11 categories of maladaptive schema. Her strongest statements and areas of major concern are in the categories of defectiveness/shame,

emotional inhibition, mistrust/abuse, and social isolation. The majority of comments revolved around her unresolved issues with family. By the end of her recorded interview, it became clear that she continues to have strong issues with mistrust and defectiveness/shame particularly related to her relationship with her father and the way she was treated by him when she was a child.

Margaret made comments in 10 categories of maladaptive schema. Some of Margaret's strongest statements were in the area of subjugation. She admits that she still struggles with her ability to be assertive and express her thoughts and feelings to others. She continues to identify with that compliant child who could sit quietly for hours and wait on her mother to come home. She admitted that she tends to be passive-aggressive rather than confronting issues outright, just as she did as an adolescent when she realized she could just turn off the television a half hour before her mother came home. She also continues to have strong emotions regarding mistrust, particularly in her willingness to build new relationships related to the abuse she witnessed by both her father and mother. Margaret successfully lost weight several years ago when her doctor warned her of some health issues. She has regained all the weight and the health issues have returned. However, her inability to re-commit to losing the weight may be a direct result of the maladaptive schema that continue to play a role in her thought processes.

Further discussion regarding the importance of these findings and possible use in the treatment of disordered eating will be discussed later in this chapter regarding overall conclusions, possible uses, and limitations of this study.

## Bulimia Nervosa

Previous research indicates that maladaptive schema may predict bingeing and purging behaviors in those diagnosed with bulimia nervosa. The research suggests that bingeing and purging are related to reducing emotions, particularly those associated with defectiveness and shame (Waller, et al., 1999). In all, 14 studies found a relationship between maladaptive schema and binge purge activities in participants diagnosed with bulimia nervosa. The current study found that three participants diagnosed with bulimia nervosa were identified as having thoughts and beliefs that fall into 16 of Young's, et al., (2003) maladaptive schema categories. All three participants made statements that were coded in the categories of abandonment, defectiveness/shame, emotional deprivation, mistrust/abuse, emotional inhibition, and unrelenting standards.

Each of the women made comments that suggested a perception on their part they were abandoned by one or both parents at different times in each participant's life. Donna's parents were both alcoholics during her childhood. She made several comments regarding her relationship with both parents that fell into the category of abandonment. Donna recalled that her father, on more than one occasion, rescued and protected her from her mother who appeared to be more volatile in her relationship with Donna. However, when her father sought help for his alcoholism he then became obsessed with trying to save his marriage and this left Donna feeling abandoned. As she stated: "...so he really didn't have time for the kids until they got divorced and then he knew we were the only family he had left and had a change of heart." Donna also expressed thoughts regarding abandonment when she was being sent from one parent to the other to live because neither parent seemed to know how to cope with her behavior:

My mother sent me to live with my father. I was 15 and I stayed there for four months and that didn't work. My dad sent me back to my mom's for a month then my mom put me in a teen crisis shelter.

Jade recalled feeling abandoned when she was left in Mexico at the age of 17 years old to live on her own. She stated:

My parents said we would move back to Mexico after I graduated. Once we were there they decided not to stay and so I was left alone. For those nine months I was pretty much living on my own. ...I was dealing with being lonely. I was very lonely. I just didn't know how to cope with it any other way.

Jade also expressed feeling abandoned because both her parents worked so hard when she was young that she felt like she had no real relationship with them. As she stated "I mean I literally grew up on my own." Carla's mother was an alcoholic. She described her mother in terms of abandonment/instability in three words: "unreliable, unpredictable, abandoned." She also indicated her feelings of abandonment when she stated: "...my mother moved to Florida and actually left me with my step-dad until I graduated from high school." All three participants expressed concerns that one or both parents were unreliable and were unable to provide them the protection they believed they needed.

All three participants made comments in the category of defectiveness/shame confirming for each of the participants their feelings of being bad, unwanted or inferior in some aspect of their lives. As Donna stated: "I have not had a day go by that I did not reject some part of my body. ... I don't know how to love myself." Donna also talks some about how her recovery program has helped her to work on her defective and shameful thoughts and feelings. She stated:

I have to practice at being somebody that I want to be and I think it was six months ago that I finally started to feel really successful at this practicing being someone that I wanted to be thing and I started to feel a lot of these feelings of esteem.

Jade's issues with defectiveness and shame had to do with growing up both in Mexico and the United States and struggling to figure out how she fit in. As she stated:

...growing up it was a lot of you don't fit in, as far as being Hispanic or being American. I was like not good enough for either one. ...The older I got the more my mother pointed out that I was getting too involved in the American life style and that I was denying my roots.

Carla made only a couple of comments that fit into this category. In reference to helping to raise her step-daughter, she felt that perhaps she was inadequate as a parent and in this regard she stated: "when I think about it I feel guilty."

All three participants also made comments in the area of emotional deprivation. Young, et al., (2003) described this maladaptive schema as the desire for a normal degree of emotional support. Each of the three participants made comments that showed their thoughts and feelings regarding a lack of warmth and affection and lack of guidance being offered to them by family. As Donna stated regarding her mother: "she would just try to control and when she couldn't control me she would ignore me. She would not speak to me." Jade's comments regarding emotional deprivation stemmed from her lack of a relationship with her father. She stated: "my father was very distant ...emotions don't count so he doesn't have a lot of emotions." One thing she suggested she wanted was: "someone I could rely on like my dad to protect me or care for me." Carla also felt emotionally deprived by the adults in her life growing up. As she commented about her mother abandoning her and moving to Florida, she also indicated that her stepfather "wasn't really like a parent either. He was more like a person who kept the lights on. He definitely displayed a lack of warmth and affection."

All three participants identified issues in the maladaptive schema of mistrust/abuse. Donna's issues of mistrust/abuse are associated with her relationship with her mother. As she commented very simply: "liar is the word that comes to mind" when asked to describe her mother. She commented further: "she never told me this and never will but I know she was lying to me." She continues to mistrust her mother. Jade's issues with mistrust/abuse also stem from her relationship with her mother. As she indicated: "...she has this powerful character and personality that is manipulative. At the same time that if you get too close to her she will make your life miserable." Based on the experiences Carla had during childhood she commented: "I have been through so much that it is fairly easy for me to not rely on anybody in any situation."

Emotional inhibition is the need to inhibit spontaneous actions in order to avoid disapproval by others (Young, et al., 2003). Donna commented that when her parents were kicking her out she would become numb stating: "I had no feelings." Jade related bingeing and purging to inhibiting her emotional stress. She stated: "Well I was really stressed and I would eat, and eat, and eat, and then just get rid of it again. There was a lot of stress because I didn't know what I was going to do." She talked about living in Mexico on her own and not knowing how to deal with her emotions particularly of feeling lonely. She stated:

...I was in Mexico by myself so I was dealing with being lonely. I just didn't know how to cope with it any other way and the coping mechanism came in that way. I just can't control anything, so I will eat and purge and I will stay skinny. While you are eating it just kind of relaxes you.

Jade's way of dealing with her emotions was to avoid feeling them by bingeing and purging, only to feel quilt and shame later.



Carla suggested that she and her husband struggle with their ability to share emotions. She stated: “I really sometimes think that maybe we will have a dish of ice cream at night or we will bond over food, popcorn, and a movie instead of actually physically bonding.” When asked if she thought she was replacing sex with food she indicated: “I think sometimes I am” showing how she inhibited her emotions with the use of food even though she no longer purges afterward. In all three cases each of the participants appeared to be inhibiting sadness, frustration, stress, or even anger with the use of food to find a way to feel better about themselves or their situation.

All three participants made strong statements in the category of unrelenting standards. Each appeared to have set very high internalized standards regarding their behavior or performance to avoid being criticized (Young, et al., 2003). Donna commented: “I have lots of obsessive compulsive and self centered behaviors in my life.” Her unrelenting standards regarding food generally left her believing that she had not been perfect in her daily intake of calories and she would then have to purge. She indicated that she set a limit of 1,350 calories and that her rigid black and white thinking would not allow her to go over that. When asked what she did when she went over her limit she stated very matter-of-factly: “I would throw up.”

Jade admitted to being a perfectionist. As she stated:

I have always been an over achiever. I think again I always tried to keep the faith that I was that perfect kid who never did anything wrong. And as an adult, I still want to keep the thing that I never make a mistake.

Jade is working on this maladaptive schema in her recovery. As she stated: “There is a little voice somewhere in the back of my head that is just an over achiever and it is like you are not going to get stuck in that.”

Carla also stated her issues with perfectionism: “I am too much of a perfectionist. ...I have control issues.” She related how her bulimia played a part in her unrelenting standards:

Once I started to lose weight it was like an addictive quality that I wanted to lose more weight. I went through a stage where even if I ate a little bit I didn't even have to try to throw up. I would just get sick. And that was scary that I didn't have control of it.

Two participants also made comments that fit in the category of approval seeking. As Donna stated regarding her relationship with her mother: “I wanted her attention more than everyone else because everyone else will just give it to me and she made me beg for it.” She further commented in general regarding a need for approval: “I think if I do this then I will be loved, if I do that I will be okay. If I do this then I will be accepted in society.” Jade commented that she didn't believe that she was being accepted even by family except if she was thin. Her comment:

There was so much of a desire to be accepted and I felt that by losing a little bit of weight that I would be accepted and then it becomes sort of a like a circle. Because people say you look good, so then you want to continue to do it. And it isn't so much that you want to do it but you do it more, and more, and more and it becomes a pattern. ...I am only accepted when I am little. You have to get rid of the food right away.

Jade and Carla also made comments that fit into the three categories of enmeshment, self sacrifice, and failure. Jade commented on her relationship with her mother and a belief that as a child she was responsible for her mother. Enmeshment is defined by Young, et al., (2003) as excessive emotional involvement and closeness with significant others, usually a parent at the expense of being able to have a normal social development. Jade indicated that her mother also had an eating disorder and that: “she leaned on me. ...I felt like it was my responsibility to make her feel better. ...I still try

to fix her.” Jade indicated she has a fear of being over involved in other’s lives and indicated her involvement in her mother’s life has left her feeling like she has no life of her own. Carla commented regarding her mother: “I have been the parent in the relationship for a lot of years. And I have always, out of a sense of obligation, like helped.” Carla struggles with boundaries, which contributes to her issues of enmeshment. She talked about taking a leave of absence from two jobs and driving all night to another state because her half-brother indicated that he was thinking about suicide. She believed that other members of the family who lived closer to him would not reach out to help him and, therefore, she was the only one who could provide support. This also showed the extent to which Carla self sacrifices to help others before taking care of herself. Young (2003) defined this category as an excessive focus on voluntarily meeting the needs of others at the expense of one’s own gratification. As Carla indicated: “I just can’t walk away and not do anything.” Jade also made comments that fit the category of self sacrifice. In reference to her perceived responsibility to care for her mother she stated:

My dad was working all the time and so it all came down to me. I was forced to grow up real quick when I was little. I had to protect her [mom]. I had to make her feel good, I had to keep her happy. And for a kid that is kind of hard.

Carla and Jade also made comments that fit into the maladaptive schema of failure. Young, et al., (2003) defined this category as the belief that one has failed or will inevitably fail. There is often a belief that one is stupid, untalented, and less successful than others. Jade commented again regarding her relationship with her mother and stated: “when I can’t do it I feel like a failure because I’m still not there for my mother the way I wish I could.” She also commented about her own fear of “always making the

wrong decisions for a lot of things.” Carla indicated that she was certain that her marriage was a mistake. As she stated: “three weeks after our wedding I thought I might have made the biggest mistake of my life.” She also continues to blame herself for the mistakes her step-daughter has made in her life thinking: “I feel guilty because looking back I have learned some things and I think there were so many things I could have done better with her.”

Only Jade made comments that showed a dependence and sense of incompetence as she stated: “I feared decision making and that even applies now. I am still struggling with that, and giving in to other’s wishes. I didn’t have them myself I just had to go by what everybody else told me.” She was also the only participant in the category of bulimia nervosa to express statements that fit in the category of social isolation. This stemmed from her childhood when her family moved from Mexico to the United States. Because her parents were migrant workers and went where the crops were, not only was she unable to speak the language, she also found it difficult to establish friendships. As she stated so eloquently:

...It is like you come here, you don’t know the language, you have to learn a new language, you can’t communicate, you have to move around a lot, you never have friends, your parents work all the time. ...you can’t talk to anyone because you don’t know how to speak the language.

Jade continues to struggle with social isolation. She indicated while her mother tells her she is too Americanized that even when she tries to embrace her Hispanic culture she continues to not be able to do that well enough to please her family.

Carla also made comments in the category of entitlement. Carla has begun to question her self sacrificing but has gone to the opposite extreme to entitlement. Young,

et al., (2003) described this as having a sense of special rights and privilege. This often includes the insistence that one should be able to do or have whatever one wants regardless of what others might see as reasonable. Carla's sense of entitlement appeared to come from the stress of being over involved in her mother's, and her step-daughter's lives, as well as having taken on the responsibility of keeping her husband's business open. As she stated:

The point when I was ready to leave him I said, look I opened your business store. I struggled with two electric bills, two phone bills, I mean I did everything. I mean I managed the store and the household and I raised your daughter. I said I gave you 10 years. Now I am going to school. It is going to be harder for me to go to school if I leave you so like it or not you are going to be stuck with me until I finish school.

Donna was the only participant in the bulimia nervosa group to make comments in the categories of insufficient self control, subjugation, and punitiveness. Insufficient self control is defined by Young, et al., (2003) as a difficulty in exercising sufficient self control in order to achieve one's personal goals or restrain from excessive impulses. It is also an avoidance of pain or discomfort, conflict, confrontation, and responsibility for ones actions. When asked what Donna thought she gained from bingeing and purging, she commented: "control of my feelings, avoiding reality, not taking personal responsibility for my life, myself, my feelings, everything" which easily fits within Young's, et al., definition for insufficient self control.

Donna also commented about her thoughts regarding subjugation. "Every time I did something wrong they would take my life away. They would take the little jar that is me and turn it upside down in an effort to control me and I would work to feel nothing." Young, et al., (2003) explained subjugation as someone usually having the perception

that one's own desires and opinions are not valid or important to others. This will lead to outburst of anger, passive-aggressive behavior, acting out, and substance abuse. Donna clearly felt that her wants and needs were of no concern. As her parents continued to try and control her behavior, the more angry she became, the more she acted out, and eventually turned to drugs, alcohol, and bulimia in an attempt to suppress her emotions.

While Donna appeared to have the best recovery program of the three participants in this category, she still admits to some punitive behaviors in reference to her mother. Punitiveness is defined as the belief that people should be harshly punished for their mistakes (Young, et al., (2003). Donna continues to have a love-hate relationship with her mother and made one strong comment regarding this "I never thought my mother was giving me her approval so I rejected her as a punishment and as a way of dealing with the rejection of myself from her."

#### *Conclusions Relating to Bulimia Nervosa*

The three participants in the current study expressed thoughts and feelings that were identified in 16 of Young's, et al., (2003) categories of maladaptive schema. The only two categories that were not identified by at least one participant in this group included vulnerability to harm and negativity. Through the review and coding process Donna made comments that fell into 10 categories in six distinct areas: abandonment, defectiveness/shame, insufficient self control, mistrust/abuse, subjugation, and approval seeking. Donna practices a 12 step program in her recovery and takes pride in her two years of being binge and purge free. Of the three women, she appeared to have the strongest recovery and the best understanding of her disease and the recovery process. For example she made several comments regarding defectiveness and shame that showed

she is working on not only identifying the problem but correcting it as well. A positive sign in this regard included her thoughts: "I used to loath myself for now I see as more of a quirky, you know, traits I still need to work on to be of better service to other people." Donna appeared to have the best understanding of how her maladaptive schema have affected her bulimia.

Two areas stood out in the 12 maladaptive schema categories identified in the coding of Jade's transcript, defectiveness/shame and her approval seeking behavior. Jade struggled to fit in and this issue continues to be a concern for her. However, a good sign is Jade's ability to express her perceived defects when she admitted to her mother that she had an eating disorder. Unfortunately she has not admitted this to her father because she fears his response. Her need to continue to hold on to the unrelenting standard of not making mistakes may also play a role in her ability to maintain her recovery. Jade has sought out 12 step recovery programs, but has not consistently attend and admitted that she has not worked the specific steps associated with this type of program. Her admission that she still occasionally will binge on cereal may be related to her unresolved issues in these areas.

Carla made comments that fell into 10 of Young's, et al., (2003) maladaptive schema. Four categories stood out as continued areas of concern and may play a role in her inability to maintain a normal weight. These included self sacrifice, emotional deprivation, mistrust/abuse, and unrelenting standards. The mistrust/abuse appears to be related to unresolved issue regarding her lack of trust related to her mother. She also admitted that she continues to generally put everyone else's needs before her own.

Unfortunately when she finally identified this behavior she began to lean toward the opposite extreme, a sense of entitlement.

In the past, the treatment protocol for bulimia nervosa included cognitive behavioral therapy and focused on body shape, weight, and eating (Wilson & Fairburn, 1993). Rates of success using this treatment have been reported as relatively high at approximately 40 to 50 percent (Agras, 1997; Anderson & Maloney, 2001). Of those who successfully completed treatment there was a reported relapse rate of 35% (Keel, et al., 2005). This high rate of relapse may indicate that the scope of treatment should be expanded to include other issues and concerns beyond the focus of body shape, weight, and eating. Several studies using quantitative methods of research identified the existence of other maladaptive schema in participants diagnosed with bulimia nervosa (Leung, et al, 2000; Jones, et al., 2005; Joiner, et al., 1997; Waller, 2002; Waller, et al., 1999, 2001, 2002, Dingemans, et al., 2006; Cooper, et al., 2006; Hayaki, 2002; Leung & Price, 2007, Rogers & Petrie, 2001; Hurley, 2008). The results of the current study provide further conformation to the body of evidence regarding the involvement of maladaptive schema on persons diagnosed with bulimia nervosa. Leung, et al (2000) investigated the role of core beliefs in the treatment of bulimia nervosa. The results of the study indicated that even after treatment, participants diagnosed with bulimia continued to have more maladaptive core beliefs particularly in the areas of defectiveness/shame, isolation, and social undesirability and that these areas were considered high predictors of failure to stop or reduce vomiting (Leung, et al.). Each of the women in the current study indicated that they have not vomited in the past two years prior to this study. However Jade admitted to occasional binge behavior and Carla



struggles to keep her weight within a normal range, although she does not perceive herself as a binge or compulsive eater. Each of these women made statements that suggest they still struggle with issues of defectiveness/shame. Jade continues to have with issues associated with social isolation. Jade and Donna both admit to continued approval seeking. These findings help to provide confirmation of Leung's earlier findings.

Heatherton, et al., (1997) concluded that bulimic symptoms and perfectionism are highly related particularly in the perception of weight. Heatherton, et al., focused on perfectionism as it relates to body image and the symptoms of bulimia. The current study also found a relationship between unrelenting standards which includes perfectionism and bulimia nervosa. While some of the unrelenting standards reported by each of the participants in the current study related to body image, they made other comments that reached beyond that scope. Donna admitted to having "lots of obsessive compulsive and self centered behaviors," while Jade indicated, "I think again I always try to keep the faith that I was the perfect kid who never did anything wrong. And as an adult I still want to keep the thing that I never make a mistake." Carla stated, "I am too much of a perfectionist. I expected too much from him [husband] as far as how I think our relationship should be and how I think the house should be. I have real control issues." These responses show that perfectionism or unrelenting standards go beyond body shape. Expanding the scope of treatment to include other types of perfectionistic behaviors beyond body shape may help to increase recovery rates and decrease the rate of relapse.

Waller, Dickson & Ohanian (2002) found that women who displayed more bulimic attitudes perceived themselves as socially different, deprived of emotional

support, and had low self control. All three women in the current study made statements that confirmed the conclusions of Waller, et al., in the area of emotional deprivation and would concur with the suggestion that this should be included as a regular part of all treatment programs. Not to dismiss the other findings, only Jade expressed statements regarding her feelings of being socially isolated or different and only Donna made statements that would suggest insufficient self control. In the opinion of this researcher, bingeing and purging behaviors are a sign of insufficient self control. Thus, since the three participants in this study at least denied purging behavior for at least two years, this may be why fewer comments were made in reference to issues of insufficient self control. Overall, the importance of insufficient self control should be recognized and addressed in the course of treatment.

Hayaki, et al., (2002) looked at the association of shame, related specifically to bulimia nervosa and found that women diagnosed with bulimia nervosa do show higher levels of shame than a control group of non-bulimic women. As a quantitative study Hayaki, et al., did not explore particular reasons except to identify a higher rate of depressed mood associated with shame. The current study found that all three women expressed statements associated with defectiveness and shame particularly in relationship to their bingeing/purge behaviors. However, they also expressed statements that appeared to go beyond the specifics of bingeing and purging. Donna commented “I use to loath myself. ..I don’t think there is any hope for me. There is no reason to try and help myself because I will always be just this screwed up.” Jade commented “I feel so inadequate and I still wake up some days and think you have done nothing with your life.” Carla commented regarding her relationship with her husband that when he is not

interested in her sexually she feels unattractive. Depression was not a topic of discussion in the current study, however, each of the statements made by these women expressed a sense of sadness which may or may not be related to depression. While depression may be a concern, at the least issues of sadness should be included and addressed in the course of treatment and depression may need to be ruled out

The current study confirms previous studies indicating that maladaptive schema beyond body shape, weight, and eating play a role in bulimia nervosa and should be addressed as a part of a standard treatment program for this type of disordered eating. An overall discussion regarding the importance of these findings and the possible uses in treatment is discussed later in this chapter.

#### Anorexia Nervosa

Three women volunteered to participate in this study who met the criteria for a diagnosis of anorexia nervosa. Limited research has been conducted specific to anorexia nervosa and the association of maladaptive schema. It was found that in much of the literature anorexia nervosa binge/purge subtype was included in studies with participants diagnosed with bulimia nervosa. No research was found that specifically addressed maladaptive schema in relationship to anorexia nervosa regardless of subtype. For the purposes of this study anorexia nervosa was included as a separate eating disorder and data was collected from three participants all meeting the DSM-IV-TR (American Psychiatric Association, 2000) diagnosis for anorexia nervosa, regardless of subtype. In the process of interviewing the three participants, 13 of Young's, et al., (2003) maladaptive schema categories were identified. Of those 13 categories all three

participants made comments in the categories of defectiveness/shame, emotional deprivation, unrelenting standards, and approval seeking.

All three participants made statements that fit into the category of defectiveness/shame. Jillian may have made the strongest statement regarding her feelings of defectiveness when she stated: “I despise myself. A color that comes to mind is very black very angry black. ...I find it very hard to say nice things about myself.” Monica made statements associated with her relationship with her mother and her feelings of defectiveness in her mother’s eyes. She stated “I would get into trouble for putting a spoon in the wrong drawer. ...If I didn’t read the recipe right then I didn’t know how to cook.” Andrea’s thoughts regarding defectiveness come from being adopted and not always clearly understanding her place in her family system. She stated: “I started questioning my place in the world and trying to understand why anybody would want to give me up. Then I started to believe that she didn’t love me, I wasn’t good enough.”

Each of the three participants also commented on emotional deprivation which is generally associated with each participant’s parents. Jillian described her father as having “a lack of warmth, and a lack of understanding.” Monica commented regarding her father: “our relationship is good but it is not what I want with him sometimes. He would never call me.” She commented regarding her mother: “we didn’t know how to stand up to her. Because she is a rooster. The you are all wrong type.” Andrea commented about both her parents indicating: “they were always proud of me but never wanted to tell me that.”

Each of the three participants made numerous statements regarding their unrelenting standards and need for perfection. Jillian plainly stated “I am driven. I am very driven, compulsive. ...Sometimes I will sacrifice everything physically and mentally whatever and it ends up in a mess.” Monica stated: “I am already a perfectionist and very controlling. I am very organized can be detailed oriented.” Andrea commented on her unrelenting standards by saying: “I need to be perfect.” When trying to write a letter to her birth mother she stated:

So I had to in my mind create the perfect letter. And so it took me probably three days to write the letter. And I literally wrote, and wrote, and re-wrote and I threw away and it had to be the perfect paper, it had to be the perfect pen, the handwriting had to be perfect.

The final category in which all three participants made comments in was the maladaptive schema of approval seeking. Each admitted that some of their unrelenting standards had to do with being accepted by others. As Jillian stated “I was driven more by wanting to be accepted. I went to a small school and I had trouble with relationships and stuff, not really fitting in.” Monica related her relapse in college to approval seeking. She stated:

I slipped back into counting calories and I kept it under 100. And I remember people making comments... if I just had your discipline. ...it was pretty much an identity thing for me. It wasn't body image it was about the fact that oh look they think I am really in control.

Andrea talked about her need to seek approval from her birth mother. Her letter to her needed to be perfect “because she was going to judge me based on this.” She also commented that even though she was allowed to move back to her home town, she continued to battle with her eating disorder. She believed her boyfriend was not accepting her in the way she thought she needed. She stated: “he still wasn't taking care of me the way I wanted him to. If I gained weight he wouldn't want me.”

While the three participants all identified four categories of maladaptive schema, at least two of them made statements in five categories. Jillian and Monica made comments that fit in the categories of dependence incompetence, mistrust/abuse, and emotional inhibition. For the two women who talked about their thoughts on dependence incompetence this continues to be an area of concern for each of them. Jillian stated: “I fear decision making.” She attributed this fear to her relationship with her father. As she stated:

My father’s overbearing affected my decision making. It affects how I feel about myself. A lot of it is things that have been said by him. I need to give into other’s wishes, allow my partner to make all the important decisions.

Monica indicated:

I find that I have a hard time making decisions without – not that I have to consult her but I have to consult somebody. A \$3.00 shirt can sometimes be hard and I think this is ridiculous I shouldn’t have to call my mom to buy a frickin shirt.

Both Monica and Jillian made comments that fit into the category of emotional inhibition. Jillian’s diagnosis is anorexia nervosa binge/purge subtype. Her comments regarding emotional inhibition clearly showed her disorder when she stated: “I think I continued to binge, purge, binge, purge cause I didn’t want to deal with the emotions that were coming on so I began relying more on food to feel better.” Monica talked about her relapse in college her sophomore year. She indicated that she rushed a sorority and while she was accepted her best friend was not. She stated: “if I had been the person that I am today I would have just said forget you guys but instead I dropped back down to 95 [pounds]” indicating her need for acceptance at that time. Over the course of her

recovery, Monica believes she has become a different person and would not allow herself to give into peer pressure any longer.

Jillian and Andrea made comments that fit into the categories of enmeshment, mistrust/abuse, and self sacrifice. While Monica portrayed her mother as somewhat of a mentally abusive person, her discussions regarding her mother appeared to fit more closely in other maladaptive schema categories, and therefore, were not included in the area of mistrust/abuse. Both Jillian and Andrea appeared to have issues of enmeshment with one or more family members. Jillian very clearly described herself stating: "I have a lack of separate identity." She commented that in every relationship she has been in she simply takes on the likes and dislikes of the person she is with rather than identifying her own likes and dislikes. This most likely stems from her relationship with her father who continued to make all her decisions up until the time she moved in with her boyfriend. Now she defers to her boyfriend as the decision maker. Jillian also commented that she has a very close relationship with her mother indicating "I still share everything with her." Andrea commented on her relationship with her boyfriend:

I was that girlfriend that I had to be with him 24/7. My world revolved around him. I would give up anything and everything to make sure that I could be with him. ...I had nothing for myself. Everything was around him, and everything was around my parents.

This very likely ties in with Andrea's fear of abandonment as an adopted child. At the same time it shows her inability to individuate herself from her family.

Both Jillian and Andrea commented on issues of mistrust/abuse making statements that suggest a fear of being hurt, humiliated, cheated on or lied to by others. Jillian's concerns are with her father. She described him as mentally and emotionally

abusing her to a point now that she no longer lives at home and she protects herself regarding her visits with him. As she stated: “the time I spend with him now is all in protected settings that I can control.” She makes all the contacts and decides when and where she will spend time with him. She indicated that her favorite time is going grocery shopping with him because he will be concentrating on his shopping and coupons and will not have time to focus on her.

Andrea grew up with an alcoholic, abusive father. She indicated that he was verbally and emotionally abusive to her. In her mind she decided that she would never allow this type of behavior to happen in her relationships. She stated:

So I refused to live like that, I refused. The biggest impact was that I would go and get my education and I wouldn't have to rely on anybody to take care of me. I would be able to support myself no matter what and that was the most important thing to me.

Andrea and Jillian also made comments that fit in the area of self sacrifice. Jillian only made one comment but it seemed to describe her quite clearly and therefore was important to note. She indicated “I put others before me.” Andrea's self sacrifice again ties in with her adoptive status and a need to find her place within her family. She made numerous comments regarding how she has sacrificed her needs for the needs of her family. One statement that seemed to have a profound impact on her was: “I sacrificed my education to try and be there for my family.” Her education was her way out of an abusive household, yet at the same time her need to be a caregiver pulled her right back in.



Andrea was the only participant in this category that made comments regarding abandonment. This again centered around her being adopted. This seemed to hit home for her in the seventh grade. As she stated:

A family friend that went to school with us, his parents were friends with my parents, made jokes about me being adopted and that I wasn't loved and I was given up and I was found in a dumpster. ...It had a profound effect on me that I wasn't loved. I started questioning my place in the world and trying to understand why anybody would want to give me up and not understanding. ...So that is where a lot of this whole rejection came into play. Abandonment and not loved and trying to find my place although I always had a place. That one incident in middle school caused me to – it had a profound effect on me, that kid telling me I wasn't wanted.

Jillian was the only participant in this category to make statements regarding insufficient self control. She continues to battle with bingeing and purging. She has not been able to make a full recovery from her anorexia. She indicated the need to binge and purge overwhelms her, and that she lacks the self control to work her way through the thoughts and feelings without acting on them. As she stated:

...it is kind of out of my control, something I can't control and it like some days I am good about it where I will follow my little routine, whatever. And some days I don't know it just gets to me. ...And I start, gotta do this, and immediately it starts and it is right there and there is no stopping me.

Jillian also commented on her social isolation. She commented that this actually began with her parents whom she described as “different from other people. Not a part of any community.” She stated about herself: “I was not very social. ...I still lack a lot of social stuff. I still don't like to go out or do things.”

Lastly, Jillian is the only participant in this group to make comments regarding a sense of failure. When asked early in the interview to describe herself she stated: “inadequate, not standing up for myself, failure, stupid.” While this was the only

comment she made in the category, it stands out indicating she is being extremely harsh on herself.

### *Conclusions Regarding Anorexia Nervosa*

In total the three participants identified with 13 of Young's, et al., (2003) maladaptive schema. Jillian identified with 12 categories of maladaptive schema. Her strongest statements appeared to fall in the areas of insufficient self control, mistrust/abuse, emotional inhibition, and unrelenting standards. While she did not make many statements in the area of defectiveness and shame and dependence incompetence, the statements she did make continue to be areas of concern and hold the key to her continued relapse. Her statement associated with her thoughts regarding her perception of herself, "I despise myself. A color that comes to mind is very black, very angry black" suggests that she still sees herself as defective. She also made an interesting statement regarding her decision making skills indicating she still considers herself as dependent and/or incompetent. She stated: "So I usually make a decision but before I actually go through with it I am always asking is this okay, should I do this. I am not really sure of myself I guess." Based on the results of the short food journal that Jillian returned, she continues to restrict calories and appears to eat the very minimum on a daily basis to sustain her energy, not necessarily her weight. She also admitted that she continues to struggle with urges to binge and purge. While she does not always give in to those urges she admitted that it is a struggle on a near daily basis.

Monica showed the best recovery indicating that she has been in recovery for 10 years. She admitted that she still counts points when planning her food menus. She does appear to eat appropriate amounts of food and indicated she does not punish herself for a

splurge in food intake. She continues to maintain a healthy weight based on her size. She did recognize that her issues with perfectionism and dependence/incompetence are still problem areas for her. She indicated that neither of these areas triggers her need to restrict in order to find control.

Andrea made statements that were coded into eight of Young's, et al., (2003) maladaptive schema. She does show good signs of recovery for her anorexia. However, it appeared clear that there are a couple of maladaptive schema that continues to cause concern. Her issues of abandonment stemmed from comments made by a childhood friend related to her being adopted and carried over in adulthood to being rejected by the birth mother. This maladaptive thinking appears to creep into current issues like her mother's recent illness. Andrea believed she needed to call her adoptive mother everyday and check on her. At certain times her mother did not feel up to talking on the phone. Andrea had to fight off her first thoughts of "I feel like she is rejecting me" in order to realize that her mother just did not want to talk at that time, unrelated to her feelings about Andrea. Andrea admits that food continues to be a source of control and comfort for her when she becomes overwhelmed. She admitted that she will use food to inhibit emotions. When she realizes she has overeaten she will at least consider restricting for a day in order to make up for the extra calories. While she appeared to have the anorexia nervosa under control, she does struggle to maintain a healthy weight since food has now become a source of comfort.

Only one previous study was found specifically related to the eating disorder of anorexia nervosa, relevant to maladaptive schema. Rogers & Petrie (1996) examined the relationship of obsessiveness, dependency, hostility toward self, and assertiveness as it

relates to attitudes and behaviors associated with anorexia nervosa. The results of this study indicated that there did not appear to be a direct relationship between the symptoms of anorexia and self-directed hostility or assertiveness. However, there was some relationship between symptoms of anorexia and obsessiveness and dependency. Rogers & Petrie did not use participants that were diagnosed with anorexia nervosa. Instead this was a quantitative study where participants were selected who demonstrate attitudes related to anorexia nervosa based on the Eating Attitudes Test developed by Garner & Garfinkle (1997, as cited in Rogers & Petrie). One of the limitations of the Rogers & Petrie study is that none of the women involved in the study were diagnosed with any type of eating disorder. The EAT only reports that there is a propensity for the test taker to have or develop an eating disorder. The current qualitative study expanded on Rogers & Petrie's work by using three participants who fit the DSM IV –TR (American Psychiatric Association, 2000) diagnosis for anorexia nervosa. It found that all three participants made statements that were identified and coded in the areas of defectiveness/shame, emotional deprivation, unrelenting standards and approval seeking.

The current study suggests that further research should be conducted regarding the relationship of maladaptive schema beyond body shape, weight, and eating that may be associated with anorexia nervosa. Further discussion regarding the importance of these findings and possible uses will be discussed later in the chapter.

### General Conclusions

Overall, the findings generated from the data analysis supported the goals of the research. A summary of the findings which developed during the process of analyzing the data were presented earlier in this chapter. The findings are presented in summary

with some interpretation of the results. The next section provides a generalized discussion of the effect of maladaptive schema associated with disordered eating and provides conclusions derived from these results. Each of the original research questions will be addressed through a synthesis of the data from all three disordered eating types that were the subject of this research.

Five previous studies used a more generalized approach to identifying maladaptive schema related to disordered eating and will be discussed as a part of this general conclusion. A study by Jones, et al., (2005) found that women reporting to be in recovery from a non-specified eating disorder scored lower on the Young Maladaptive Schema inventory in the areas of mistrust/abuse, social isolation, defectiveness/shame, failure to achieve, and vulnerability to harm than women with a current eating disorder. The scores for this recovery group were still higher than scores from a control group of participants who denied ever having an eating disorder. All six participants in this study who fit the DSM IV-TR (American Psychiatric Association, 2000) diagnosis of either Bulimia Nervosa or Anorexia Nervosa indicated that they saw themselves as being in recovery. However, all six participants made statements that would suggest that they may still be struggling with issues associated with defectiveness/shame, while five indicated concerns with mistrust/abuse. Fewer indicated issues with failure, and social isolation. The current study found that all the participants in the categories of bulimia nervosa and anorexia nervosa made statements that fit in the category of emotional deprivation and unrelenting standards. Issues with emotional deprivation appeared to be associated with unresolved issues regarding relationships with one or both parents. Each participant made statements that suggest that they still may not have the relationship they desire. For

example, Monica stated: “our relationship is good but it is not what I want with him [father] sometimes,” while Jillian continues to describe her father as having “a lack of warmth, and a lack of understanding.” Jade also made comments in the present regarding her father’s emotional deprivation when she stated “my father is very distant. ...Emotions don’t count so he doesn’t have a lot of emotions.”

A study by Leung & Price (2007) found that a group of participants with an unspecified eating disorder scored significantly higher on the Young Schema Questionnaire Short version in the areas of emotional deprivation, mistrust/abuse, social isolation, defectiveness/shame, failure to achieve, dependence/incompetence, and vulnerability to harm. The current study agrees with the majority of findings in the Leung & Price study. Seven of the eight categories were also identified by one or more groups of participants in this qualitative analysis. Interestingly, two categories did not appear as areas of concern for any of the participants in the current study: vulnerability to harm, and negativity.

It should be noted that vulnerability to harm presented a source of some debate for this researcher and the auditor. Young, et al., (2003) defined vulnerability to harm as an “exaggerated fear that imminent catastrophe will strike” (p. 15). Throughout the review several of the participants made comments that at first glance suggested a vulnerability to harm. Based on Young’s, et al., definition none of the statements appeared to identify an exaggerated fear that imminent catastrophe would occur to self or others, therefore, those statements were reviewed and found to fit better in other categories such as continued mistrust. Young’s, et al., strong definition made it difficult to identify this category in this qualitative study. However, the Young Schema Questionnaire identified specific

statements which participants are asked to rate. Those statements could provide a more clear and specific picture of vulnerability to harm which could explain the differences in the results between the current study and that of Jones, et al., (2005) and Leung and Price (2007).

Another maladaptive schema not found in the coding process was negativity. This maladaptive schema is defined by Young, et al (2003) as a pervasive, lifelong focus on the negative aspects of life which usually includes an exaggerated expectation that things will ultimately fall apart. While all 10 women discussed the negative aspects of previous life events none of them indicated they believed they had no hope of a better future and therefore their comments fit better in other categories of maladaptive schema. Each has been successful in her own right at work, and in her personal life; and all identify some personal strengths which continue to motivate them forward. This may help to better understand why neither the researcher nor the auditor identified negativity as a maladaptive schema in any of the transcripts.

It should be noted that none of the participants in the category of compulsive overeaters resulting in obesity were in recovery at the time of this study. Three of the four participants continue to weigh in the obese range. They do not show signs of changing behaviors in order to lose weight. The fourth participant was currently in the overweight range, but was struggling to stay on track toward recovery. Because they are not clearly in recovery this group was omitted from this part of the discussion and relationships made between the current study and the Jones, et al., (2005) study.

Waller, et al., (1999) questioned whether or not different eating disorders showed different patterns of core beliefs relative to each other and to a comparison group. The

study included women diagnosed with bulimia nervosa, anorexia nervosa binge/purge subtype, and binge eaters, as well as a group of non-clinical women. The findings indicated that defectiveness/shame was a significant predictor of purging in bulimic women, while emotional inhibition was a significant predictor of bingeing behavior. Across the board, all 10 participants in the current study made statements coded in the maladaptive schema category of defectiveness/shame. A few examples include Joan's comment: "When I get half way through the semester I get so depressed and hopeless and I want to give up...and I feel that I am not good at it." Cathy made the statement "what is wrong with me." Laura stated "I feel disappointed in myself that I am at this age I have not achieved what it was I set out to achieve." Jade also spoke in the present tense when she stated "I feel so inadequate and I still wake up some days and think you have done nothing with your life."

Waller, et al (1999) also found that emotional inhibition was a clear predictor of binge eating. The current study confirms this finding as a predictor of binge behavior in all three participants in the category of bulimia. Emotional inhibition appeared to also trigger binge eating in the compulsive overeaters as well. All seven of the participants in the categories of compulsive overeating resulting in obesity and bulimia nervosa made statements that related to attempting to inhibit emotions through the use of large quantities of food. For example: Margaret indicated "whenever I have stressful or hurtful times I tend to overeat and I tend to eat quite a bit of crap." Cathy related this to a specific incident: "I was sitting there crying and I am just shoveling piles in my mouth and all of the sudden I looked down and realized, oh my gosh, almost the whole bag was gone, and I opened the bag." Jade stated:



Like this eating is going to make me feel better, and it was just a coping mechanism because I was so stressed out that I would eat and then just keep eating, and eating, and eating and by the time you realize it you have eaten so much and then you do not feel good.

The current study shows some agreement with the findings of Waller, et al., (1999) and confirms that maladaptive schema beyond the scope of body image, weight, and eating should be considered for inclusion in the treatment of disordered eating.

Dingeman, et al., (2006) conducted a study which included various eating disorders. This study included anorexia nervosa separating the two subtypes of restricting and binge/purging, as well as bulimia nervosa, a binge eating group, and a control group of non-clinical participants. All the participants were asked to take the Young Schema Questionnaire Short version, as well as other qualifying types of questionnaires. Those participants in the study who utilized purging behaviors were more likely to have maladaptive core beliefs. This suggests that purging may not be used just to control weight, but is also related to other types of maladaptive schema. The current study also found a relationship between bingeing and purging. Each behavior appeared to provide a source of relief and or comfort. As related above, the compulsive overeaters, as well as the bulimics attempted to emotionally inhibit with binge type behaviors. Jillian was the only identified anorexic, binge/purge subtype in the current study. Her comments confirmed that bingeing and purging was not entirely associated with controlling weight as she stated: "I think I continued to binge, purge because I didn't want to deal with the emotions that were coming on so I began relying more on food to feel better."

### Contributions of This Study

This study adds to the body of literature and confirms that maladaptive schema beyond body shape, weight, and eating do have an effect on the ability of women diagnosed with anorexia nervosa, bulimia nervosa, and compulsive overeating resulting in obesity to recover. The participants were very generous with their time and willingness to be open and share traumatic events from their lives, as well as strong emotional thoughts and feelings. Their candidness produced ample data for review. The data is focused on 18 categories of maladaptive schema (Young, et al., 2003) and how traumatic events in the lives of these 10 participants fit into each of Young's, et al., categories as seen in Table 2.

Table 2  
Relationship of maladaptive schema to each  
of the disordered eating categories

Disorder/ Maladaptive Schema	OE	OE	OE	OE	BN	BN	BN	AN	AN	AN
Abandonment	X	X		X	X	X	X			X
Defectiveness	X	X	X	X	X	X	X	X	X	X
Dependence	X		X			X		X	X	
Emotional Deprivation	X	X	X		X	X	X	X	X	X
Enmeshment	X	X	X			X	X	X		X
Entitlement							X			
Insufficient/ Self Control	X		X			X	X	X		X
Mistrust/ Abuse	X	X	X	X	X	X	X	X		X
Subjugation		X	X	X	X					
Social Isolation		X	X	X		X		X		X
Self Sacrifice	X					X	X	X		X
Emotional Inhibition	X	X	X	X	X	X	X	X	X	
Failure	X	X	X	X		X	X	X		
Unrelenting	X	X		X	X	X	X	X	X	X

Standards										
Vulnerability to Harm	X	X		X	X	X	X	X	X	X
Approval Seeking	X	X	X	X	X	X		X	X	X
Negativity										
Punitiveness				X	X					

Table 2 shows the relationship of maladaptive schema to each of the disordered eating categories. Compulsive Overeaters resulting in Obesity are represented by the letters “OE”, Bulimia Nervosa is represented by the letters “BN”, and Anorexia Nervosa is represented by the letters “AN”. Each column with an “X” represents statements that were made by a participant in the study specific to that category of maladaptive schema. The shading represents the relationship of maladaptive schema associated with each type of disordered eating. It also shows which maladaptive schema within and across the three types of disordered eating were held in common.

A second contribution is that it helps to identify maladaptive schema using a conversational interview process which might be similar to any psycho-social assessment used in treatment. It is the opinion of this researcher that many people who seek treatment for disordered eating focus on body shape and weight as key issues when they enter treatment. This may explain the focus of cognitive behavioral treatment in the past. However, with a relapse rate of approximately 35% of those who complete treatment it becomes clear that other issues play a role. One assumption guiding this study was, maladaptive schema contribute to the inability of those diagnosed with disordered eating to sustain a long term recovery. Several previous quantitative studies provided a variety of conclusions regarding the various maladaptive schemas involved in disordered eating. The studies agreed that more maladaptive schema should be addressed in the course of

treatment in order to gain long term recovery. The purpose of the current study was to use a qualitative approach in order to further explore and identify maladaptive schema associated with anorexia nervosa, bulimia nervosa, and compulsive overeating resulting in obesity that may interfere with long term recovery. An interview process similar to assessing a potential client for treatment was used rather than asking participants to fill out numerous types of testing materials. Through the course of conversation, 10 participants in this collective case study revealed a variety of maladaptive schema which appeared to be associated with their ability to be successful in long term recovery. Table 2 provides a breakdown by disordered eating category and maladaptive schema categories all of which have been discussed earlier in this body of work.

It was anticipated by this researcher that these three disordered eating categories would share more maladaptive schemas in common. The more categories of maladaptive schema that were held in common the more that could be used in a common group setting that addressed any type of disordered eating during treatment. Unfortunately, within the group of 10 participants in this collective case study only defectiveness/shame appeared as a common thread to all three types of disordered eating.

It is important to point out the strength of this specific maladaptive schema. While some of the defectiveness/shame was related to body shape it is clear that the statements made by the participants regarding defectiveness/shame go beyond that scope. For example, Cathy's simple statement of "I am not good enough" is referring to her ability to be a good mother, a good employee, and a good wife and clearly described her thoughts of being defective. This shows that defectiveness/shame, as a maladaptive schema clearly needs to be a part of any group therapy program that addresses disordered

eating. The fact that no other maladaptive schema appeared to transcend all categories of disordered eating may be simply a limitation of how this study was conducted. Further research is necessary to resolve this concern.

### Recommendations for Use

The findings of this study provide some possible recommendations for the use of maladaptive schema in the treatment for disordered eating. It is very important for counseling professionals to stay current with trends and realities in counseling. This can be done through continued research and clinical observations. The findings in this collective case study confirm a trend identified in earlier research that maladaptive schema beyond body shape, weight, and eating play a key role in the recovery and relapse of persons diagnosed with various types of disordered eating. It also offers the counseling profession suggestions in three areas of case conceptualization, intervention planning, and training to provide better outcomes in the treatment of all types of disordered eating.

#### *Case Conceptualization*

Case conceptualization provides the counselor with an empathetic understanding of the client's situation and promotes an effective therapeutic process, allowing counselors to identify the influences and interactions that may be affecting the client. Understanding and identifying maladaptive schema beyond body shape, weight, and eating have an effect on disordered eating is critical to helping the client to reach and stay in recovery. The current study confirmed previous studies that maladaptive schema beyond body shape, weight, and eating should be included to achieve a successful outcome in the treatment of disordered eating, adding to the body of evidence and

creating a more complete understanding of the problem at hand. Comprehension of the number and identification of all possible maladaptive schema involved in disordered eating will allow for the development of more affective interventions by counselors who chose to treat disorder eating.

### *Planning Interventions*

The participants of this study have provided evidence related to 16 defined maladaptive schema which may be involved in the lack of recovery and/or relapse process of disorder eating. These findings provide information that can promote the development of more effective interventions for working with clients diagnosed with disordered eating. Through effective conceptualization regarding how maladaptive schema are involved and affect the process of recovery and relapse in disordered eating, interventions can be planned to address the needs of the individual's, or the group's recovery. This can promote the individual's or group's avoidance of the relapse process.

### *Training Implications*

Knowledge and understanding of the issues involved in disorder eating is crucial to providing effective treatment. In order to consider treating eating disorders counselors should consider this an area of specialization and seek out training prior to offering treatment to a client diagnosed with disorder eating. The majority of studies found in the review of the literature indicated that the concept of more maladaptive schema being involved in disordered eating beyond body shape, weight, and eating has only been seriously investigated over the course of the last 10 years. Development of treatment protocols addressing a variety of maladaptive schema may be limited and still in the

development process. Further studies may be indicated in order to truly understand the impact on the treatment process.

#### Recommendations for Additional Research

The current study helped to confirm previous research that maladaptive schema beyond body shape, weight, and eating are involved in disordered eating. While other studies have included binge eating disorder, the current study chose to expand the concept of binge eating to compulsive overeating resulting in obesity. This researcher elected to pursue this direction due to the fact that obesity is a major issue particularly in the United States (Cooper & Fairburn, 2001; Flegal, et al, 1998). Binge eating is described as a specific disorder in the DSM-IV-TR (American Psychiatric Association, 2000). However, compulsive overeating and obesity are not listed as disorders. It is the opinion of this researcher that there are some similarities and differences in binge eating and compulsive overeating. Binge eating disorder requires that binge episodes occur at least 2 times a week (American Psychiatric Association, 2000). While it could be considered that compulsive overeating is a form of binge eating, binge eaters do not necessarily fall in the category of obese. A person with a binge eating disorder may only binge under extreme periods of stress, anxiety, or depression. Compulsive overeaters tend to binge more often and for more reasons as the current study identified 16 of Young's, et al (2003) maladaptive schema. This culminates in extreme weight gain, and over time can result in obesity. Since this is one researcher's speculation, this should be an important topic for future research that could compare maladaptive schema involved in binge eating and compulsive overeating resulting in obesity.

The majority of research to date regarding maladaptive schema associated with various disordered eating generally combined or included more than one type of disordered eating as a topic of the research. Future quantitative studies might consider identifying maladaptive schema associated with a particular type of disordered eating, rather than contrasting and comparing the effects of maladaptive schema on two or more types. More studies that are specific to one disorder or another could help in the process of identifying the specific maladaptive schema that can be included and consistently used in a treatment protocol. While contrasts and comparisons are important and move the investigation forward it does not necessarily help in the identification of protocols for treatment.

One of the issues identified in the research was the high rate of relapse in those who successfully completed treatment for disordered eating. With the contribution of the new research which has identified other maladaptive schema involved in disorder eating, it seems prudent that a longitudinal study would be another course of research. A longitudinal study could include the development of a treatment protocol that addresses other maladaptive schema associate with eating disorders beyond body shape, weight, and eating. After setting and using the protocol in treatment the study could follow the progress in the continuing recovery of the participants referred to the study for treatment to determine if the treatment of more maladaptive schema in fact decreases the risk of relapse in clients who successfully complete treatment. The study could check on the progress of the participants at two and five years post treatment for an update on their recovery.



Young, et al., (2003) indicated that the Young Schema Questionnaire can diagnose maladaptive schema in a number of Axis I disorders. It would appear from the research that this does include eating disorders that are listed as Axis I in the DSM-IV-TR (American Psychiatric Association, 2000). However, the development of an assessment tool specific to disordered eating may help to identify issues that are specific to these disorders. Further research is necessary to better understand which categories are more likely to be associated generally with disordered eating. Having a diagnostic tool specific to disordered eating could help in the process of treatment planning and the organization of group and individual therapy.

#### Limitations

This study was intended to further the understanding of the effect of maladaptive schema on disordered eating. As a qualitative study, the results were not intended to generalize to the total population of those diagnosed with disordered eating. The experience of the 10 participants in this study suggests a trend supporting the concept of transferability to a larger population of persons diagnosed with disordered eating. However there are a few limitations to the sample and the research design that should be addressed in order to assess the strength of the findings.

First, there were only 10 participants in total and three specific types of disordered eating were being explored. Four participants volunteered in the category of compulsive overeating resulting in obesity. Three volunteered in the category of anorexia, and three in the category of bulimia. While the 10 participants generated an enormous amount of data it should in no way be considered as a representative sample of all persons who are diagnosed with disordered eating. Commonalities among the participants in each

category and across categories suggest a degree of transferability. Analyzing data from a larger sample in each category of disordered eating would be more labor intensive, but could end up producing similar results. This would increase the possibility of transferability.

Second, another possible limitation is the homogeneity of the participants to the population. All the participants involved in this study live in rural Polk County, Florida. All but two of the participants were students at a regional campus of a major university located in Polk County, Florida. Also, in the categories of bulimia nervosa and anorexia nervosa each of the participants indicated that they had been and continued to be in recovery for their eating disorder. The results may have been different if the focus included participants who were not in the recovery process of their disorder. This may explain why the participants in the category of compulsive overeating resulting in obesity identified with more maladaptive schema than those participants in the categories of bulimia and anorexia. The participants in the category of compulsive overeaters resulting in obesity based on current weight, suggests that clearly they are not in recovery and, therefore, continue to struggle with their ability to lose and maintain a healthy weight.

It was interesting to this researcher that in some cases two out of three or three out of four participants would make statements that identified a specific maladaptive schema but one participant did not. Because this study used case studies and followed the flow of the conversation it is possible that the participant who did not identify with the specific maladaptive schema was simply not focused in that area during that specific interview. Two possible options could resolve this problem. First, this study only intended to record one interview for the body of the information and one interview to add or change

information after review of the transcript. Only two participants actually added information at a second interview. The use of more clarifying questions might have enhanced the process and prompted more information from the participant. Second, this study used individual interviews only to gather information. A second interview involving all 10 participants in a focus group might have helped to trigger similar experiences among the participants. This could have resulted in more comparisons and similarities across the categories of disordered eating.

A third limitation was that not all the participants filled out and returned the food journals. Of those that were returned, several only tracked their eating sporadically. The journal may not be a necessary part of identifying maladaptive schema, however, those that were returned did provide confirmation of eating to inhibit emotions as well as other maladaptive schema. In the completion of the study it is unclear to this researcher that there was any real impact on the use of a food journal in the process.

It is also important to note that one participant indicated she did not want to review her transcript when it was provided to her. She indicated she did not realize how difficult it would be to tell her story and wasn't sure she wanted to read it back now that it was transcribed. She gave permission for its use as is. This may not have any effect on the outcome of the data. However, it did not allow this researcher the opportunity to gather any further information. Since only two participants actually added more information at a second interview once they had read their transcripts there would appear to be a strong likelihood that the results of this specific transcript would not have changed the outcome of the study. However, it is important to identify it as a possible limitation.

The number of identified maladaptive schema may also be related to the stage of recovery reported by the participants. For example, Jillian made statements coded into 12 categories of maladaptive schema while Monica only made statements in six categories and Andrea made comments in eight. Of those three participants, Jillian continues to be the one who continues to struggle with her recovery. Although she perceives herself as being in recovery, she admitted that while she does not restrict her intake as much, she struggles with bingeing and purging.

Another possible limitation of this study is that all the participants self-selected to participate in the research after hearing about the project described in a class, or by a therapist, or a friend. It can therefore be assumed that they were seeking to explore these issues and had a level of self-awareness that gave them the confidence to consent to be interviewed. The issues of the participants who volunteered may be very different from those who did not choose to participate and even more different than someone who is in a lesser stage of recovery. Future research is needed where recruited participants appear more reserved at first or who have not had some level of success in treatment to determine if their experiences are different than those who readily volunteer.

Researcher bias was a major concern and had the most potential for impacting the results of this study. This researcher was responsible for setting up the design of the study, recruiting the participants, conducting all the interviews, personally transcribing all the data, and interpreting the results. The use of an auditor was the major tool used to counteract researcher bias and increase the confirmability and credibility of the study. The auditor not only evaluated the research design she was indispensable in the interpretation of the results. This was done both independently to improve inter-rater

reliability, collectively, and to generate a consensus of the findings. The auditor's contribution to this process significantly reduced threats to the credibility of the study.

Despite these limitations, the results of this study do lend support to earlier studies regarding the existence of maladaptive schemas beyond body shape, weight, and eating, in disordered eating. The research supports the need to develop treatment protocols that address more maladaptive schema in treatment in order to decrease the risk of relapse in recovery. Future research is encouraged to continue to explore the effect of maladaptive schema on disordered eating in order to develop affective interventions in treatment.

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## Appendices

## Appendix A

## Sample Recruitment Letter

Date

Re: Research on Eating Disorders

Dear Student:

I am a doctorate student at the University of South Florida in the Counselor Education program currently working on my dissertation. I am conducting a qualitative case study on the impact of maladaptive schema on disordered eating and need student's who are willing to volunteer a few hours of their time for an interviewing process.

If you have ever received a diagnosis of Anorexia Nervosa, Bulimia Nervosa or believe that your current weight would place you in the obese category based on the Body Mass Index and consider yourself a compulsive overeater, I would appreciate an opportunity to include you in my study. Those who volunteer as part of the study would be afforded complete confidentiality. Your name and identity would not be used.

The time you would spend in the interview would not be a therapeutic session. My goal would be to interview you no more than three times in order to gather as much information as possible regarding your thoughts and emotions associated with your disordered eating. I would be happy to provide you with a copy of my proposal and answer any questions in advance of your joining my study.

Please feel free to contact me so that we may discuss my study and qualifications further.

Sincerely,

Susan Hurley, LMHC

## Appendix B

## Sample Recruitment Letter

Date

Name

Address

Re: Research on Eating Disorders

Dear :

I am a doctorate student at the University of South Florida in the Counselor Education program, and a Licensed Mental Health Counselor working on my dissertation. For my dissertation I am currently conducting a qualitative collective case study on the impact of maladaptive schema on anorexia nervosa, bulimia nervosa, and compulsive overeating resulting in obesity. If you are currently seeing or have seen a patient diagnosed with anorexia, bulimia, or would fit the Body Mass Index criteria for obese, not due to any medical reason I would appreciate an opportunity to include them in my study.

This would not be a therapeutic session. My goal would be to interview the participant approximately four times in order to gather as much information as possible regarding their thoughts and emotions associated with their disorder. The first session would be to introduce the study to them and answer any questions they might have. They would then be asked to sign an Informed Consent to Participate. The sessions would be recorded and transcribed by me and then I would ask each participant to review the transcription for errors or additional information. All information will be held confidential and no names will be included in the written report.

This study has been approved by the USF Institutional Review Board. I would be happy to provide you with a copy of my proposal and answer any questions in advance of your referring individuals to the study. Please feel free to contact me so that we may discuss my study and qualifications further.

Sincerely,

Susan Hurley, LMHC



## Appendix C

## Sample Questions

This is a sample and not to be considered a complete list of questions. They are presented in no particular order

Name: \_\_\_\_\_

Date of Interview: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Interview # \_\_\_\_\_

Information Gathering:

Have you ever been treated for your eating disorder and if so what was the outcome?

How do you feel about the outcome of your treatment?

Describe yourself?

Are there any words or phrases on the list you were provided that best describe how you think or feel about yourself?

Describe your father? How would you characterize his personality? What effect do you see his personality and the description you have provided affecting you?

Describe your mother? How would you characterize his personality? What effect do you see his personality and the description you have provided affecting you?

Describe your siblings? How would you characterize his personality? What effect do you see his personality and the description have provided affecting you?

Are there any other family members who you see having an affect on your life?

Are there any words or phrases on the list you were provided that best describe how you think or feel about those family members?

Describe the beginning of your eating disorder. Where were you, how old were you, what type of events were taking place in your life?

Bulimia

How long have your binge and purge episodes been going on?

Recall a first memory of this behavior? Was there a specific event?

What types of thoughts, activities, or feelings trigger your need to binge and purge?

Did you try any of the coping skills you have learned in treatment to not binge and purge?

What thoughts and feelings did you have at the time of this episode?

What life events do you attribute to your eating disorder?

What do you believe you gain from bingeing and purging?

What do you believe you control from bingeing and purging?

Obesity

At what age do you recall being aware of being overweight?

What diets, or eating plans have you tried to loose weight?

What effect has your weight had on your life?

What life events do you attribute to your eating disorder?

Do any specific events, thoughts, and feelings cause you to eat more than normal?

What do you believe you gain by eating?

Anorexics:

How long has it been since you last ate?

What life events to you equate with your eating disorder, if any?

What do you believe you gain by not eating?

What do you believe you control by not eating?



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## Appendix D

### Informed Consent to Participate in Research

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#### **Information to Consider Before Taking Part in this Research Study**

Researchers at the University of South Florida (USF) study many topics. To do this, we need the help of people who agree to take part in a research study. This form tells you about this research study.

We are asking you to take part in a research study that is called:

*The Impact of Maladaptive Schemas on Disordered eating: A Collective Case Study.*

The person who is in charge of this research study is Susan Hurley, LMHC.

Other research personnel who you may be involved include: Herbert A. Exum, Ph.D.

The research will be done at the University of South Florida Polytechnic Counseling Center, located on at 3433 Winter Lake Road, Lakeland, FL 33813.

#### **Purpose of the study**

The purpose of this study is to help researchers understand how negative adjustment to thoughts and feelings in a person's early life may play a role in disordered eating, in order to find more successful treatment options.

#### **Study Procedures**

If you take part in this study, you will be asked to attend 4-5 appointments to be interviewed by Susan Hurley, a Licensed Mental Health Counselor regarding your specific eating disorder and thoughts and feelings from your early childhood which may contribute to this eating disorder. You will be expected to keep a daily food journal, indicating when, and what you ate and what feelings or thoughts went along with eating, if any. These diaries may be used in the interview process to help both you and the interviewer to better understand how thoughts and feelings might trigger why people choose to eat or not eat. Each session will be audio recorded and typed word for word. You will have an opportunity to read your typed interviews and change anything within your interviews that you believe may have not been clear or could be misunderstood. The sessions should not take more than 1-2 hours per week, and your part in the study should not take more than 3 months. The interviews and review of information will all take place at the office of Susan Hurley, LMHC at the University of South Florida Polytechnic Counseling Center.

**Alternatives**

You may choose not to participate in this research study.

**Benefits**

We don't know if you will get any benefits by taking part in this study.

**Risks or Discomfort**

There are no known risks to those who take part in this study.

**Compensation**

We will not pay you for the time you volunteer while being in this study.

**Confidentiality**

We must keep your study records confidential. All audio tape recordings, food diaries, and research notes will be held in a locked cabinet in the counselor's office and this counselor will have the only key. The records for this study will be kept separate from client files and student records. The records will be identified by number only and all tapes, diaries and research notes will be identified with the same number. The list of numbers applied to each participants name will be keep separate from the research files. The identity of the participants will be known to the researcher only. Once the audio tapes have been transcribed and approved by the participant for accuracy, the tapes will be destroyed. The transcriptions of the audio tapes may be reviewed by another researcher, however, that person or persons will not have access to your identity. The transcription of your audio tapes, food diaries, and the researcher's notes may be kept for up to three (3) years at which time all the records will be destroyed.

However, certain people may need to see your study records. By law, anyone who looks at your records must keep them completely confidential. The only people who will be allowed to see these records are:

- The research team, including the Principal Investigator, study coordinator, and all other research staff
- Certain government and university people who need to know more about the study. For example, individuals who provide oversight on this study may need to look at your records. This is done to make sure that we are doing the study in the right way. They also need to make sure that we are protecting your rights and your safety. These include:
  - the University of South Florida Institutional Review Board (IRB) and the staff that work for the IRB. Other individuals who work for USF that provide other kinds of oversight may also need to look at your records.
  - the Florida Department of Health, people from the Food and Drug Administration (FDA), and people from the Department of Health and Human Services (DHHS).

We may publish what we learn from this study. If we do, we will not let anyone know your name. We will not publish anything else that would let people know who you are.

### **Voluntary Participation / Withdrawal**

You should only take part in this study if you want to volunteer. You should not feel that there is any pressure to take part in the study, to please the investigator or the research staff. You are free to participate in this research or withdraw at any time. There will be no penalty or loss of benefits you are entitled to receive if you stop taking part in this study. Your decision to participate or not to participate will not affect your student status (course grade) or job status.

### **Questions, concerns, or complaints**

If you have any questions, concerns or complaints about this study, call Susan Hurley, LMHC at 863-667-7046.

If you have questions about your rights, general questions, complaints, or issues as a person taking part in this study, call the Division of Research Integrity and Compliance of the University of South Florida at (813) 974-9343.

If you experience an adverse event or unanticipated problem call Susan Hurley, LMHC at 863-667-7046. If you have questions about your rights as a person taking part in this research study you may contact the Florida Department of Health Institutional Review Board (DOH IRB) at (866) 433-2775 (toll free in Florida) or 850-245-4585.

### **Consent to Take Part in this Research Study**

It is up to you to decide whether you want to take part in this study. If you want to take part, please sign the form, if the following statements are true.

**I freely give my consent to take part in this study.** I understand that by signing this form I am agreeing to take part in research. I have received a copy of this form to take with me.

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Signature of Person Taking Part in Study

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Date

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Printed Name of Person Taking Part in Study

### **Statement of Person Obtaining Informed Consent**

I have carefully explained to the person taking part in the study what he or she can expect.

I hereby certify that when this person signs this form, to the best of my knowledge, he or she understands:

- What the study is about.
- What procedures/interventions/investigational drugs or devices will be used.
- What the potential benefits might be.
- What the known risks might be.

I also certify that he or she does not have any problems that could make it hard to understand what it means to take part in this research. This person speaks the language that was used to explain this research.

This person reads well enough to understand this form or, if not, this person is able to hear and understand when the form is read to him or her.

This person does not have a medical/psychological problem that would compromise comprehension and therefore makes it hard to understand what is being explained and can, therefore, give informed consent.

This person is not taking drugs that may cloud their judgment or make it hard to understand what is being explained and can, therefore, give informed consent.

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Signature of Person Obtaining Informed Consent

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Date

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Printed Name



## Appendix F

## Words and Phrases Most Often Associated With Maladaptive Schema

Unreliable	Take care of self
Unstable	Solve daily problems
Unprotected	Exercise good judgment
Unpredictable	Tackle new tasks
Abandoned	Make good decisions
	Helpless
	Fear
Hurt	
Abused	Over involvement in other lives
Humiliated	No life of my own
Cheated	Lack of separate identity
Lied	Fear of decision making
Manipulated	Need to give in to others wishes
Taken advantage of	Allow partner to make all important decisions
	Let others make decisions for me
Absence of attention	Do not stand up for self
Lack of affection	
Lack of warmth	
Lack of companionship	Inadequate
Lack of understanding	Failure
Not listened to	Stupid
Unprotected	Inept
Lack of guidance	Untalented
	Ignorant
Defective	Lower in Status
Bad	Less successful than others
Unwanted	
Inferior	Entitlement
Unlovable	A feeling of superiority
Criticized	Forcing ones point of view on others
Rejected	Controlling behavior of others
Blamed	Lack of empathy for others
Self-conscious	
Insecure	Lack of self control
Shame	Avoid pain
	Avoid conflict
Isolated	Avoid confrontation
Different from other people	Avoid responsibility
Not part of a group or community	
	Suppression of my desires and needs



Suppression of anger  
Suppression of other emotions  
My feelings and emotion do not count  
Feeling trapped  
Avoiding pain by constantly meeting other's  
need

Need to gain approval  
Need to gain recognition  
My self esteem is dependent on how others  
see me

Pessimistic  
Fear of making mistakes  
Worried  
Over vigilance  
Complainer  
Indecisive  
Lack of spontaneity  
Insecurity to show joy, affection  
Insecurity to show sexual excitement  
Insecurity to show vulnerability  
Insecurity to express feelings  
Insecurity to express needs

Perfectionism  
Inordinate attention to detail  
Hypercritical toward self  
Rigid rules  
High moral percepts  
High ethical percepts  
High religious percepts  
Preoccupation with time

Tendency to be intolerant  
Tendency toward anger  
Tendency toward impatience  
Lack of forgiveness for mistakes (self/others)

Appendix G  
Coding  
Cathy  
Compulsive Overeater/Obesity

Category	Definition	Participant Statement
Abandonment/Instability (AB)	The perceived instability or unreliability of those available for support and connection. Involves the sense that significant others will not be able to continue providing emotional support, connection, strength, or practical protection because they are emotionally unstable and unpredictable, unreliable, or erratically present; because they will die imminently; or because they will abandon the patient in favor of someone better.	<p>I think he draws himself away from everything and that is when he falls out of our lives, my brothers and my lives.</p> <p>I went through a divorce with my first husband. He was just running around all the time.</p> <p>I want the mom and the dad to wake up with the babies because that is all I ever wanted as a kid.</p>
Defectiveness/Shame (DS)	The feeling that one is defective, bad, unwanted, inferior, or invalid in important respects; or that one would be unlovable to significant others if exposed. May involved hypersensitivity to criticism, rejection, and blame; self-consciousness, comparisons, and insecurity around others; or a sense of shame regarding one's perceived flaws. These flaws may be private (e.g. selfishness, angry impulses, unacceptable sexual desires) or	<p>It is almost to the point where he had demons. I felt like as a child and even grown up today that he has demons. Or a devil has just taken over his body because he is not a good person when he is on drugs and drinking.</p> <p>Defective, I see the word right there. There are some other ones but defective is definitely the word.</p>

	<p>public (undesirable physical appearance, social awkwardness).</p>	<p>And on the bad part, just low self esteem and it is just putting yourself down a lot</p> <p>I am not good enough.</p> <p>Sometimes I feel like I am driving down the road, with no Bluetooth in my ear or anything just talking and hoping no one is looking at me like I am crazy.</p> <p>...and through just talking through why I would feel bad about myself.</p> <p>...and my dad was so verbally abusive and he would put her down. So I think seeing that I then internally was putting that in my own mind.</p> <p>I felt like I am not a good mom because my kids are all apart and I wasn't a great wife.</p> <p>I could have done this better.</p> <p>What is wrong with me.</p> <p>I cry a lot, and then put myself down inside.</p> <p>I was sitting there crying and I am just shoveling piles in my mouth and all of a sudden I realized oh my gosh almost the whole bag was gone and I</p>
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		<p>opened the bag. And I said, what is wrong with you? What is seriously wrong with you?</p> <p>So I know that there is something inside saying you're self destructive.</p> <p>I love you honey and you are not overweight. If I could be your size. And I am thinking mom that is beautiful but that is not helping me at all because I don't see that in myself.</p> <p>I would say an outside looking in they would say Cathy is very successful. Cathy says this is luck. And why are they picking me for all these.</p>
Dependence/Incompetence (DI)	Belief that one is unable to handle one's everyday responsibilities in a competent manner, without considerable help from others (e.g., take care of oneself, solve daily problems, exercise good judgment, tackle new tasks, make good decisions). Often presents as helplessness.	<p>And at that point I thought he loves me no matter what and so I can continue to do this because I don't have anybody telling me I wish this or that like my mom and dad.</p> <p>This is the second time I have been married and I am failing. What is wrong with me? And so finally my husband said you need to do something and we finally came to the decision to move forward and we got it done.</p> <p>It is always good to have someone to do it with.</p>

		<p>Right now my friend is joining me in the gym and we are putting together our plans of what we are going to eat and really paying attention to that. So I think her and I together can make it work because she lost a lot of weight too when we did it together.</p> <p>I would surround myself with people and say look if I do this you got to say something to me. My best friend would say I am going to slap you if you don't knock it off. We had this understanding. She never had to hit me. I got it.</p>
<p>Emotional Deprivation (ED)</p>	<p>Expectation that one's desire for a normal degree of emotional support will not be adequately met by others. The three major forms of deprivation are:</p> <p>A. deprivation of Nurture: Absence of attention, affection, warmth, or companionship.</p> <p>B. Deprivation of Empathy: Absence of understanding, listening, self-disclosure, or mutual sharing or feelings from others.</p> <p>C. Deprivation of Protection: Absence of strength, direction, or guidance from others.</p>	<p>[Mom] loves her children, puts them first over anybody. It is so much to a point where she forgets her grandchildren.</p> <p>...I think she does that only because she has guilt for how we were raised in the family and so she is trying to make it up to us not realizing that what we really want is the love for our children that would make me happy.</p> <p>He says he doesn't care about people's feelings. He is very factual and does not want to hear that fluff stuff. He likes to pick on me. He likes to push my buttons and get me all riled up.["</p>
<p>Enmeshment (EM)</p>	<p>Excessive emotional involvement and</p>	<p>So kind of I am living through her and doing those</p>

	<p>closeness with one or more significant others (often parents), at the expense of full individuation or normal social development. Often involves the belief that at least one of the enmeshed individuals cannot survive or be happy without the constant support of the other. May also include feelings of being smothered by, or fused with, others or insufficient individual identity. Often experienced as a feeling of emptiness and floundering, having no direction, or in extreme cases questioning one's existence.</p>	<p>things with her you know probably doing a little bit more than I should.</p>
Entitlement (ET)	<p>The belief that one is superior to other people; entitled to special rights and privileges; or not bound by the rules of reciprocity that guide normal social interactions. Often involves insistence that one should be able to do or have whatever one wants, regardless of what is realistic, what others consider reasonable, or the cost to others; or an exaggerated focus on superiority (being among the most successful, famous, wealthy) in order to achieve power or control (not primarily for attention or approval). Sometimes includes excessive competitiveness toward, or domination of others: asserting one's power, forcing one's point of view, or controlling the behavior of others in line with one's own desires – without</p>	

	empathy or concern for others' needs or feelings	
Insufficient Self Control (IS)	Pervasive difficulty or refusal to exercise sufficient self-control and frustration tolerance to achieve one's personal goals, or to restrain the excessive expression or one's emotions and impulses. In its milder form, patient presents with an exaggerated emphasis on discomfort-avoidance: avoiding pain, conflict, confrontation, responsibility, or overexertion—at the expense of personal fulfillment, commitment, or integrity.	<p>It is what makes me feel good.</p> <p>I like comfort food.</p> <p>It works for a minute then you are uncomfortable as you're going oh I feel horrible.</p> <p>I think I don't care I was so desperate to do something without realizing that the real issue was within me.</p> <p>I cried every day, I ate, I ate late, super late because I'd go to bed late. Sometimes two or three in the morning so I would be eating, and that is not a good time to eat certainly, but that was the comfort.</p> <p>It is a glass of milk and some cookies or pie sitting there watching television.</p>
Mistrust/Abuse (MA)	The expectation that others will hurt, abuse, humiliate, cheat, lie, manipulate, or take advantage. Usually involves the perception that the harm is intentional or the result of unjustified and extreme negligence. May include the sense that one always ends up being cheated relative to others or "getting the short	<p>He was manipulative in getting things his way. Twisting it toward where it worked out to his benefit.</p> <p>He loves them so much and there is never a doubt when my daughter sits on his lap. And that wasn't the case for me. I would question what is</p>

	end of the stick.”	happening here.
Subjugation (SB)	<p>Excessive surrendering of control to others because one feels coerced – usually to avoid anger, retaliation or abandonment. The two major forms of subjugation are:</p> <p>A. Subjugation of Needs: Suppression of one’s preferences, decisions, and desires.</p> <p>B. Subjugation of Emotions: Suppression of emotional expression, especially anger.</p> <p>Usually involves the perception that one’s own desires, opinions, and feelings are not valid or important to others. Frequently presents as excessive compliance, combined with hypersensitivity to feeling trapped. Generally leads to a build up of anger, manifested in maladaptive symptoms (e.g., passive-aggressive behavior, uncontrolled outbursts of temper, psychosomatic symptoms, withdrawal of affection, “acting out” substance abuse.</p>	
Social Isolation/Alienation (SI)	The feeling that one is isolated from the rest of the world, different from other people, and/or not part of any group or community.	
Self Sacrifice (SS)	Excessive focus on voluntarily meeting the needs of others in daily situations, at the expense of one’s own gratification. The most common reasons are: to prevent causing pain to others; to avoid guilt from feeling selfish; or to maintain the connection with others perceived	I have seen people all my life who say that is a mean person. I have never wanted to be that person that someone speaks at the dinner table about. Have I not liked people? Absolutely but they would never know it dealing with them because I just have always believed that.



	<p>as needy. Often results from an acute sensitivity to the pain of others. Sometimes leads to a sense that one's own needs are not being adequately met and to resentment of those who are taken care of. (overlaps with sense of co-dependency)</p>	<p>Personality wise I can walk up to a group of people and just chit chat about whatever and pick up very quickly what interests them and then have a conversation around that and I may not know anything about it.</p>
<p>Emotional inhibition (EI)</p>	<p>The excessive inhibition of spontaneous action, feeling or communication – usually to avoid disapproval by others, feelings of shame, or losing control of one's impulses. The most common areas of inhibition involve: (a) inhibition of anger &amp; aggression, (b) inhibition of positive impulses (e.g. joy, affection, sexual excitement, play); (c) difficulty expressing vulnerability or communicating freely about one's feelings, needs, etc., or (d) excessive emphasis on rationality while disregarding emotions.</p>	<p>This is what makes me feel good. Like the comfort food.</p> <p>All I know is that I ate and it made me feel good.</p> <p>I would be eating, and that is not a good time to eat certainly but that was the comfort. I would comfort myself going through that very serious depression. Q: And then go eat anyway? A: Yes I eat anyway.</p> <p>I was sitting there crying and I am just shoveling piles in my hand, and all of the sudden I looked down and realized oh my gosh almost the whole bag was gone, and I opened the bag.</p> <p>I don't know if it is taking away the pain of the outside, and the hurt of the heart and say all right if my stomach is hurting like crazy then it takes everything else away.</p>

		<p>Q: Do any specific events cause you to eat more than others? A: Probably just any type of low moment.</p> <p>Q: What do you think you gain by eating? A: Just feeling good at that moment.</p>
Failure to achieve (FA)	The belief that one has failed, will inevitably fail, or is fundamentally inadequate relative to one's peers, in areas of achievement (school, career, sports, etc). Often involves beliefs that one is stupid, inept, untalented, ignorant, lower in status, less successful than others, etc.	<p>I felt like I am not a good mom because my kids are all apart and I wasn't a great wife because you know this and that. You pick apart all the things you do in the whole marriage and you think I could have done this better.</p> <p>I would say an outsider looking in would say Cathy is very successful. Cathy says it is luck.</p> <p>When I got divorced my thoughts were I am just not good enough. What it says about me is that I failed.</p> <p>This is the second time I am married and I am failing at it. I put it all on myself. Maybe this is your fault.</p> <p>Everything points to you.</p>
Unrelenting standards/Hyper-criticalness (US)	The underlying belief that one must strive to meet very high internalized standards of behavior and performance, usually to avoid	I want the mom and the dad to wake up with the babies because that is all I ever wanted as a kid. I want the mother and the father and the children all

	<p>criticism. Typically results in feelings or pressure or difficulty slowing down; and in hypercriticalness toward oneself and others. Most involve significant impairment in: pleasure, relaxation, health, self-esteem, sense of accomplishment, or satisfying relationships.</p> <p>Unrelenting standards typically present as (a) perfectionism, inordinate attention to detail, or an underestimate of how good one’s own performance is relative to the norm; (b) rigid rules and “shoulds” in many areas of life, including unrealistically high moral, ethical, cultural, or religious precepts; or (c) preoccupation with time and efficiency, so that more can be accomplished.</p>	<p>together under one roof.</p> <p>He is a great father. I could not ask for any person better. Sometime it makes me angry at him because I wanted that, I wanted that life.</p>
<p>Vulnerability to harm (VH)</p>	<p>Exaggerated fear that imminent catastrophe will strike at any time and that one will be unable to prevent it. Fears focus on one or more of the following: (a) medical catastrophe: e.g., heart attacks, AIDS; (b) emotional catastrophes e.g., going crazy (c) external catastrophes; e.g. elevators collapsing, victimized by criminals, airplanes crashes, earthquakes.</p>	
<p>Approval-seeking/Recognition-seeking (AS)</p>	<p>Excessive emphasis on gaining approval, recognition, or attention from other people, or fitting in, at the expense of developing a secure</p>	<p>If I die I want to be fun, happy, I want everyone to have a party and say man that girl was the coolest</p>

	<p>and true sense of self. One's sense of esteem is dependent primarily on the reactions of others rather than one's own natural inclinations. Sometimes includes an overemphasis on status, appearance, social acceptance, money, or achievement – as mean of gaining approval, admiration, or attention (not primarily for power or control). Frequently results in major life decisions that are inauthentic or unsatisfying; or in hypersensitivity to rejection.</p>	<p>person in the world, or the neatest person, most interesting or something.</p> <p>And I like being around people so being the group settings and bragging and saying yeah, I did it too and look what we can do together.</p> <p>I want people to see me as successful.</p> <p>So it is like I really, really care about what people think of me. Almost too much.</p> <p>Even today I care about what people think about me in the sense of my reputation.</p> <p>I don't want them to see mom is a basket case or whatever it may be.</p>
Negativity/Pessimism (NP)	<p>A pervasive, lifelong focus on the negative aspects of life (pain, death, loss, disappointment, conflict, guilt, resentment, unsolved problems, potential mistakes, betrayal, things that could go wrong, etc) while minimizing or neglecting the positive or optimistic aspects. Usually includes an exaggerated expectation – in a wide range of work, financial, or interpersonal situations – that things will ultimately fall apart. Usually</p>	
Punitiveness (PU)	<p>The belief that people should be harshly</p>	

	<p>punished for mistakes. Involves the tendency to be angry, intolerant, punitive, and impatient with those people (including oneself) who do not meet one's expectations or standards. Usually includes difficulty forgiving mistakes in oneself or others, because of a reluctance to consider extenuating circumstances, allow for human imperfection or empathize with feelings.</p>	
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Appendix H  
Coding  
Joan  
Compulsive Overeater/Obesity

Category	Definition	Participant Statement
Abandonment/Instability (AB)	The perceived instability or unreliability of those available for support and connection. Involves the sense that significant others will not be able to continue providing emotional support, connection, strength, or practical protection because they are emotionally unstable and unpredictable, unreliable, or erratically present; because they will die imminently; or because they will abandon the patient in favor of someone better.	<p>When I was younger she was always dating a lot. And she made it her personal mission to find me a dad. What she didn't realize was that she was pushing me away by not spending time with me. I felt rejected because she was working so hard at trying to keep them happy that I wasn't getting any attention.</p> <p>I didn't realize how much it bothered me that he wasn't around until I started counseling.</p>
Defectiveness/Shame (DS)	The feeling that one is defective, bad, unwanted, inferior, or invalid in important respects; or that one would be unlovable to significant others if exposed. May involved hypersensitivity to criticism, rejection, and blame; self-consciousness, comparisons, and insecurity around others; or a sense of shame regarding one's perceived flaws. These flaws may be private (e.g. selfishness, angry impulses, unacceptable sexual desires) or public (undesirable physical appearance, social	<p>It wasn't like I couldn't be a kid, but I knew I was different than other kids.</p> <p>I remember having low self esteem when I was a kid because of some of the same reasons. It probably started when I was in kindergarten or first grade that I started having doubts about my self esteem and about the way I looked because all the girls in my school were straight...not curvy and I have always been curvy. ...And so I always felt different from the other girls. And I remember even</p>

	<p>awkwardness).</p>	<p>girls making fun of me when I was younger and calling me fat and saying things like that.</p> <p>My back was curved and my stomach poked out a little bit ... And I remember always not having confidence in myself because of that. I have issues with my weight and feeling bad about myself.</p> <p>I didn't realize how much of a self esteem issue I have because of my ethnicity.</p> <p>My whole life I thought if I am skinny I will be so happy. And then it was like, well if I just didn't have braces, and I was skinny I will be so happy. If I could get rid of all those things at the same time then things would be great.</p> <p>I remember being more paranoid about my self esteem because I thought, well I finally look pretty on the outside. If guys don't pay attention to me now its got to be something I am doing wrong with me instead. Because if you are overweight you can say oh if a guy doesn't like me it is because I am fat and that is fine. I don't care. And it is not as personal. But if you feel like you look really pretty on the outside and guys still don't want to give you that attention it is like wait a second that doesn't</p>
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		<p>make sense.</p> <p>My step-grandmother embarrassed me in front of the whole family basically and so ever since then I haven't really gone back. It was kind of embarrassing. I use to wet the bed till I was 10.... I said can we take home a watermelon. She said...I don't know why you would eat it you are just going to pee all over the bed, in front of everybody.</p> <p>Her daughter was there and I go upset and she came to talk to me later and blamed me for it and she said I don't know why you're upset about it. It is you fault.</p> <p>When I get half way through the semester I get so depressed and hopeless and I want to give up every time ...and I feel that I am not good at it.</p> <p>...but I always feel like everyone is doing better than me.</p> <p>That you are never good enough. That you will never be powerful. You don't mean as much as the people who are like that.</p> <p>So I think it does impact your self esteem a lot if you can't meet those expectations then there must</p>
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		be something wrong with you. And you are not as pretty as everybody else.
Dependence/Incompetence (DI)	Belief that one is unable to handle one's everyday responsibilities in a competent manner, without considerable help from others (e.g., take care of oneself, solve daily problems, exercise good judgment, tackle new tasks, make good decisions). Often presents as helplessness.	
Emotional Deprivation (ED)	Expectation that one's desire for a normal degree of emotional support will not be adequately met by others. The three major forms of deprivation are: A. deprivation of Nurture: Absence of attention, affection, warmth, or companionship. B. Deprivation of Empathy: Absence of understanding, listening, self-disclosure, or mutual sharing or feelings from others. C. Deprivation of Protection: Absence of strength, direction, or guidance from others.	I did have a lot of baby sitters when I was little. Any my mom she worked full time. She would come home and on Sunday she would sleep all day. And I remember watching TV because that would keep me busy. I remember waking my mom up a lot. Hey mom can I eat the Doritos? And she would say no you can have a bowl of cereal. And I would be like please, please can I eat the Doritos. And I remember eating a lot. I would have a little carpet picnic and eating lots of food. And I don't really know how much it was. it may have been like three or four bowls of cereal over five hours. So I think it really impacted me a lot not having my dad around.
Enmeshment (EM)	Excessive emotional involvement and closeness with one or more significant others (often parents), at the expense of full individuation or normal social development.	My mom has always needed my help.  She constantly asked for my help. I didn't really have a choice.

	<p>Often involves the belief that at least one of the enmeshed individuals cannot survive or be happy without the constant support of the other. May also include feelings of being smothered by, or fused with, others or insufficient individual identity. Often experienced as a feeling of emptiness and floundering, having no direction, or in extreme cases questioning one's existence.</p>	<p>My mom has started the Adkins diet....And so I remember eating that and drinking diet coke for lunch because that is what my mom drank and that is what we had at home.</p> <p>When I was younger it seemed like she always mentioned it....You can try to cheer the person up and say oh mom you are not fat or you are pretty or I love you. Or you start to take it out on yourself and say well if my mom thinks that then maybe that is what I should do. You start to think it is normal and you start to do it to yourself. And I realize I do that to myself.</p> <p>Probably if she has told me once she has told me a million times that I am the most important thing in the world to her. And that she doesn't want anything to ever happen to me and that nobody is going to ever hurt me no matter what.</p> <p>Q: You said we feel better, we find happiness in food. A: Me and my mom.</p> <p>Whenever I asked her a question she would always tell me the truth no matter how difficult it was or her. Or she would tell me I will tell you in a few</p>
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		<p>years. But I remember that being so different from my other friend's parents that I really could talk to my mom about anything.</p> <p>I remember us talking about it for about three hours straight crying. And it was so exhausting trying to have a conversation and trying to understand her point of view because in her mind she had tried to protect me during this whole, during my whole life and it was like I was throwing that in her face if I wanted to meet him anyway.</p> <p>My grandmother is someone we have both avoided. We don't want to talk to her anymore to tell the truth.</p> <p>I think we have gotten to the point where we kind of like our privacy and we are happy where we are. (473-475)</p> <p>Why don't other people get excited about food the way we do. We don't get it.</p>
Entitlement (ET)	The belief that one is superior to other people; entitled to special rights and privileges; or not bound by the rules of reciprocity that guide normal social interactions. Often involves insistence that one should be able to do or have whatever one wants, regardless of what is	

	<p>realistic, what others consider reasonable, or the cost to others; or an exaggerated focus on superiority (being among the most successful, famous, wealthy) in order to achieve power or control (not primarily for attention or approval). Sometimes includes excessive competitiveness toward, or domination of others: asserting one's power, forcing one's point of view, or controlling the behavior of others in line with one's own desires – without empathy or concern for others' needs or feelings</p>	
<p>Insufficient Self Control (IS)</p>	<p>Pervasive difficulty or refusal to exercise sufficient self-control and frustration tolerance to achieve one's personal goals, or to restrain the excessive expression or one's emotions and impulses. In its milder form, patient presents with an exaggerated emphasis on discomfort-avoidance: avoiding pain, conflict, confrontation, responsibility, or overexertion—at the expense of personal fulfillment, commitment, or integrity.</p>	
<p>Mistrust/Abuse (MA)</p>	<p>The expectation that others will hurt, abuse, humiliate, cheat, lie, manipulate, or take advantage. Usually involves the perception that the harm is intentional or the result of unjustified and extreme negligence. May include the sense that one always ends up being</p>	<p>I was almost convinced ...to actually try to meet him. Just to meet him once just to see what he was like. But I was kind of scared because what if he is not what I expect. What if he is not a nice person? And then all of those fears that I have of being associated with someone that is not a good person</p>

	<p>cheated relative to others or “getting the short end of the stick.”</p>	<p>would come true. And then I would start to internalize that and say well if he is like that and he is half of me what does that make me</p> <p>My mom always tried to be really careful with me and would say you need to always be aware of your surroundings and you need to be careful. I remember her also saying something about it someone is looking at you, look them in the eye because that means they know you are not someone who is shy.</p> <p>I was unsure about that. And I was also unsure what if he doesn’t want me to be around?</p> <p>I have a lot of trust issues with guys because my dad wasn’t around. And because the only guys I saw that were around my mom I thought the only reason they were around her was because they wanted something. I thought they just wanted her for sex.</p> <p>I don’t really understand the relationship and because I had never had a really positive male relationship it didn’t make sense to me. And I still struggle with it. Trying to understand how there are good guys out there but so many of them are bad. It is just complicated sometimes.</p>
<p>Subjugation (SB)</p>	<p>Excessive surrendering of control to others</p>	<p>But at the same time she also told me don’t tell</p>

	<p>because one feels coerced – usually to avoid anger, retaliation or abandonment. The two major forms of subjugation are:</p> <p>A. Subjugation of Needs: Suppression of one’s preferences, decisions, and desires.</p> <p>B. Subjugation of Emotions: Suppression of emotional expression, especially anger.</p> <p>Usually involves the perception that one’s own desires, opinions, and feelings are not valid or important to others. Frequently presents as excessive compliance, combined with hypersensitivity to feeling trapped. Generally leads to a build up of anger, manifested in maladaptive symptoms (e.g., passive-aggressive behavior, uncontrolled outbursts of temper, psychosomatic symptoms, withdrawal of affection, “acting out” substance abuse.</p>	<p>people where your dad is from. And I think in her mind she was trying to protect me because the town she grew up in was very prejudice. And I think in her mind she didn’t want me to face the same prejudice that she may have faced or others may have faced. And so she was trying to protect me but I didn’t really understand that when I was younger and it was so confusing for me.</p> <p>Well how is it that I am not suppose to be ashamed of who I am but I am not suppose to tell anybody where my dad is from but he is not bad. I never got it. It didn’t make sense to me. Because she would always say your dad is not a bad person, but I don’t want him to find us and take you away.</p>
Social Isolation/Alienation (SI)	The feeling that one is isolated from the rest of the world, different from other people, and/or not part of any group or community.	Well I think that I felt different from everybody. All the other girls were skinny and they could shop in the skinny girls sections. I remember having to shop in the women’s section when I was younger because they didn’t have shorts that would fit my bottom.
Self Sacrifice (SS)	Excessive focus on voluntarily meeting the needs of others in daily situations, at the expense of one’s own gratification. The most common reasons are: to prevent causing pain to	

	others; to avoid guilt from feeling selfish; or to maintain the connection with others perceived as needy. Often results from an acute sensitivity to the pain of others. Sometimes leads to a sense that one's own needs are not being adequately met and to resentment of those who are taken care of. (overlaps with sense of co-dependency)	
Emotional inhibition (EI)	The excessive inhibition of spontaneous action, feeling or communication – usually to avoid disapproval by others, feelings of shame, or losing control of one's impulses. The most common areas of inhibition involve: (a) inhibition of anger & aggression, (b) inhibition of positive impulses (e.g. joy, affection, sexual excitement, play); (c) difficulty expressing vulnerability or communicating freely about one's feelings, needs, etc., or (d) excessive emphasis on rationality while disregarding emotions.	<p>When I was little I think it was more boredom than anything. No I think a lot of emotions. I mean when I get upset. We relate food to happiness.</p> <p>Food brightens my day. If I am having a bad day and I find out there is free food on campus I am like, free food, yes! My day just got better. But that is something that is really important to me and makes me feel better. If I am really upset and eat certain foods I usually feel better.</p> <p>I do know that if I have a bad day at work or I am really stressed out or I am in a really bad mood I will eat. Or a lot of times when I am home and see something good on TV or I am bored I eat.</p> <p>I think that when you eat you get those feelings of happiness and you feel so much better.</p>
Failure to achieve (FA)	The belief that one has failed, will inevitably	I would think that I was doing really good and it

	<p>fail, or is fundamentally inadequate relative to one's peers, in areas of achievement (school, career, sports, etc). Often involves beliefs that one is stupid, inept, untalented, ignorant, lower in status, less successful than others, etc.</p>	<p>would say I went over my limit all the time. And I was like, but I haven't really eaten that much. Like it just didn't seem to be very realistic and a lot of the things I would eat weren't on the data base that I was trying to check from. And the exercises I did wouldn't be in the data base either so it was really frustrating and I felt like I wasn't making very much progress so I stopped using it.</p>
<p>Unrelenting standards/Hyper-criticalness (US)</p>	<p>The underlying belief that one must strive to meet very high internalized standards of behavior and performance, usually to avoid criticism. Typically results in feelings or pressure or difficulty slowing down; and in hypercriticalness toward oneself and others. Most involve significant impairment in: pleasure, relaxation, health, self-esteem, sense of accomplishment, or satisfying relationships.</p> <p>Unrelenting standards typically present as (a) perfectionism, inordinate attention to detail, or an underestimate of how good one's own performance is relative to the norm; (b) rigid rules and "shoulds" in many areas of life, including unrealistically high moral, ethical, cultural, or religious precepts; or (c) preoccupation with time and efficiency, so that more can be accomplished.</p>	<p>When I got older I started exercising. I would do pushups and sit-ups for 30 minutes a night. I would test myself all the time to make sure my abs were tight.</p> <p>I remember being pre-occupied with that.</p>



Vulnerability to harm (VH)	Exaggerated fear that imminent catastrophe will strike at any time and that one will be unable to prevent it. Fears focus on one or more of the following: (a) medical catastrophe: e.g., heart attacks, AIDS; (b) emotional catastrophes e.g., going crazy (c) external catastrophes; e.g. elevators collapsing, victimized by criminals, airplanes crashes, earthquakes.	
Approval-seeking/Recognition-seeking (AS)	Excessive emphasis on gaining approval, recognition, or attention from other people, or fitting in, at the expense of developing a secure and true sense of self. One's sense of esteem is dependent primarily on the reactions of others rather than one's own natural inclinations. Sometimes includes an overemphasis on status, appearance, social acceptance, money, or achievement – as mean of gaining approval, admiration, or attention (not primarily for power or control). Frequently results in major life decisions that are inauthentic or unsatisfying; or in hypersensitivity to rejection.	<p>Partly I think I loved it because you are in the club now because everyone is working out and talking about their gym and I could say I go to the gym. And it was just fun to be one of those people.</p> <p>...you are suppose to find a happy median in accepting who you are no matter what size you are and having confidence. And it is really hard to have confidence when you don't like the way you look or you are worried about how other people perceive you and those types of things.</p> <p>I have always been interested in other cultures...I really thought I was trying to find one to identify with.</p> <p>I wish I could marry an Italian or American Indian or some other culture that I look like that I can envelop myself in and be absorbed by so I don't feel</p>

		<p>so outed or that there is something wrong with me because I am a part of a culture that nobody likes.</p> <p>I was always the bigger person in the group. And that was hard because you don't want to be different. You want to be accepted and you want to be able to buy the clothes that everyone else is wearing and that was hard</p>
Negativity/Pessimism (NP)	<p>A pervasive, lifelong focus on the negative aspects of life (pain, death, loss, disappointment, conflict, guilt, resentment, unsolved problems, potential mistakes, betrayal, things that could go wrong, etc) while minimizing or neglecting the positive or optimistic aspects. Usually includes an exaggerated expectation – in a wide range of work, financial, or interpersonal situations – that things will ultimately fall apart. Usually</p>	.
Punitiveness (PU)	<p>The belief that people should be harshly punished for mistakes. Involves the tendency to be angry, intolerant, punitive, and impatient with those people (including oneself) who do not meet one's expectations or standards. Usually includes difficulty forgiving mistakes in oneself or others, because of a reluctance to consider extenuating circumstances, allow for human imperfection or empathize with feelings.</p>	

Appendix I  
Coding  
Laura  
Compulsive Overeater/Obesity

Category	Definition	Participant Statement
Abandonment/Instability (AB)	The perceived instability or unreliability of those available for support and connection. Involves the sense that significant others will not be able to continue providing emotional support, connection, strength, or practical protection because they are emotionally unstable and unpredictable, unreliable, or erratically present; because they will die imminently; or because they will abandon the patient in favor of someone better.	
Defectiveness/Shame (DS)	The feeling that one is defective, bad, unwanted, inferior, or invalid in important respects; or that one would be unlovable to significant others if exposed. May involved hypersensitivity to criticism, rejection, and blame; self-consciousness, comparisons, and insecurity around others; or a sense of shame regarding one's perceived flaws. These flaws may	<p>I didn't want to cook. I was in school. We were always on the go. ...it was easier to go buy food than to cook.</p> <p>I tire easily. I am tired most of the time. I take so much stuff just to stay up.</p> <p>I am so disappointed with myself.</p>

	<p>be private (e.g. selfishness, angry impulses, unacceptable sexual desires) or public (undesirable physical appearance, social awkwardness).</p>	<p>But you know I feel like if I am this size when I finish school I will be discriminated against trying to get a job.  I do regret it because I can't spend time with my kids like I want  I feel disappointed in myself that I am at this age I have not achieved what it was I set out to achieve by a certain age.</p> <p>And so I am really disappointed with myself.</p> <p>I felt unwanted, inferior, criticized, rejected, blamed and insecure.</p> <p>I think I just mentally wasn't a strong person.</p> <p>I don't know if I have any true strengths.</p> <p>I haven't believed in myself in anything and I never have completed anything but high school and that was because I had to.</p>
<p>Dependence/Incompetence (DI)</p>	<p>Belief that one is unable to handle one's everyday responsibilities in a competent manner, without considerable help from others (e.g., take care of oneself, solve daily problems, exercise good judgment, tackle new tasks, make good decisions).</p>	<p>My world revolved around him and there was no more going out with the girls because they were single and so it was no more going to the gym.</p> <p>He came into the picture and had an extra</p>

	Often presents as helplessness.	<p>income and so I wasn't struggling as much anymore (husband).</p> <p>Financially we just couldn't make it so we moved back down here where we had help from my parents.</p>
Emotional Deprivation (ED)	<p>Expectation that one's desire for a normal degree of emotional support will not be adequately met by others. The three major forms of deprivation are:</p> <p>A. deprivation of Nurturance: Absence of attention, affection, warmth, or companionship.</p> <p>B. Deprivation of Empathy: Absence of understanding, listening, self-disclosure, or mutual sharing or feelings from others.</p> <p>C. Deprivation of Protection: Absence of strength, direction, or guidance from others.</p>	<p>I felt a lack of affection, and lack of understanding, that I wasn't listened to.</p> <p>She [Mom] was sleeping with two men. She was married. But my birth certificate says that my sister's father is my father. Because she was still married I had his last name up until I was eight. And then she moved in with my current father. When they would go off for the weekends they would send the whole family over to stay with her former husband. And then when they moved into a bigger home in a different neighborhood they said I couldn't go anymore with the other kids to see their father.</p> <p>They made me say he is my dad all my life. My dad...growing up he was horrible. He was an alcoholic on the weekends...and when he drank he was very abusive both physically and mentally. If he was angry he wanted everyone in the house to be angry. I would try to hide in</p>

		<p>my room and he would literally come back there and tell me to come out of my room and sit out in the front and be around him while he was angry. When I first started gaining weight he said he would pay me a thousand dollars to lose it because I wasn't attractive anymore.</p> <p>I felt a lack of affection and lack of understanding that I wasn't listened to.</p>
Enmeshment (EM)	<p>Excessive emotional involvement and closeness with one or more significant others (often parents), at the expense of full individuation or normal social development. Often involves the belief that at least one of the enmeshed individuals cannot survive or be happy without the constant support of the other. May also include feelings of being smothered by, or fused with, others or insufficient individual identity. Often experienced as a feeling of emptiness and floundering, having no direction, or in extreme cases questioning one's existence.</p>	<p>If something happens to one of us it happens to both of us. We are not separate.</p> <p>My world revolved around him.</p>
Entitlement (ET)	<p>The belief that one is superior to other people; entitled to special rights and privileges; or not bound by the rules of</p>	

	<p>reciprocity that guide normal social interactions. Often involves insistence that one should be able to do or have whatever one wants, regardless of what is realistic, what others consider reasonable, or the cost to others; or an exaggerated focus on superiority (being among the most successful, famous, wealthy) in order to achieve power or control (not primarily for attention or approval). Sometimes includes excessive competitiveness toward, or domination of others: asserting one's power, forcing one's point of view, or controlling the behavior of others in line with one's own desires – without empathy or concern for others' needs or feelings</p>	
<p>Insufficient Self Control (IS)</p>	<p>Pervasive difficulty or refusal to exercise sufficient self-control and frustration tolerance to achieve one's personal goals, or to restrain the excessive expression or one's emotions and impulses. In its milder form, patient presents with an exaggerated emphasis on discomfort-avoidance: avoiding pain, conflict, confrontation, responsibility, or overexertion—at the expense of personal fulfillment, commitment, or integrity.</p>	<p>When you get bored you don't have anything to do and you just knick knack all day long. I mean I would open up the pack and eat it all.</p> <p>I find it hard to just fight off just eating something.</p>

<p>Mistrust/Abuse (MA)</p>	<p>The expectation that others will hurt, abuse, humiliate, cheat, lie, manipulate, or take advantage. Usually involves the perception that the harm is intentional or the result of unjustified and extreme negligence. May include the sense that one always ends up being cheated relative to others or “getting the short end of the stick.”</p>	<p>He was one of those people that would say things that only your enemy would say like, he would call me names. He called me ugly, slut, the “B” word, whatever. Anything that would come out of his mouth. He called me fat. If I gained a little weight he would say things like you are unattractive and this and that. He was horrible.</p> <p>It was like he would lose interest and when he did he would publicly embarrass me. We were out at a function and he poured a 64 oz orange soda on my head. He would make statements.</p> <p>...When he drank he became very abusive both physically and mentally.</p> <p>Q: When he does it, does he still become abusive? A: Yes, I get away from him then.</p> <p>He was pretty much just as abusive as my boyfriend.</p> <p>And he called me names. He would call me a slut and whore and tell me I was doing this and that and I am telling him I am not.</p> <p>They made me say he is my dad all my life.</p>
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		<p>At one point I felt like I gained weight so he wouldn't look at me anymore. So that I would not be appealing to him anymore.</p> <p>He would come to visit and I would stand in the window and cry because I wasn't allowed to go outside. And if I did go outside I would get beat or what have you.</p> <p>When he moved up there with me and that was the worst time of my life. That is when I had enough because it was constant non-stop with him.</p> <p>He would do things like not come home and then blame me for when he did get there. I was like how was it my fault.</p>
Subjugation (SB)	<p>Excessive surrendering of control to others because one feels coerced – usually to avoid anger, retaliation or abandonment. The two major forms of subjugation are:</p> <p>A. Subjugation of Needs: Suppression of one's preferences, decisions, and desires.</p> <p>B. Subjugation of Emotions: Suppression of emotional expression,</p>	

	<p>especially anger. Usually involves the perception that one's own desires, opinions, and feelings are not valid or important to others. Frequently presents as excessive compliance, combined with hypersensitivity to feeling trapped. Generally leads to a build up of anger, manifested in maladaptive symptoms (e.g., passive-aggressive behavior, uncontrolled outbursts of temper, psychosomatic symptoms, withdrawal of affection, "acting out" substance abuse.</p>	
Social Isolation/Alienation (SI)	<p>The feeling that one is isolated from the rest of the world, different from other people, and/or not part of any group or community.</p>	<p>I would tell my mom some things but then I realized in that relationship that you can't involve family in everything about your relationship because when you forgive him your parents still remember. So I learned from that not to involved them in that.</p> <p>So it was pretty much I have been a loner most of my whole life. They just tell you that you don't tell other people your business. What happens at home stays home and Black women have to be stronger than that. You don't go to anyone else to help you with your problems.</p>
Self Sacrifice (SS)	<p>Excessive focus on voluntarily meeting</p>	

	<p>the needs of others in daily situations, at the expense of one's own gratification. The most common reasons are: to prevent causing pain to others; to avoid guilt from feeling selfish; or to maintain the connection with others perceived as needy. Often results from an acute sensitivity to the pain of others. Sometimes leads to a sense that one's own needs are not being adequately met and to resentment of those who are taken care of. (overlaps with sense of co-dependency)</p>	
Emotional inhibition (EI)	<p>The excessive inhibition of spontaneous action, feeling or communication – usually to avoid disapproval by others, feelings of shame, or losing control of one's impulses. The most common areas of inhibition involve: (a) inhibition of anger &amp; aggression, (b) inhibition of positive impulses (e.g. joy, affection, sexual excitement, play); (c) difficulty expressing vulnerability or communicating freely about one's feelings, needs, etc., or (d) excessive emphasis on rationality while disregarding emotions.</p>	<p>So I try not to get into those feelings that will lead me to depression or things of that nature.</p> <p>I tried to act like it didn't make me feel. I pretended around other people that I wasn't affected but it just hurt my esteem too much.</p> <p>Q: Do you know what you are really looking for because it really isn't food. A: No it is not food, but right now my financial situation, with the economy being the way it is...I don't have the means to do what I am in the mood to do. I just had enough. I couldn't cry anymore. I couldn't even force myself to cry anymore. No words would come out. I had had enough. I had gotten to my breaking point and that was</p>

		<p>enough for me.</p> <p>So I try not to get into those feelings that will lead me to depression or things of that nature. I don't want to be depressed. I am not beneficial to anyone if I am unhappy.</p>
Failure to achieve (FA)	<p>The belief that one has failed, will inevitably fail, or is fundamentally inadequate relative to one's peers, in areas of achievement (school, career, sports, etc). Often involves beliefs that one is stupid, inept, untalented, ignorant, lower in status, less successful than others, etc.</p>	<p>I feel disappointed with myself that I am this age and I have not achieved what I set out to achieve.</p> <p>When I enrolled, can I really do this? I haven't believed in myself in anything, and I have never completed anything but high school and that was because I had to.</p>
Unrelenting standards/Hypercriticalness (US)	<p>The underlying belief that one must strive to meet very high internalized standards of behavior and performance, usually to avoid criticism. Typically results in feelings or pressure or difficulty slowing down; and in hypercriticalness toward oneself and others. Most involve significant impairment in: pleasure, relaxation, health, self-esteem, sense of accomplishment, or satisfying relationships.</p> <p>Unrelenting standards typically present as (a) perfectionism, inordinate attention to</p>	

	<p>detail, or an underestimate of how good one's own performance is relative to the norm; (b) rigid rules and "shoulds" in many areas of life, including unrealistically high moral, ethical, cultural, or religious precepts; or (c) preoccupation with time and efficiency, so that more can be accomplished.</p>	
Vulnerability to harm (VH)	<p>Exaggerated fear that imminent catastrophe will strike at any time and that one will be unable to prevent it. Fears focus on one or more of the following: (a) medical catastrophe: e.g., heart attacks, AIDS; (b) emotional catastrophes e.g., going crazy (c) external catastrophes; e.g. elevators collapsing, victimized by criminals, airplanes crashes, earthquakes.</p>	
Approval-seeking/Recognition-seeking (AS)	<p>Excessive emphasis on gaining approval, recognition, or attention from other people, or fitting in, at the expense of developing a secure and true sense of self. One's sense of esteem is dependent primarily on the reactions of others rather than one's own natural inclinations. Sometimes includes an overemphasis on status, appearance, social acceptance, money, or achievement – as mean of gaining approval, admiration, or attention</p>	<p>He was the first person to ever really open up and talk to me and want to know about me.</p> <p>I was pudgy in middle school and no one looked at me but then I went to high school and everyone saw me. But he paid the most attention to me. He was the first one who wanted to know who I was.</p> <p>I was always a pleaser.</p>

	(not primarily for power or control). Frequently results in major life decisions that are inauthentic or unsatisfying; or in hypersensitivity to rejection.	
Negativity/Pessimism (NP)	A pervasive, lifelong focus on the negative aspects of life (pain, death, loss, disappointment, conflict, guilt, resentment, unsolved problems, potential mistakes, betrayal, things that could go wrong, etc) while minimizing or neglecting the positive or optimistic aspects. Usually includes an exaggerated expectation – in a wide range of work, financial, or interpersonal situations – that things will ultimately fall apart. Usually	
Punitiveness (PU)	The belief that people should be harshly punished for mistakes. Involves the tendency to be angry, intolerant, punitive, and impatient with those people (including oneself) who do not meet one's expectations or standards. Usually includes difficulty forgiving mistakes in oneself or others, because of a reluctance to consider extenuating circumstances, allow for human imperfection or empathize with feelings.	

Appendix J  
Coding  
Margaret  
Compulsive Overeater/Obesity

Category	Definition	Participant Statement
Abandonment/Instability (AB)	The perceived instability or unreliability of those available for support and connection. Involves the sense that significant others will not be able to continue providing emotional support, connection, strength, or practical protection because they are emotionally unstable and unpredictable, unreliable, or erratically present; because they will die imminently; or because they will abandon the patient in favor of someone better.	<p>After my parents got divorced we lived in our little apartment. My mom had to work and I was a latch key kid and I remember it was a Christmas holiday. It was like the week before Christmas and we didn't have to go to school but my mom still had to work and so I am in the apartment. And I just remember feeling for the first time in my life feeling profoundly alone.</p> <p>My mom was 25 when she got divorced and she was still pretty young and cute and she wanted to go out. So I wouldn't say she left me alone every night but she used to leave me alone a lot. She would come home from work and check to see that I had a bath and everything and then she would get ready and she would say "remember your bedtime is 9:00 and you need to get to bed."</p>
Defectiveness/Shame (DS)	The feeling that one is defective, bad, unwanted, inferior, or invalid in important respects; or that one would be unlovable to significant others if exposed. May involved	My mother showed me how to dial for help on the phone so that the next time he beat her I could call for help. It just happened that the next time he beat her it was so severe that I just froze. I was just

	hypersensitivity to criticism, rejection, and blame; self-consciousness, comparisons, and insecurity around others; or a sense of shame regarding one's perceived flaws. These flaws may be private (e.g. selfishness, angry impulses, unacceptable sexual desires) or public (undesirable physical appearance, social awkwardness).	standing there with the phone in my hand. I remember the beatings. I remember how he use to choke her. I remember that incident with the phone being one of the most shameful things of my life.
Dependence/Incompetence (Dependence/Incompetence)	Belief that one is unable to handle one's everyday responsibilities in a competent manner, without considerable help from others (e.g., take care of oneself, solve daily problems, exercise good judgment, tackle new tasks, make good decisions). Often presents as helplessness.	
Emotional Deprivation (ED)	Expectation that one's desire for a normal degree of emotional support will not be adequately met by others. The three major forms of deprivation are: A. deprivation of Nurturance: Absence of attention, affection, warmth, or companionship. B. Deprivation of Empathy: Absence of understanding, listening, self-disclosure, or mutual sharing or feelings from others. C. Deprivation of Protection: Absence of strength, direction, or guidance from others.	
Enmeshment (EM)	Excessive emotional involvement and	



	<p>closeness with one or more significant others (often parents), at the expense of full individuation or normal social development. Often involves the belief that at least one of the enmeshed individuals cannot survive or be happy without the constant support of the other. May also include feelings of being smothered by, or fused with, others or insufficient individual identity. Often experienced as a feeling of emptiness and floundering, having no direction, or in extreme cases questioning one's existence.</p>	
Entitlement (ET)	<p>The belief that one is superior to other people; entitled to special rights and privileges; or not bound by the rules of reciprocity that guide normal social interactions. Often involves insistence that one should be able to do or have whatever one wants, regardless of what is realistic, what others consider reasonable, or the cost to others; or an exaggerated focus on superiority (being among the most successful, famous, wealthy) in order to achieve power or control (not primarily for attention or approval). Sometimes includes excessive competitiveness toward, or domination of others: asserting one's power, forcing one's point of view, or controlling the behavior of others in line with one's own desires – without</p>	

	empathy or concern for others' needs or feelings	
Insufficient Self Control (IS)	Pervasive difficulty or refusal to exercise sufficient self-control and frustration tolerance to achieve one's personal goals, or to restrain the excessive expression or one's emotions and impulses. In its milder form, patient presents with an exaggerated emphasis on discomfort-avoidance: avoiding pain, conflict, confrontation, responsibility, or overexertion—at the expense of personal fulfillment, commitment, or integrity.	
Mistrust/Abuse (MA)	The expectation that others will hurt, abuse, humiliate, cheat, lie, manipulate, or take advantage. Usually involves the perception that the harm is intentional or the result of unjustified and extreme negligence. May include the sense that one always ends up being cheated relative to others or “getting the short end of the stick.”	<p>I do very much resent how things transpired in my parent's marriage because it has been very hard for me to really feel safe around people and trust them to get close with them. To connect with them.</p> <p>I have blanket trust issues period. But maybe that is why I am not married because I don't know what. Because my dad is a pretty charming guy and nice, but how can I make sure I don't end up with the same kind of situation my mother was in.</p> <p>My mother has a bit of an irrational temper. Like she will just start and go at it and it is a bit much.</p> <p>My mother would call him all kinds of names. She would talk about his mother and he would never</p>

		push back on that.
Subjugation (SB)	<p>Excessive surrendering of control to others because one feels coerced – usually to avoid anger, retaliation or abandonment. The two major forms of subjugation are:</p> <p>A. Subjugation of Needs: Suppression of one’s preferences, decisions, and desires.</p> <p>B. Subjugation of Emotions: Suppression of emotional expression, especially anger.</p> <p>Usually involves the perception that one’s own desires, opinions, and feelings are not valid or important to others. Frequently presents as excessive compliance, combined with hypersensitivity to feeling trapped. Generally leads to a build up of anger, manifested in maladaptive symptoms (e.g., passive-aggressive behavior, uncontrolled outbursts of temper, psychosomatic symptoms, withdrawal of affection, “acting out” substance abuse.</p>	<p>I was a incredibly compliant kid. My mother wasn’t home but she said I had to be in bed by 8:30 or 9:00 and I would be in bed by 8:30 or 9:00.</p> <p>She used to tell me a couldn’t watch TV until my homework was done. I was 14 or 15 until I realized that I could watch TV until about half an hour before she got home and then turn it off and the TV would be cold and that she probably wouldn’t even think to check to see if the TV had been on. So I was really compliant.</p> <p>I didn’t want to get in trouble for messing up their stuff so again being the compliant person I would just like bring a book or I would pray they had some magazines and I would read magazines. I would just sit there and read a magazine and watch TV.</p> <p>And I kind of learned that my mother is not a mind reader and so I would have to express myself. The compliant child thing wouldn’t work forever so I had to speak up for myself.</p> <p>He never hit me but I didn’t know what was going on. He still drank quite a bit. And I would just go</p>

		<p>and we would do stuff and I was expected to try and shake him down for stuff anyway, so I had to go and I had to kind of make an effort to at least try because I knew when I got home that my mother was going to say “did you tell your daddy you have a class trip to go on? Did your daddy give you some money? Yeah I really felt obliged to go. I can’t say I really enjoyed visiting my father. It was like just get this over with.</p> <p>Because it is not like I say oh well, I don’t like that and how can I change it. I just go I don’t like that and I shrug and try to focus on something else. And that is a pretty unsatisfactory way to be. I will find myself grouching to myself about some issue where I should have spoken up or something and/or when taken it on and it is not really something I can do anything about and I will be like –oh my gosh- I will be thinking about it over some cookies and so I think sometimes thank God I don’t like alcohol because I think I could really have a problem.</p> <p>I feel comfort. Oh food feels good in your stomach and it tastes good and it takes you out of whatever painful thing you were thinking about especially if you have to make or go get it or wait for someone to bring it to you.</p>
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Social Isolation/Alienation (SI)	The feeling that one is isolated from the rest of the world, different from other people, and/or not part of any group or community.	<p>I may not have been overweight when I look at it now. I went to a predominately white school. And I developed early and secondly I have very different characteristics. My butt was rounder my thighs were bigger I looked probably more womanly then the other 13 year old girls.</p> <p>I think also my experience with being usually the only minority person or African American in a lot of school settings was very isolating.</p> <p>Or something would come up to remind me of my outsider status and that would upset me very much because there was nothing I could really do about it.</p>
Self Sacrifice (SS)	Excessive focus on voluntarily meeting the needs of others in daily situations, at the expense of one's own gratification. The most common reasons are: to prevent causing pain to others; to avoid guilt from feeling selfish; or to maintain the connection with others perceived as needy. Often results from an acute sensitivity to the pain of others. Sometimes leads to a sense that one's own needs are not being adequately met and to resentment of those who are taken care of. (overlaps with sense of co-dependency)	
Emotional inhibition (EI)	The excessive inhibition of spontaneous action,	Q: Would you say you are a stress eater? A: Yes.

	<p>feeling or communication – usually to avoid disapproval by others, feelings of shame, or losing control of one’s impulses. The most common areas of inhibition involve: (a) inhibition of anger &amp; aggression, (b) inhibition of positive impulses (e.g. joy, affection, sexual excitement, play); (c) difficulty expressing vulnerability or communicating freely about one’s feelings, needs, etc., or (d) excessive emphasis on rationality while disregarding emotions.</p>	<p>And whenever I have stressful or hurtful time I tend to overeat and I tend to eat quite a bit of crap.</p> <p>So I don’t know what to do about it and I bake up a couple dozen cookies and eat them.</p> <p>So I guess I try to be sensible about it and maybe my sensibility has affected my look since I don’t care about my looks it makes it easier to be overweight.</p> <p>I feel comforted. Oh food feels good in your stomach and it tastes great and it takes you out of whatever painful thing you were thinking about especially if you have to make or go get or wait for someone to bring it to you.</p> <p>I remember being home alone at the age of 7 and feeling profoundly alone.</p> <p>We had some cereal and little snack packs of chips and soda and some snack cakes. I ate just about all of it. I ate the chips... and I ate about half of a box of Twinkies and I must have drank three or four sodas.</p> <p>So I remember that it was one of the first instances</p>
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		<p>where I did connect food with an emotion. And you know it was loneliness and that was my solution, just eat.</p> <p>When I am frustrated, angry or sad I eat.</p> <p>There was a period in junior high where there was just a lot of racial incidents that kept happening on the school bus and I would get home and be pretty upset about it and I would eat. I would have a full meal. If there were leftovers I would eat those and then I would look for something else and then I would eat dinner to try and cover up for the other.</p> <p>I guess I just cook up a couple dozen cookies. Q: And eat them? A: Yeah.</p>
Failure to achieve (FA)	The belief that one has failed, will inevitably fail, or is fundamentally inadequate relative to one's peers, in areas of achievement (school, career, sports, etc). Often involves beliefs that one is stupid, inept, untalented, ignorant, lower in status, less successful than others, etc.	I have been struggling with this for a while...I feel like I let myself down that I didn't keep some kind of agreement with myself.
Unrelenting standards/Hyper-criticalness (US)	The underlying belief that one must strive to meet very high internalized standards of behavior and performance, usually to avoid criticism. Typically results in feelings or pressure or difficulty slowing down; and in	I think I feel like it is incredibly superficial to do that. I would like to think that I am not a judgmental person but I see somebody come in with French tips I make a snap judgment. And the snap judgment I make on them is not one I want

	<p>hypercriticalness toward oneself and others. Most involve significant impairment in: pleasure, relaxation, health, self-esteem, sense of accomplishment, or satisfying relationships.</p> <p>Unrelenting standards typically present as (a) perfectionism, inordinate attention to detail, or an underestimate of how good one's own performance is relative to the norm; (b) rigid rules and "shoulds" in many areas of life, including unrealistically high moral, ethical, cultural, or religious precepts; or (c) preoccupation with time and efficiency, so that more can be accomplished.</p>	<p>people to making about me.</p> <p>I know how people are suppose to be and I am very a tuned to that. I like, order, I like priority, I like decency. The fact that it has not always been a value of the people around me is painful because I feel like an outlier. And sometimes I question...why don't I just lower my standards? And I can't because I have seen the result of it.</p>
Vulnerability to harm (VH)	<p>Exaggerated fear that imminent catastrophe will strike at any time and that one will be unable to prevent it. Fears focus on one or more of the following: (a) medical catastrophe: e.g., heart attacks, AIDS; (b) emotional catastrophes e.g., going crazy (c) external catastrophes; e.g. elevators collapsing, victimized by criminals, airplanes crashes, earthquakes.</p>	
Approval-seeking/Recognition-seeking (AS)	<p>Excessive emphasis on gaining approval, recognition, or attention from other people, or fitting in, at the expense of developing a secure and true sense of self. One's sense of esteem is dependent primarily on the reactions of others</p>	<p>I developed early and secondly I had very different characteristics. But I always thought that if I lost weight I would look like this. So that became kind of a spiral of trying to be skinnier. If I looked like this I would fit in better.</p>



	rather than one's own natural inclinations. Sometimes includes an overemphasis on status, appearance, social acceptance, money, or achievement – as mean of gaining approval, admiration, or attention (not primarily for power or control). Frequently results in major life decisions that are inauthentic or unsatisfying; or in hypersensitivity to rejection.	
Negativity/Pessimism (NP)	A pervasive, lifelong focus on the negative aspects of life (pain, death, loss, disappointment, conflict, guilt, resentment, unsolved problems, potential mistakes, betrayal, things that could go wrong, etc) while minimizing or neglecting the positive or optimistic aspects. Usually includes an exaggerated expectation – in a wide range of work, financial, or interpersonal situations – that things will ultimately fall apart. Usually	
Punitiveness (PU)	The belief that people should be harshly punished for mistakes. Involves the tendency to be angry, intolerant, punitive, and impatient with those people (and self) who do not meet one's expectations or standards. Usually includes difficulty forgiving mistakes in because of a reluctance to consider extenuating circumstances, allow for human imperfection, or empathize with feelings.	I decided I was sick of all this and it is easy to just not deal with my father at all. At 19 I decided I don't have to see him anymore and I am not going to. I never called him or saw him after that. (Father).

Appendix K  
Coding  
Donna  
Bulimia Nervosa

Category	Definition	Participant Statement
Abandonment/Instability (AB)	The perceived instability or unreliability of those available for support and connection. Involves the sense that significant others will not be able to continue providing emotional support, connection, strength, or practical protection because they are emotionally unstable and unpredictable, unreliable, or erratically present; because they will die imminently; or because they will abandon the patient in favor of someone better.	<p>He was too obsessed with their failing marriage so he didn't really have time for the kids until they got divorced and then he knew we were the only family he had left and had a change of heart. But he didn't really have a lot of time to think about us kids because he was trying to hold on to the marriage.</p> <p>My dad sent me back to my mom after four months. I was back at my mom's for a month. Once I was there I was only successful in my parents home for a month before I actually got caught at school smoking pot and they did not press charges but my mom put me in the teen crisis shelter.</p> <p>My mother said do whatever you want. You think you are a grown up you do what you want and just stay there. And then 6 hours later the cops came to pick me up because she had changed her mind. So I went to juvey and they called my mother and said we can't hold her because she ran away. This is not</p>

		<p>an offense. And my mom said I am not coming to get her. They said then we consider that abandonment and I was turned over to child protective services.</p> <p>It depended on how many cases of alcohol they had at the time. My father has the standing record today for being pretty stable. My mother has the record for being somewhat stable for prolonged periods of time.</p> <p>I wanted her attention more than everyone else because everyone else will just give it to me and she made me beg for it.</p>
Defectiveness/Shame (DS)	<p>The feeling that one is defective, bad, unwanted, inferior, or invalid in important respects; or that one would be unlovable to significant others if exposed. May involve hypersensitivity to criticism, rejection, and blame; self-consciousness, comparisons, and insecurity around others; or a sense of shame regarding one's perceived flaws. These flaws may be private (e.g. selfishness, angry impulses, unacceptable sexual desires) or public (undesirable physical appearance, social awkwardness).</p>	<p>I have not had a day go by that I have not rejected some part of my body.</p> <p>I didn't think there was any hope for me. So I started eating potato chips and then threw them up.</p> <p>Because I would give up and I don't think there is any hope for me. There is no reason to try and help myself because I will always be just this screwed up.</p> <p>I have lots of obsessive-compulsive and self centered behaviors in my.</p>

		<p>...It started out with food and trying to feel loved.</p> <p>I don't know how to love myself.</p> <p>So in my recovery what I have been trying to address for a long time is to stop hating myself so much.</p> <p>I have to practice at being somebody that I want to be and I think it was 6 months ago that I finally started to feel really successful at this practicing being someone that I wanted to be thing and I started to feel a lot of these feelings of esteem.</p> <p><i>Recovery</i></p> <p>I used to loath myself for now I see as more of a quirky – you know traits I still need to work on to be of better service to other people. <i>Recovery</i></p> <p>Yes and I have always hated myself for that and then recently it is just you know what I know what I think and that is okay and I will just have to learn more politeness. I have already been learning about politeness and this is actually okay that I can incorporate this into my confidence and my idea of myself. <i>Recovery</i></p>
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		I started out with this hatred for myself and now it has just changed. <i>Recovery</i>
Dependence/Incompetence (DI)	Belief that one is unable to handle one's everyday responsibilities in a competent manner, without considerable help from others (e.g., take care of oneself, solve daily problems, exercise good judgment, tackle new tasks, make good decisions). Often presents as helplessness.	
Emotional Deprivation (ED)	Expectation that one's desire for a normal degree of emotional support will not be adequately met by others. The three major forms of deprivation are: A. deprivation of Nurturance: Absence of attention, affection, warmth, or companionship. B. Deprivation of Empathy: Absence of understanding, listening, self-disclosure, or mutual sharing or feelings from others. C. Deprivation of Protection: Absence of strength, direction, or guidance from others.	She did not have the ability to talk things out which is what I really would have benefited from. which is what I really would have benefited from. You know you don't have to eat because you are bored, or you don't have to eat a lot. We can do other things that make us feel good then just eating and stuff like that but she just didn't talk about her problems.  She would just try to control. And when she couldn't control me she would ignore me.  She would not speak to me. And I would beg for her attention and be all up in her face and she would completely ignore me.
Enmeshment (EM)	Excessive emotional involvement and closeness with one or more significant others	

	<p>(often parents), at the expense of full individuation or normal social development. Often involves the belief that at least one of the enmeshed individuals cannot survive or be happy without the constant support of the other. May also include feelings of being smothered by, or fused with, others or insufficient individual identity. Often experienced as a feeling of emptiness and floundering, having no direction, or in extreme cases questioning one's existence.</p>	
Entitlement (ET)	<p>The belief that one is superior to other people; entitled to special rights and privileges; or not bound by the rules of reciprocity that guide normal social interactions. Often involves insistence that one should be able to do or have whatever one wants, regardless of what is realistic, what others consider reasonable, or the cost to others; or an exaggerated focus on superiority (being among the most successful, famous, wealthy) in order to achieve power or control (not primarily for attention or approval). Sometimes includes excessive competitiveness toward, or domination of others: asserting one's power, forcing one's point of view, or controlling the behavior of others in line with one's own desires – without empathy or concern for others' needs or</p>	

<p>Insufficient Self Control (IS)</p>	<p>feelings</p> <p>Pervasive difficulty or refusal to exercise sufficient self-control and frustration tolerance to achieve one’s personal goals, or to restrain the excessive expression or one’s emotions and impulses. In its milder form, patient presents with an exaggerated emphasis on discomfort-avoidance: avoiding pain, conflict, confrontation, responsibility, or overexertion—at the expense of personal fulfillment, commitment, or integrity.</p>	<p>I didn’t know how to deal with what was going on any other way and I started bingeing and purging.</p> <p>Well when I made the decision to use it was like a compulsion. It was like I wanted to use a four letter word but screw it. You know. It is kind of a familiar thing in my stream of consciousness where it goes. I don’t care anymore I am just going to do it.</p> <p>I was very active and it wasn’t enough food and that is one of the things I say to myself. I really love to do it and I find it difficult to control myself at times and so I think it is both things. I would like to tell myself I was eating too little and my body revolted and I have to put more food in but it is also that I have less control over myself as I would like.</p> <p>Q: What do you think you were gaining from bingeing and purging/ A: Control of my feelings, avoiding reality, not taking personal responsibility for my life, myself, my feelings, everything.</p>
<p>Mistrust/Abuse (MA)</p>	<p>The expectation that others will hurt, abuse, humiliate, cheat, lie, manipulate, or take advantage. Usually involves the perception that the harm is intentional or the result of unjustified and extreme negligence. May</p>	<p>Especially me. And she would portion control my food because she believed I showed signs of over eating.</p> <p>My dad found out that my mom had been beating</p>

	<p>include the sense that one always ends up being cheated relative to others or “getting the short end of the stick.”</p>	<p>me up when I was two.</p> <p>I think he told me too soon. I wasn't on my fourth step yet and it messed me up in the head for a while.</p> <p>Liar is the word the comes to mind. I think she can twist and change the truth in her own mind. She is not an honest woman.</p> <p>I would trust her with my physical well being to a point. Because if I go on a trip with her and it is just her and she is drinking and upset, then I don't want to be in that type of situation.</p> <p>I don't want to be put in that situation. Because it is like why would you want to reason with a crazy person.</p> <p>I was 13 by then. My stepfather started hitting my younger sister and I still didn't use, but when he started hitting me that is when I started to use.</p> <p>She was lying. She never told me this and never will but I know she was lying to me.</p>
<p>Subjugation (SB)</p>	<p>Excessive surrendering of control to others because one feels coerced – usually to avoid anger, retaliation or abandonment. The two major forms of subjugation are:</p>	<p>My right to control myself had been removed. Q: By your stepfather? A: Yes.</p> <p>Every time I did something wrong they would take</p>



	<p>A. Subjugation of Needs: Suppression of one's preferences, decisions, and desires.</p> <p>B. Subjugation of Emotions: Suppression of emotional expression, especially anger.</p> <p>Usually involves the perception that one's own desires, opinions, and feelings are not valid or important to others. Frequently presents as excessive compliance, combined with hypersensitivity to feeling trapped. Generally leads to a build up of anger, manifested in maladaptive symptoms (e.g., passive-aggressive behavior, uncontrolled outbursts of temper, psychosomatic symptoms, withdrawal of affection, "acting out" substance abuse.</p>	<p>my life away. They would take the little jar that is me and turn it upside down in an effort to control me and I would work to feel nothing.</p> <p>Their own expression of themselves. My right to control myself had been removed. He was manipulative... he was definitely controlling. And that type of person goes and tries to rob that person of their control.</p> <p>Q: So he robbed you of your control? A: Yes.</p>
Social Isolation/Alienation (SI)	The feeling that one is isolated from the rest of the world, different from other people, and/or not part of any group or community.	
Self Sacrifice (SS)	Excessive focus on voluntarily meeting the needs of others in daily situations, at the expense of one's own gratification. The most common reasons are: to prevent causing pain to others; to avoid guilt from feeling selfish; or to maintain the connection with others perceived as needy. Often results from an acute sensitivity to the pain of others. Sometimes leads to a sense that one's own needs are not being adequately met and to resentment of those who are taken care of. (overlaps with	

	sense of co-dependency)	
Emotional inhibition (EI)	The excessive inhibition of spontaneous action, feeling or communication – usually to avoid disapproval by others, feelings of shame, or losing control of one’s impulses. The most common areas of inhibition involve: (a) inhibition of anger & aggression, (b) inhibition of positive impulses (e.g. joy, affection, sexual excitement, play); (c) difficulty expressing vulnerability or communicating freely about one’s feelings, needs, etc., or (d) excessive emphasis on rationality while disregarding emotions.	<p>When you parents are kicking you out it is like this resignation would be a lot of how I would feel. I would get this numb. I would describe kind of like PTSD type response. I had no feeling.</p> <p>Then I started cutting myself a little bit and then I told on myself for cutting</p> <p>The underlying feeling I was trying the suppress was having to deal with my body and accepting my body and myself.</p>
Failure to achieve (FA)	The belief that one has failed, will inevitably fail, or is fundamentally inadequate relative to one’s peers, in areas of achievement (school, career, sports, etc). Often involves beliefs that one is stupid, inept, untalented, ignorant, lower in status, less successful than others, etc.	
Unrelenting standards/Hyper-criticalness (US)	The underlying belief that one must strive to meet very high internalized standards of behavior and performance, usually to avoid criticism. Typically results in feelings or pressure or difficulty slowing down; and in hypercriticalness toward oneself and others. Most involve significant impairment in: pleasure, relaxation, health, self-esteem, sense of accomplishment, or satisfying relationships.	<p>I have lots of obsessive compulsive and self centered behaviors in my life.</p> <p>So I would eat something and then realize it was a mistake and I would have to make myself throw it up.</p> <p>Yes I would eat more than the 1350 and that rigid black and white thinking I would not think that</p>

	<p>Unrelenting standards typically present as (a) perfectionism, inordinate attention to detail, or an underestimate of how good one's own performance is relative to the norm; (b) rigid rules and "shoulds" in many areas of life, including unrealistically high moral, ethical, cultural, or religious precepts; or (c) preoccupation with time and efficiency, so that more can be accomplished.</p>	<p>1400 was a successful diet day. Q: SO if you went over 1350 what would happen. A: I would throw up.</p>
Vulnerability to harm (VH)	<p>Exaggerated fear that imminent catastrophe will strike at any time and that one will be unable to prevent it. Fears focus on one or more of the following: (a) medical catastrophe: e.g., heart attacks, AIDS; (b) emotional catastrophes e.g., going crazy (c) external catastrophes; e.g. elevators collapsing, victimized by criminals, airplanes crashes, earthquakes.</p>	
Approval-seeking/Recognition-seeking (AS)	<p>Excessive emphasis on gaining approval, recognition, or attention from other people, or fitting in, at the expense of developing a secure and true sense of self. One's sense of esteem is dependent primarily on the reactions of others rather than one's own natural inclinations. Sometimes includes an overemphasis on status, appearance, social acceptance, money, or achievement – as mean of gaining approval,</p>	<p>I wanted her attention more than everyone else because everyone else will just give it to me and she made me beg for it.</p> <p>My mom was controlling my food and I think I was trying to be in denial. I would goad her at times to tell me I was the right size.</p> <p>And I would find opportunities to ask her to tell me</p>

	admiration, or attention (not primarily for power or control). Frequently results in major life decisions that are inauthentic or unsatisfying; or in hypersensitivity to rejection.	that I was the right size.  I think that people like me if I don't do this then I will be loved, if I do that I will be okay. If I do this then I will be acceptable in society.
Negativity/Pessimism (NP)	A pervasive, lifelong focus on the negative aspects of life (pain, death, loss, disappointment, conflict, guilt, resentment, unsolved problems, potential mistakes, betrayal, things that could go wrong, etc) while minimizing or neglecting the positive or optimistic aspects. Usually includes an exaggerated expectation – in a wide range of work, financial, or interpersonal situations – that things will ultimately fall apart. Usually	
Punitiveness (PU)	The belief that people should be harshly punished for mistakes. Involves the tendency to be angry, intolerant, punitive, and impatient with those people (including oneself) who do not meet one's expectations or standards. Usually includes difficulty forgiving mistakes in oneself or others, because of a reluctance to consider extenuating circumstances, allow for human imperfection or empathize with feelings.	I never thought my mother was giving me her approval so I rejected her as a punishment and as a way of dealing with the rejection of myself from her.

Appendix L  
Coding  
Jade  
Bulimia Nervosa

Category	Definition	Participant Statement
Abandonment/Instability (AB)	The perceived instability or unreliability of those available for support and connection. Involves the sense that significant others will not be able to continue providing emotional support, connection, strength, or practical protection because they are emotionally unstable and unpredictable, unreliable, or erratically present; because they will die imminently; or because they will abandon the patient in favor of someone better.	<p>My parents said we would move back to Mexico after I graduated. Once we did they decided not to stay and so I was left alone. For those 9 months I was pretty much living on my own.</p> <p>I was in Mexico by myself so I was dealing with being lonely. I was very lonely. I just didn't know how to cope with it any other way.</p> <p>I mean I literally grew up on my own.</p>
Defectiveness/Shame (DS)	The feeling that one is defective, bad, unwanted, inferior, or invalid in important respects; or that one would be unlovable to significant others if exposed. May involved hypersensitivity to criticism, rejection, and blame; self-consciousness, comparisons, and insecurity around others; or a sense of shame regarding one's perceived flaws. These flaws may be private (e.g. selfishness, angry impulses, unacceptable sexual desires) or	<p>And so growing up it was a lot you don't fit in, as far as being Hispanic or being American. I was like not good enough for either one. I felt that way anyway. The older I got the more my mom pointed out that I was getting too involved in the American life style and then that I was denying my roots. And I knew that wasn't true but the more I tried to be Hispanic the less successful I was.</p> <p>I was not a very popular kid. Not only that, but</p>

	<p>public (undesirable physical appearance, social awkwardness).</p>	<p>when I was growing up, I was compared to a cousin. ... We were the same age but she was a very petite person. Like really, really tiny. So the comparisons were always that I was a little heavier than her.</p> <p>And somewhere in my mind I thought she was always better than me in that way.</p> <p>I feel so inadequate and I still wake up some days and think you have done nothing with your life.</p> <p>You are not successful and that is why no one wants you. You are this, and you are ugly.</p> <p>I felt like oh my God I can't believe I got rid of all that. I did so good. And then there is like a high that you get. Because you relieved but it is like well I just got rid of something that was not suppose to be there. And then it lasts for a good 5 or 10 minutes until the guilt comes in.</p> <p>And if there was any stress going on in my mind I think that it has to do with concerns like being able to control the thoughts that go in. It is like you wake up with problems that are going around the house or feelings of inadequacy that I am not good enough so I am just going to torture myself.</p>
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...and then the guilt is on the back burner oh this is going to make you fat. So not only do I not feel good this is only going to make you fat.

But at the same time I have always kept my body in shape I would still hide it under big clothes. So in my brain it was like, well I am still in really good shape but I am always hiding it...So I still felt not accepted even when my body was little.

There was always a lot of guilt afterward because I knew it was wrong.  
I felt very shameful.

I guess expectations of me being the excellent daughter has always been there and sometimes it is just like you know what I am just human. And you know what it is just like sometimes I know it is like I told my mom you thinking that I have it all put together but I don't have it all put together. I am struggling with lots of things and I need for you to understand that I am just as human as anybody else.

I am struggling with a lot of things, and I need for you to understand that I am just as human as anybody else. *Recovery*

Dependence/Incompetence (DI)	Belief that one is unable to handle one's everyday responsibilities in a competent manner, without considerable help from others (e.g., take care of oneself, solve daily problems, exercise good judgment, tackle new tasks, make good decisions). Often presents as helplessness.	<p>And I had no clue and again I had no control over anything whatsoever.</p> <p>I feared decision making and that even applies now. I am still struggling with that, and giving in to others wishes. I didn't have them myself I just had to go by what everybody else told me.</p>
Emotional Deprivation (ED)	<p>Expectation that one's desire for a normal degree of emotional support will not be adequately met by others. The three major forms of deprivation are:</p> <p>A. deprivation of Nurturance: Absence of attention, affection, warmth, or companionship.</p> <p>B. Deprivation of Empathy: Absence of understanding, listening, self-disclosure, or mutual sharing or feelings from others.</p> <p>C. Deprivation of Protection: Absence of strength, direction, or guidance from others.</p>	<p>My father is very distant. He is a caring person but I don't know how to say this...he lives in his own world. So it is like, it is about him.</p> <p>Emotions don't count, so he doesn't have a lot of emotions. He just goes through the process of living.</p> <p>I did wish that I had someone I could rely on like my dad to protect me or care for me, or whatever.</p>
Enmeshment (EM)	<p>Excessive emotional involvement and closeness with one or more significant others (often parents), at the expense of full individuation or normal social development. Often involves the belief that at least one of the enmeshed individuals cannot survive or be happy without the constant support of the other. May also include feelings of being smothered</p>	<p>My mom suffers from an eating disorder, anorexia, so through her process I was like her... she leaned on me.</p> <p>Fear, over involvement in others lives and I would say my moms would be it, no life of my own.</p> <p>I felt it was my responsibility to make her feel</p>



	by, or fused with, others or insufficient individual identity. Often experienced as a feeling of emptiness and floundering, having no direction, or in extreme cases questioning one's existence.	better.  Because I still take blame for, well not blame but I still try fix my mother.  She is such a caring person yet at the same time she is so fragile that I want to fix her.
Entitlement (ET)	The belief that one is superior to other people; entitled to special rights and privileges; or not bound by the rules of reciprocity that guide normal social interactions. Often involves insistence that one should be able to do or have whatever one wants, regardless of what is realistic, what others consider reasonable, or the cost to others; or an exaggerated focus on superiority (being among the most successful, famous, wealthy) in order to achieve power or control (not primarily for attention or approval). Sometimes includes excessive competitiveness toward, or domination of others: asserting one's power, forcing one's point of view, or controlling the behavior of others in line with one's own desires – without empathy or concern for others' needs or feelings	
Insufficient Self Control (IS)	Pervasive difficulty or refusal to exercise sufficient self-control and frustration tolerance	

	<p>to achieve one’s personal goals, or to restrain the excessive expression or one’s emotions and impulses. In its milder form, patient presents with an exaggerated emphasis on discomfort-avoidance: avoiding pain, conflict, confrontation, responsibility, or overexertion—at the expense of personal fulfillment, commitment, or integrity.</p>	
<p>Mistrust/Abuse (MA)</p>	<p>The expectation that others will hurt, abuse, humiliate, cheat, lie, manipulate, or take advantage. Usually involves the perception that the harm is intentional or the result of unjustified and extreme negligence. May include the sense that one always ends up being cheated relative to others or “getting the short end of the stick.”</p>	<p>My parents always told me we would go back to Mexico and so I thought in my mind that I always wanted to go back and it seemed like a lot of broken promises because we never did.</p> <p>But yet at the same time she has this powerful character and personality that is manipulative at the same time that if you get too close to her she will make your life miserable.</p> <p>So it is like how do I approach my mother so that I can help her but yet I can’t, and that she doesn’t affect me so much that I become miserable in the process.</p> <p>I didn’t feel like I could trust anybody to go tell anybody. Not even my mom at that point anymore.</p> <p>So I am not going there with my dad. I can’t even ask him for help.</p>

Subjugation (SB)	<p>Excessive surrendering of control to others because one feels coerced – usually to avoid anger, retaliation or abandonment. The two major forms of subjugation are:</p> <p>A. Subjugation of Needs: Suppression of one’s preferences, decisions, and desires.</p> <p>B. Subjugation of Emotions: Suppression of emotional expression, especially anger.</p> <p>Usually involves the perception that one’s own desires, opinions, and feelings are not valid or important to others. Frequently presents as excessive compliance, combined with hypersensitivity to feeling trapped. Generally leads to a build up of anger, manifested in maladaptive symptoms (e.g., passive-aggressive behavior, uncontrolled outbursts of temper, psychosomatic symptoms, withdrawal of affection, “acting out” substance abuse.</p>	
Social Isolation/Alienation (SI)	<p>The feeling that one is isolated from the rest of the world, different from other people, and/or not part of any group or community.</p>	<p>So it was easy to hide and lie about it. But here it is like you come here, you don’t know the language, you have to learn a new language, you can’t communicate, you have to move around a lot, you never have friends, your parents work all the time.</p> <p>You can’t talk to anyone because you don’t know the language.</p>
Self Sacrifice (SS)	<p>Excessive focus on voluntarily meeting the</p>	<p>So my dad was working all the time and so it all</p>

	<p>needs of others in daily situations, at the expense of one's own gratification. The most common reasons are: to prevent causing pain to others; to avoid guilt from feeling selfish; or to maintain the connection with others perceived as needy. Often results from an acute sensitivity to the pain of others. Sometimes leads to a sense that one's own needs are not being adequately met and to resentment of those who are taken care of. (overlaps with sense of co-dependency)</p>	<p>came down to me. I was forced to grow up real quick when I was little.</p> <p>I had to protect her, I had to make her feel good, I had to keep her happy. And for a kid that is kind of hard.</p> <p>My coping mechanism is stop feeling sorry for yourself and see what you can do for someone else that feels worse than you do.</p>
Emotional inhibition (EI)	<p>The excessive inhibition of spontaneous action, feeling or communication – usually to avoid disapproval by others, feelings of shame, or losing control of one's impulses. The most common areas of inhibition involve: (a) inhibition of anger &amp; aggression, (b) inhibition of positive impulses (e.g. joy, affection, sexual excitement, play); (c) difficulty expressing vulnerability or communicating freely about one's feelings, needs, etc., or (d) excessive emphasis on rationality while disregarding emotions.</p>	<p>It was one of those things you do to try and compensate the feeling the food, and you over eat so much in such a short period of time and then the guilt that I over ate too much and then the fact that I don't want to get fat because I am only accepted when I am little you have to go get rid of it right away.</p> <p>Well I was really stressed and I would eat, and eat, and eat and then just get rid of it again. There was a lot of stress because I didn't know what I was going to do.</p> <p>Like this eating is going to make me feel better, and um, it was just a coping mechanism because I was so stressed out that I would eat and then just keep eating and eating and eating and by the time you</p>

		<p>realize it you have eaten so much and then you do feel good.</p> <p>So I was in Mexico by myself so I was dealing with being lonely. I was very lonely. I just didn't know how to cope with it any other way. ...And again the coping mechanism came in that way. I just cant control anything, so I will eat and purge and I will stay skinny. While your eating it just kind of relaxes you.</p>
Failure to achieve (FA)	The belief that one has failed, will inevitably fail, or is fundamentally inadequate relative to one's peers, in areas of achievement (school, career, sports, etc). Often involves beliefs that one is stupid, inept, untalented, ignorant, lower in status, less successful than others, etc.	<p>When I can't do it I feel like a failure because I'm still not there for my mother the way I wish I could.</p> <p>A lot of fear always making the wrong decisions for a lot of things.</p> <p>But again that little voice will come out and says no you can't do it.</p>
Unrelenting standards/Hyper-criticalness (US)	The underlying belief that one must strive to meet very high internalized standards of behavior and performance, usually to avoid criticism. Typically results in feelings or pressure or difficulty slowing down; and in hypercriticalness toward oneself and others. Most involve significant impairment in: pleasure, relaxation, health, self-esteem, sense	<p>I have been a perfectionist.</p> <p>I have always been an over achiever, I always want to accomplish more than I think I can.</p> <p>Sometime I feel like I am not doing enough.</p> <p>It is like if nobody likes me, then I am going to</p>

	<p>of accomplishment, or satisfying relationships.</p> <p>Unrelenting standards typically present as (a) perfectionism, inordinate attention to detail, or an underestimate of how good one’s own performance is relative to the norm; (b) rigid rules and “shoulds” in many areas of life, including unrealistically high moral, ethical, cultural, or religious precepts; or (c) preoccupation with time and efficiency, so that more can be accomplished.</p>	<p>torture myself so that I can be skinny.</p> <p>I think again I always try to keep the faith that I was the perfect kid who never did anything wrong. And as an adult, I still want to keep the thing that I never make a mistake. The perfectionism is like oh I am this perfect...</p> <p>I still here the mom voices and the dad voices because my dad always told me I was super smart.</p> <p>There is a little voice somewhere in the back of my head that is just an over achiever and it is like you are not going to get stuck in that.</p> <p>I have been trying to present as this little robot that’s perfect and I am not.</p>
<p>Vulnerability to harm (VH)</p>	<p>Exaggerated fear that imminent catastrophe will strike at any time and that one will be unable to prevent it. Fears focus on one or more of the following: (a) medical catastrophe: e.g., heart attacks, AIDS; (b) emotional catastrophes e.g., going crazy (c) external catastrophes; e.g. elevators collapsing, victimized by criminals, airplanes crashes, earthquakes.</p>	
<p>Approval-</p>	<p>Excessive emphasis on gaining approval,</p>	<p>If I can’t be accepted any other way that at least if I</p>

<p>seeking/Recognition-seeking (AS)</p>	<p>recognition, or attention from other people, or fitting in, at the expense of developing a secure and true sense of self. One's sense of esteem is dependent primarily on the reactions of others rather than one's own natural inclinations. Sometimes includes an overemphasis on status, appearance, social acceptance, money, or achievement – as mean of gaining approval, admiration, or attention (not primarily for power or control). Frequently results in major life decisions that are inauthentic or unsatisfying; or in hypersensitivity to rejection.</p>	<p>stay little that will be the way to get accepted.</p> <p>I immediately got noticed when I lost the weight.</p> <p>And in my mind again as I got older I was like well, if I can stay this little everyone is going to like me more.</p> <p>I still do struggle with fear and trying to please others.</p> <p>There was so much of a desire to be accepted and I felt that by losing a little bit of weight that I would be accepted and then it becomes sort of like a circle. Because people say you look good, so then you want to continue to do it. And it isn't so much that you want to do it but you do it more, and more, and more and it becomes a pattern.</p> <p>I am only accepted when I am little you have to go get rid of that food right away.</p> <p>It was always in the back of my mind that I had to be skinny...That it would make me accepted.</p>
<p>Negativity/Pessimism (NP)</p>	<p>A pervasive, lifelong focus on the negative aspects of life (pain, death, loss, disappointment, conflict, guilt, resentment,</p>	

	<p>unsolved problems, potential mistakes, betrayal, things that could go wrong, etc) while minimizing or neglecting the positive or optimistic aspects. Usually includes an exaggerated expectation – in a wide range of work, financial, or interpersonal situations – that things will ultimately fall apart. Usually</p>	
Punitiveness (PU)	<p>The belief that people should be harshly punished for mistakes. Involves the tendency to be angry, intolerant, punitive, and impatient with those people (including oneself) who do not meet one's expectations or standards. Usually includes difficulty forgiving mistakes in oneself or others, because of a reluctance to consider extenuating circumstances, allow for human imperfection or empathize with feelings.</p>	



Appendix M  
Coding  
Carla  
Bulimia Nervosa

Category	Definition	Participant Statement
Abandonment/Instability (AB)	The perceived instability or unreliability of those available for support and connection. Involves the sense that significant others will not be able to continue providing emotional support, connection, strength, or practical protection because they are emotionally unstable and unpredictable, unreliable, or erratically present; because they will die imminently; or because they will abandon the patient in favor of someone better.	<p>Then my mother moved to Florida and actually left me with my step-dad until I graduated from high school.</p> <p>I was still dealing with some things from my childhood and the feeling of my mother abandoning me and stuff.</p> <p>Description of mother: Unreliable, unpredictable, abandoned.</p>
Defectiveness/Shame (DS)	The feeling that one is defective, bad, unwanted, inferior, or invalid in important respects; or that one would be unlovable to significant others if exposed. May involved hypersensitivity to criticism, rejection, and blame; self-consciousness, comparisons, and insecurity around others; or a sense of shame regarding one's perceived flaws. These flaws may be private (e.g. selfishness, angry	<p>So then I feel unattractive.</p> <p>When I think about it I feel guilty.</p>

	impulses, unacceptable sexual desires) or public (undesirable physical appearance, social awkwardness).	
Dependence/Incompetence (DI)	Belief that one is unable to handle one's everyday responsibilities in a competent manner, without considerable help from others (e.g., take care of oneself, solve daily problems, exercise good judgment, tackle new tasks, make good decisions). Often presents as helplessness.	
Emotional Deprivation (ED)	<p>Expectation that one's desire for a normal degree of emotional support will not be adequately met by others. The three major forms of deprivation are:</p> <p>A. deprivation of Nurturance: Absence of attention, affection, warmth, or companionship.</p> <p>B. Deprivation of Empathy: Absence of understanding, listening, self-disclosure, or mutual sharing or feelings from others.</p> <p>C. Deprivation of Protection: Absence of strength, direction, or guidance from others.</p>	<p>And I didn't know my biological father so there were kind of three generations and I really think that had a lot to do with my mother inability to a parent and my grandmother's inability to be a good parent as well.</p> <p>My stepfather wasn't really like a parent either. He was more like a person who kept the lights on. He definitely displayed a lack of warmth and affection.</p> <p>(father) Definitely lack of warmth and affection. (mother) hurt, lack of affection, lack of understanding, lack of guidance.</p> <p>I notice that even when I got into school she says that she is proud of me and I think that she is not proud of me but more like my daughter is a graduate student type thing not really me. And I</p>

		would tell her like real things and she is not even listening. She doesn't even hear what I say. I would be saying something really intense and she would be like – Yeah I order these new whatever that I saw in a magazine and I hope they work out.
Enmeshment (EM)	Excessive emotional involvement and closeness with one or more significant others (often parents), at the expense of full individuation or normal social development. Often involves the belief that at least one of the enmeshed individuals cannot survive or be happy without the constant support of the other. May also include feelings of being smothered by, or fused with, others or insufficient individual identity. Often experienced as a feeling of emptiness and floundering, having no direction, or in extreme cases questioning one's existence.	<p>I have been the parent in the relationship for a lot of years. And I have always, out of a sense of obligation, like helped which really doesn't make any sense because I really don't feel like she is the parent. She is just a DNA donor is how I look at it.</p> <p>But we bailed her out and moved her in with us.</p> <p>Kind of that tough love thing and I kept thinking I shouldn't have to do this.</p> <p>For years I played the mediator between the two of them.</p>
Entitlement (ET)	The belief that one is superior to other people; entitled to special rights and privileges; or not bound by the rules of reciprocity that guide normal social interactions. Often involves insistence that one should be able to do or have whatever one wants, regardless of what is realistic, what others consider reasonable, or the cost to others; or an exaggerated focus on	The point when I was ready to leave him I said, look I opened your business store, I struggled with two electric bills, two phone bills, I mean I did everything. I mean I managed the store and the household and I raised you daughter. I said I gave you 10 years now I am going to school. it is going to be harder for me to go to school if I leave you so like it or not you are going to be stuck with me until

	<p>superiority (being among the most successful, famous, wealthy) in order to achieve power or control (not primarily for attention or approval). Sometimes includes excessive competitiveness toward, or domination of others: asserting one's power, forcing one's point of view, or controlling the behavior of others in line with one's own desires – without empathy or concern for others' needs or feelings</p>	<p>I finish school.</p>
<p>Insufficient Self Control (IS)</p>	<p>Pervasive difficulty or refusal to exercise sufficient self-control and frustration tolerance to achieve one's personal goals, or to restrain the excessive expression or one's emotions and impulses. In its milder form, patient presents with an exaggerated emphasis on discomfort-avoidance: avoiding pain, conflict, confrontation, responsibility, or overexertion—at the expense of personal fulfillment, commitment, or integrity.</p>	
<p>Mistrust/Abuse (MA)</p>	<p>The expectation that others will hurt, abuse, humiliate, cheat, lie, manipulate, or take advantage. Usually involves the perception that the harm is intentional or the result of unjustified and extreme negligence. May include the sense that one always ends up being cheated relative to others or “getting the short end of the stick.”</p>	<p>I was sexually abused and I had some control issues there and I think I put on weight to keep men from wanting to look at me.</p> <p>It was multiple people, primarily an older step-brother, cousin, my step-sister did a couple of things.</p>

		<p>She calls her father every once in a while but she still won't talk to me because it is all my fault.</p> <p>It still hurts if I think about it and I still get angry sometimes when I think about it.</p> <p>It was safe there none of the other kids were there and nobody would hurt me there (139-140)</p> <p>I have been through so much that it is fairly easy for me to not rely on anybody in any situation.</p> <p>So I never know if she was telling the truth or not.</p>
Subjugation (SB)	<p>Excessive surrendering of control to others because one feels coerced – usually to avoid anger, retaliation or abandonment. The two major forms of subjugation are:</p> <p>A. Subjugation of Needs: Suppression of one's preferences, decisions, and desires.</p> <p>B. Subjugation of Emotions: Suppression of emotional expression, especially anger.</p> <p>Usually involves the perception that one's own desires, opinions, and feelings are not valid or important to others. Frequently presents as excessive compliance, combined with hypersensitivity to feeling trapped. Generally leads to a build up of anger, manifested in maladaptive symptoms (e.g., passive-</p>	

	<p>aggressive behavior, uncontrolled outbursts of temper, psychosomatic symptoms, withdrawal of affection, “acting out” substance abuse.</p>	
<p>Social Isolation/Alienation (SI)</p>	<p>The feeling that one is isolated from the rest of the world, different from other people, and/or not part of any group or community.</p>	
<p>Self Sacrifice (SS)</p>	<p>Excessive focus on voluntarily meeting the needs of others in daily situations, at the expense of one’s own gratification. The most common reasons are: to prevent causing pain to others; to avoid guilt from feeling selfish; or to maintain the connection with others perceived as needy. Often results from an acute sensitivity to the pain of others. Sometimes leads to a sense that one’s own needs are not being adequately met and to resentment of those who are taken care of. (overlaps with sense of co-dependency)</p>	<p>She was out there a couple of years and then she called and said I want to come home and go back to school. She was engaged so we said that is fine and so we got her, her fiancé and her little dog which I ended up being stuck with. I said you can come back home and live at home but you can’t live here but they were both lazy, sloppy, and dirty.</p> <p>I am not going to leave you until your daughter graduates from high school because I know what that will do to a kid.</p> <p>And I am very responsible when I make a commitment and really just for her I felt like I had made that commitment and I owed her that because it is not her fault who her parents were.</p> <p>I feel like I have sacrificed my whole life for other people.</p> <p>He told me he wanted to kill himself and he told me how he was going to do it and it freaked me out and</p>

		<p>so I begged him I will come see you just promise me you won't do anything till I get home. So I took a leave of absence from both of my jobs and I drove home and told my step-dad.</p> <p>I can't just walk away and not do anything.</p>
Emotional inhibition (EI)	<p>The excessive inhibition of spontaneous action, feeling or communication – usually to avoid disapproval by others, feelings of shame, or losing control of one's impulses. The most common areas of inhibition involve: (a) inhibition of anger &amp; aggression, (b) inhibition of positive impulses (e.g. joy, affection, sexual excitement, play); (c) difficulty expressing vulnerability or communicating freely about one's feelings, needs, etc., or (d) excessive emphasis on rationality while disregarding emotions.</p>	<p>It is just that I don't have feelings for her.</p> <p>Are you kidding me. We are barely making ends meet and I am a student. How dare you complain about taking care of my grandmother and then tell me I own my mother anything. Well I didn't say it to her but it is what I was thinking. I wasn't that strong.</p> <p>I really sometimes think that maybe we will have a dish of ice cream at night or we will bond over food, popcorn, and a movie instead of actually physically bonding.</p> <p>Q: Are you replacing sex with food? A: I think sometimes I am.</p>
Failure to achieve (FA)	<p>The belief that one has failed, will inevitably fail, or is fundamentally inadequate relative to one's peers, in areas of achievement (school, career, sports, etc). Often involves beliefs that</p>	<p>I feel guilty because looking back I have learned some things and I think there were so many things I could have done better with her.</p>

	one is stupid, inept, untalented, ignorant, lower in status, less successful than others, etc.	Three weeks after our wedding I thought I might have made the biggest mistake of my life.
Unrelenting standards/Hyper-criticalness (US)	<p>The underlying belief that one must strive to meet very high internalized standards of behavior and performance, usually to avoid criticism. Typically results in feelings or pressure or difficulty slowing down; and in hypercriticalness toward oneself and others. Most involve significant impairment in: pleasure, relaxation, health, self-esteem, sense of accomplishment, or satisfying relationships.</p> <p>Unrelenting standards typically present as (a) perfectionism, inordinate attention to detail, or an underestimate of how good one's own performance is relative to the norm; (b) rigid rules and "shoulds" in many areas of life, including unrealistically high moral, ethical, cultural, or religious precepts; or (c) preoccupation with time and efficiency, so that more can be accomplished.</p>	<p>I am too much of a perfectionist. I expected too much from him as far as how I think our relationship should be and how I think the house should be. I have real control issues.</p> <p>Once I started to lose weight it was like an addictive quality that I wanted to lose more weight.</p> <p>I went through a state where even if I ate a little bit I didn't even have to try to throw up. I would just get sick. And that was scary that I didn't have control of it.</p>
Vulnerability to harm (VH)	Exaggerated fear that imminent catastrophe will strike at any time and that one will be unable to prevent it. Fears focus on one or more of the following: (a) medical catastrophe: e.g., heart attacks, AIDS; (b) emotional catastrophes e.g., going crazy (c) external catastrophes; e.g. elevators collapsing,	Just feeling attractive was kind of scary. I wanted it but I was afraid of it due to the sexual abuse.



	victimized by criminals, airplanes crashes, earthquakes.	
Approval-seeking/Recognition-seeking (AS)	Excessive emphasis on gaining approval, recognition, or attention from other people, or fitting in, at the expense of developing a secure and true sense of self. One's sense of esteem is dependent primarily on the reactions of others rather than one's own natural inclinations. Sometimes includes an overemphasis on status, appearance, social acceptance, money, or achievement – as mean of gaining approval, admiration, or attention (not primarily for power or control). Frequently results in major life decisions that are inauthentic or unsatisfying; or in hypersensitivity to rejection.	I got real thin and the boys started noticing me.
Negativity/Pessimism (NP)	A pervasive, lifelong focus on the negative aspects of life (pain, death, loss, disappointment, conflict, guilt, resentment, unsolved problems, potential mistakes, betrayal, things that could go wrong, etc) while minimizing or neglecting the positive or optimistic aspects. Usually includes an exaggerated expectation – in a wide range of work, financial, or interpersonal situations – that things will ultimately fall apart. Usually	
Punitiveness (PU)	The belief that people should be harshly punished for mistakes. Involves the tendency to be angry, intolerant, punitive, and impatient	

	<p>with those people (including oneself) who do not meet one's expectations or standards. Usually includes difficulty forgiving mistakes in oneself or others, because of a reluctance to consider extenuating circumstances, allow for human imperfection or empathize with feelings.</p>	
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Appendix N  
Coding  
Jillian  
Anorexia Nervosa

Category	Definition	Participant Statement
Abandonment/Instability (AB)	The perceived instability or unreliability of those available for support and connection. Involves the sense that significant others will not be able to continue providing emotional support, connection, strength, or practical protection because they are emotionally unstable and unpredictable, unreliable, or erratically present; because they will die imminently; or because they will abandon the patient in favor of someone better.	
Defectiveness/Shame (DS)	The feeling that one is defective, bad, unwanted, inferior, or invalid in important respects; or that one would be unlovable to significant others if exposed. May involved hypersensitivity to criticism, rejection, and blame; self-consciousness, comparisons, and insecurity around others; or a sense of shame regarding one's perceived flaws. These flaws may be private (e.g. selfishness, angry impulses, unacceptable sexual desires) or	<p>I despise myself. A color that comes to mind is very black very angry black. I hate the way I look because of the way I have put on the weight.</p> <p>I find it very hard to say nice things about myself.</p> <p>I didn't like being around people because I always felt fat and unacceptable.</p> <p>Old habits die hard and I was into a lot of stuff that I</p>

	public (undesirable physical appearance, social awkwardness).	wish I had never gotten involved in.  I find it very hard to say nice things about myself.
Dependence/Incompetence (DI)	Belief that one is unable to handle one's everyday responsibilities in a competent manner, without considerable help from others (e.g., take care of oneself, solve daily problems, exercise good judgment, tackle new tasks, make good decisions). Often presents as helplessness.	<p>My father's overbearing affects my decision making. It affects how I feel about myself a lot of it is things that have been said by him. I fear decision making. I need to give into other's wishes, allow my partner to make all the important decisions.</p> <p>It is kind of weird because I know I can make my own decisions but I almost feel like I don't know how. So I usually make a decision but before I actually go through with it I am always asking is this okay should I do this. I am not really sure of myself I guess.</p> <p>I knew nothing about moving until the day I was getting released. My fiancé told me on the telephone that he and dad had a chat.</p> <p>I was freaking out and had a panic attack in the hospital.</p> <p>It is weird because I know I can make my own decisions but I almost feel like I don't know how.</p>

<p>Emotional Deprivation (ED)</p>	<p>Expectation that one's desire for a normal degree of emotional support will not be adequately met by others. The three major forms of deprivation are:</p> <p>A. deprivation of Nurture: Absence of attention, affection, warmth, or companionship.</p> <p>B. Deprivation of Empathy: Absence of understanding, listening, self-disclosure, or mutual sharing or feelings from others.</p> <p>C. Deprivation of Protection: Absence of strength, direction, or guidance from others.</p>	<p>A lack of warmth, and lack of understanding (father).</p>
<p>Enmeshment (EM)</p>	<p>Excessive emotional involvement and closeness with one or more significant others (often parents), at the expense of full individuation or normal social development. Often involves the belief that at least one of the enmeshed individuals cannot survive or be happy without the constant support of the other. May also include feelings of being smothered by, or fused with, others or insufficient individual identity. Often experienced as a feeling of emptiness and floundering, having no direction, or in extreme cases questioning one's existence.</p>	<p>Mom and I have a really good relationship. We talk every day. I still share everything with her.</p> <p>I don't know what happened if anything but it did start of slew of mistrust between my parents and I would consistently hear from my mom what my dad was doing and consistently hearing from my dad what my mom was doing and it was constantly back and forth. I was like the person that could hear everybody's garbage because no one else would listen or they didn't feel comfortable talking to anybody.</p> <p>I have a lack of separate identity. With him, he listened to country music so I listened to country music.</p>

		I don't think I have changed the lacking separate identity. I am working on it. I kind of lose it and then I get stuck into it and then I start feeling miserable, and I am like why am I feeling and I figure out oh I am acting like what the other person is acting like and I gotta get out of there.
Entitlement (ET)	The belief that one is superior to other people; entitled to special rights and privileges; or not bound by the rules of reciprocity that guide normal social interactions. Often involves insistence that one should be able to do or have whatever one wants, regardless of what is realistic, what others consider reasonable, or the cost to others; or an exaggerated focus on superiority (being among the most successful, famous, wealthy) in order to achieve power or control (not primarily for attention or approval). Sometimes includes excessive competitiveness toward, or domination of others: asserting one's power, forcing one's point of view, or controlling the behavior of others in line with one's own desires – without empathy or concern for others' needs or feelings	
Insufficient Self Control (IS)	Pervasive difficulty or refusal to exercise sufficient self-control and frustration tolerance to achieve one's personal goals, or to restrain	A couple of instances I have dissociated during the day and ended up in places where I have no idea how I got there.

	<p>the excessive expression or one's emotions and impulses. In its milder form, patient presents with an exaggerated emphasis on discomfort-avoidance: avoiding pain, conflict, confrontation, responsibility, or overexertion—at the expense of personal fulfillment, commitment, or integrity.</p>	<p>And it is kind of out of my control, something I can't control and it like some days I am good about it where I will follow my little routine, whatever. And some days I don't know it just gets to me.</p> <p>And I start, gotta do this, and immediately it starts and it is right there and there is no stopping me.</p>
Mistrust/Abuse (MA)	<p>The expectation that others will hurt, abuse, humiliate, cheat, lie, manipulate, or take advantage. Usually involves the perception that the harm is intentional or the result of unjustified and extreme negligence. May include the sense that one always ends up being cheated relative to others or “getting the short end of the stick.”</p>	<p>The time I spend with him now is all in protected settings.</p> <p>My first boyfriend was my first kiss, my first a lot of things and he kind of took advantage of my – I was naïve I think he took advantage of me in a lot of ways.</p> <p>The way he was treating me I did not feel was matching what he was saying.</p> <p>I won't ask advice from certain people because I know I will get what I don't really want to hear or get a what you should do answer.</p>
Subjugation (SB)	<p>Excessive surrendering of control to others because one feels coerced – usually to avoid anger, retaliation or abandonment. The two major forms of subjugation are:</p>	

	<p>A. Subjugation of Needs: Suppression of one’s preferences, decisions, and desires.          B. Subjugation of Emotions: Suppression of emotional expression, especially anger.          Usually involves the perception that one’s own desires, opinions, and feelings are not valid or important to others. Frequently presents as excessive compliance, combined with hypersensitivity to feeling trapped. Generally leads to a build up of anger, manifested in maladaptive symptoms (e.g., passive-aggressive behavior, uncontrolled outbursts of temper, psychosomatic symptoms, withdrawal of affection, “acting out” substance abuse.</p>	
<p>Social Isolation/Alienation (SI)</p>	<p>The feeling that one is isolated from the rest of the world, different from other people, and/or not part of any group or community.</p>	<p>My dad, different from other people I think both and not part of a group or community, my dad.</p> <p>Maybe different from other people. You don’t understand me, neither do I.</p> <p>I was not very social – didn’t like to be around people because I always felt fat and unacceptable.</p> <p>I still lack a lot of social stuff. I still don’t like to go out or do things. I like to hide and am very uncomfortable in the way my body looks right now.</p>
<p>Self Sacrifice (SS)</p>	<p>Excessive focus on voluntarily meeting the</p>	<p>I put others before myself.</p>



	<p>needs of others in daily situations, at the expense of one's own gratification. The most common reasons are: to prevent causing pain to others; to avoid guilt from feeling selfish; or to maintain the connection with others perceived as needy. Often results from an acute sensitivity to the pain of others. Sometimes leads to a sense that one's own needs are not being adequately met and to resentment of those who are taken care of. (overlaps with sense of co-dependency)</p>	
<p>Emotional inhibition (EI)</p>	<p>The excessive inhibition of spontaneous action, feeling or communication – usually to avoid disapproval by others, feelings of shame, or losing control of one's impulses. The most common areas of inhibition involve: (a) inhibition of anger &amp; aggression, (b) inhibition of positive impulses (e.g. joy, affection, sexual excitement, play); (c) difficulty expressing vulnerability or communicating freely about one's feelings, needs, etc., or (d) excessive emphasis on rationality while disregarding emotions.</p>	<p>I didn't cry for years about that.</p> <p>To control my emotions.</p> <p>I think I continued to binge, purge, binge, purge cause I didn't want to deal with the emotions that were coming on so I began relying more on food to feel better.</p> <p>I didn't want to deal with the emotions that were coming on so I began relying more on the food to feel better.</p> <p>I think a lot I was just numb. In elementary school I was close to people and one minute they are your friends, and the next minute they are not.</p>

		So if someone said something mean to me or whatever, flush it down the toilet.
Failure to achieve (FA)	The belief that one has failed, will inevitably fail, or is fundamentally inadequate relative to one's peers, in areas of achievement (school, career, sports, etc). Often involves beliefs that one is stupid, inept, untalented, ignorant, lower in status, less successful than others, etc.	Not standing up for myself, inadequate, failure, stupid.  Failure still stands out.
Unrelenting standards/Hyper-criticalness (US)	The underlying belief that one must strive to meet very high internalized standards of behavior and performance, usually to avoid criticism. Typically results in feelings of pressure or difficulty slowing down; and in hypercriticalness toward oneself and others. Most involve significant impairment in: pleasure, relaxation, health, self-esteem, sense of accomplishment, or satisfying relationships.  Unrelenting standards typically present as (a) perfectionism, inordinate attention to detail, or an underestimate of how good one's own performance is relative to the norm; (b) rigid rules and "shoulds" in many areas of life, including unrealistically high moral, ethical, cultural, or religious precepts; or (c) preoccupation with time and efficiency, so that	I am driven. I am very driven, compulsive.  But when I set my mind to do something I do get it done. Sometimes I will sacrifice everything physically and mentally whatever and ends up in a mess.  I took that way to the max, over 500 miles that summer and that is when I ended up in the hospital.  You are looking good. You are running really fast and I was pushed to even do better than that. And so of course I wanted to succeed and thought losing a few pounds although I had lost a few running so the more I ran the more I lost. So at first it was a total runner's high. I was number one on the team. Compliments still were coming because I continued to lose weight and that summer after cross country

	more can be accomplished.	and track my coach challenged me to run more than he did. I took that way to the max, over 500 miles that summer and that is when I ended up in the hospital.
Vulnerability to harm (VH)	Exaggerated fear that imminent catastrophe will strike at any time and that one will be unable to prevent it. Fears focus on one or more of the following: (a) medical catastrophe: e.g., heart attacks, AIDS; (b) emotional catastrophes e.g., going crazy (c) external catastrophes; e.g. elevators collapsing, victimized by criminals, airplanes crashes, earthquakes.	
Approval-seeking/Recognition-seeking (AS)	Excessive emphasis on gaining approval, recognition, or attention from other people, or fitting in, at the expense of developing a secure and true sense of self. One's sense of esteem is dependent primarily on the reactions of others rather than one's own natural inclinations. Sometimes includes an overemphasis on status, appearance, social acceptance, money, or achievement – as mean of gaining approval, admiration, or attention (not primarily for power or control). Frequently results in major life decisions that are inauthentic or unsatisfying; or in hypersensitivity to rejection.	I was driven more by wanting to be accepted. I went to a small school and I had trouble with relationships and stuff, not really fitting in.
Negativity/Pessimism (NP)	A pervasive, lifelong focus on the negative aspects of life (pain, death, loss,	

	<p>disappointment, conflict, guilt, resentment, unsolved problems, potential mistakes, betrayal, things that could go wrong, etc) while minimizing or neglecting the positive or optimistic aspects. Usually includes an exaggerated expectation – in a wide range of work, financial, or interpersonal situations – that things will ultimately fall apart. Usually</p>	
Punitiveness (PU)	<p>The belief that people should be harshly punished for mistakes. Involves the tendency to be angry, intolerant, punitive, and impatient with those people (including oneself) who do not meet one's expectations or standards. Usually includes difficulty forgiving mistakes in oneself or others, because of a reluctance to consider extenuating circumstances, allow for human imperfection or empathize with feelings.</p>	

Appendix O  
Coding  
Monica  
Anorexia Nervosa

Category	Definition	Participant Statement
Abandonment/Instability (AB)	The perceived instability or unreliability of those available for support and connection. Involves the sense that significant others will not be able to continue providing emotional support, connection, strength, or practical protection because they are emotionally unstable and unpredictable, unreliable, or erratically present; because they will die imminently; or because they will abandon the patient in favor of someone better.	
Defectiveness/Shame (DS)	The feeling that one is defective, bad, unwanted, inferior, or invalid in important respects; or that one would be unlovable to significant others if exposed. May involved hypersensitivity to criticism, rejection, and blame; self-consciousness, comparisons, and insecurity around others; or a sense of shame regarding one's perceived flaws. These flaws may be private (e.g. selfishness, angry impulses, unacceptable sexual desires) or public (undesirable physical appearance, social	<p>Hello, she is a control freak. I would get into trouble for putting a spoon in the wrong drawer. And we probably did it multiple times. But putting it in the wrong drawer would piss her off. She just believed this is where things go and you don't put them anywhere else. If I didn't read the recipe right then I didn't know how to cook</p> <p>If I had eaten a little bit of fat I might still feel guilty about it.</p>

	awkwardness).	
Dependence/Incompetence (DI)	Belief that one is unable to handle one's everyday responsibilities in a competent manner, without considerable help from others (e.g., take care of oneself, solve daily problems, exercise good judgment, tackle new tasks, make good decisions). Often presents as helplessness.	<p>I find that I have a hard time making decisions without – not that I have to consult her but I have to consult somebody. So I feel like okay I can't make that decision. A \$3.00 shirt sometimes can be hard and I think this is ridiculous I shouldn't have to call my mom to buy a \$3.00 shirt. Just by the frickin shirt.</p> <p>Because being in an eating disorder facility I don't feel equipped to do what I am doing quite yet and so I still have a lot of anxiety about am I doing this the right way?</p> <p>And I -- the problem is I felt horrible for doing it like that. And I ended up talking to one of the therapists about it because I felt so bad I had done that. That was so triggering. And the I am like, I don't know what the heck I am doing.</p>
Emotional Deprivation (ED)	<p>Expectation that one's desire for a normal degree of emotional support will not be adequately met by others. The three major forms of deprivation are:</p> <p>A. deprivation of Nurture: Absence of attention, affection, warmth, or companionship.</p> <p>B. Deprivation of Empathy: Absence of understanding, listening, self-disclosure, or mutual sharing or feelings from others.</p>	<p>Our relationship is good but it is not what I want with him sometimes. He would never call me.</p> <p>We didn't know how to stand up to her. Because she is a rooster. The "you" are all wrong type.</p>

	C. Deprivation of Protection: Absence of strength, direction, or guidance from others.	
Enmeshment (EM)	Excessive emotional involvement and closeness with one or more significant others (often parents), at the expense of full individuation or normal social development. Often involves the belief that at least one of the enmeshed individuals cannot survive or be happy without the constant support of the other. May also include feelings of being smothered by, or fused with, others or insufficient individual identity. Often experienced as a feeling of emptiness and floundering, having no direction, or in extreme cases questioning one's existence.	
Entitlement (ET)	The belief that one is superior to other people; entitled to special rights and privileges; or not bound by the rules of reciprocity that guide normal social interactions. Often involves insistence that one should be able to do or have whatever one wants, regardless of what is realistic, what others consider reasonable, or the cost to others; or an exaggerated focus on superiority (being among the most successful, famous, wealthy) in order to achieve power or control (not primarily for attention or approval). Sometimes includes excessive competitiveness toward, or domination of others: asserting one's power, forcing one's point of view, or	

	controlling the behavior of others in line with one's own desires – without empathy or concern for others' needs or feelings	
Insufficient Self Control (IS)	Pervasive difficulty or refusal to exercise sufficient self-control and frustration tolerance to achieve one's personal goals, or to restrain the excessive expression or one's emotions and impulses. In its milder form, patient presents with an exaggerated emphasis on discomfort-avoidance: avoiding pain, conflict, confrontation, responsibility, or overexertion—at the expense of personal fulfillment, commitment, or integrity.	
Mistrust/Abuse (MA)	The expectation that others will hurt, abuse, humiliate, cheat, lie, manipulate, or take advantage. Usually involves the perception that the harm is intentional or the result of unjustified and extreme negligence. May include the sense that one always ends up being cheated relative to others or “getting the short end of the stick.”	
Subjugation (SB)	Excessive surrendering of control to others because one feels coerced – usually to avoid anger, retaliation or abandonment. The two major forms of subjugation are: A. Subjugation of Needs: Suppression of one's preferences, decisions, and desires. B. Subjugation of Emotions: Suppression of emotional expression, especially anger. Usually	



	involves the perception that one's own desires, opinions, and feelings are not valid or important to others. Frequently presents as excessive compliance, combined with hypersensitivity to feeling trapped. Generally leads to a build up of anger, manifested in maladaptive symptoms (e.g., passive-aggressive behavior, uncontrolled outbursts of temper, psychosomatic symptoms, withdrawal of affection, "acting out" substance abuse.	
Social Isolation/Alienation (SI)	The feeling that one is isolated from the rest of the world, different from other people, and/or not part of any group or community.	
Self Sacrifice (SS)	Excessive focus on voluntarily meeting the needs of others in daily situations, at the expense of one's own gratification. The most common reasons are: to prevent causing pain to others; to avoid guilt from feeling selfish; or to maintain the connection with others perceived as needy. Often results from an acute sensitivity to the pain of others. Sometimes leads to a sense that one's own needs are not being adequately met and to resentment of those who are taken care of. (overlaps with sense of co-dependency)	
Emotional inhibition (EI)	The excessive inhibition of spontaneous action, feeling or communication – usually to avoid disapproval by others, feelings of shame, or losing control of one's impulses. The most	Sophomore year I dropped back down because I did rush and something terrible – they didn't let my best friend in. And had I been the person then that I am today I would have just said forget you

	<p>common areas of inhibition involve: (a) inhibition of anger &amp; aggression, (b) inhibition of positive impulses (e.g. joy, affection, sexual excitement, play); (c) difficulty expressing vulnerability or communicating freely about one's feelings, needs, etc., or (d) excessive emphasis on rationality while disregarding emotions.</p>	<p>guys but I dropped back down to 95.</p> <p>Controlled my weight, ah controlled my emotions, I probably by not eating I probably controlled not my school work, but it was just another way it controlled everything. It was one of the things I was disciplined about. But probably more so my emotions were in control.</p>
Failure to achieve (FA)	<p>The belief that one has failed, will inevitably fail, or is fundamentally inadequate relative to one's peers, in areas of achievement (school, career, sports, etc). Often involves beliefs that one is stupid, inept, untalented, ignorant, lower in status, less successful than others, etc.</p>	
Unrelenting standards/Hyper-criticalness (US)	<p>The underlying belief that one must strive to meet very high internalized standards of behavior and performance, usually to avoid criticism. Typically results in feelings of pressure or difficulty slowing down; and in hypercriticalness toward oneself and others. Most involve significant impairment in: pleasure, relaxation, health, self-esteem, sense of accomplishment, or satisfying relationships.</p> <p>Unrelenting standards typically present as (a) perfectionism, inordinate attention to detail, or an underestimate of how good one's own performance is relative to the norm; (b) rigid</p>	<p>I am already a perfectionist and very controlling. I am very organized can be detail oriented.</p> <p>I didn't know how to not I was just stuck on the calories and my through process was almost like this obsession to not go over a certain amount of calories...to be a certain size.</p> <p>But part of my thinking about perfectionism and controlling was that this thing was something I could control in my life, because I didn't know at that time how to cope.</p> <p>I was obsessed with calories and stuff.</p>

	<p>rules and “shoulds” in many areas of life, including unrealistically high moral, ethical, cultural, or religious precepts; or (c) preoccupation with time and efficiency, so that more can be accomplished.</p>	<p>But I remember looking at the calories and being obsessed about it. I wrote down how many calories were one point.</p> <p>Let’s investigate like 10 vacuums and then decide which one to buy. You don’t want to spend money on crappy stuff.</p> <p>Because of my mom I am the way I am. The things that piss me off or create anxiety in me or I have realized just recently, or frustrate me, actually frustrated her.</p> <p>It is more of a way to control something and a way to cope. It is very much was a way to a I can control this.</p> <p>I had great discipline. I could be skinny.</p> <p>I do the check book now. I can’t let it go.</p> <p>I have loosened my grip on some things. Just because I had to if I didn’t I wouldn’t.</p> <p>I want to do the best job, and the best job to me is that you have all the information.</p>
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Vulnerability to harm (VH)	Exaggerated fear that imminent catastrophe will strike at any time and that one will be unable to prevent it. Fears focus on one or more of the following: (a) medical catastrophe: e.g., heart attacks, AIDS; (b) emotional catastrophes e.g., going crazy (c) external catastrophes; e.g. elevators collapsing, victimized by criminals, airplanes crashes, earthquakes.	My fear was I never wanted to be sent away. I didn't want to do anything that would get me sent away. Literally like terror was I don't want to be sent away.
Approval-seeking/Recognition-seeking (AS)	Excessive emphasis on gaining approval, recognition, or attention from other people, or fitting in, at the expense of developing a secure and true sense of self. One's sense of esteem is dependent primarily on the reactions of others rather than one's own natural inclinations. Sometimes includes an overemphasis on status, appearance, social acceptance, money, or achievement – as mean of gaining approval, admiration, or attention (not primarily for power or control). Frequently results in major life decisions that are inauthentic or unsatisfying; or in hypersensitivity to rejection.	<p>I dropped the weight... and I slipped back into counting calories and I kept it under 100. And I remember people making comments...if I just had you discipline if I just had your body...it was pretty much an identity thing for me. It wasn't about body image it was about the fact that oh look they think I am really in control.</p> <p>Oh yeah people fed the disease.</p> <p>And you it was pretty much an identity thing for me.</p> <p>It wasn't about body image it was about the fact that oh look they think I am really in control.</p> <p>Q: Are you a people pleaser A: It depends on who the person is professionally yes.</p>

Negativity/Pessimism (NP)	A pervasive, lifelong focus on the negative aspects of life (pain, death, loss, disappointment, conflict, guilt, resentment, unsolved problems, potential mistakes, betrayal, things that could go wrong, etc) while minimizing or neglecting the positive or optimistic aspects. Usually includes an exaggerated expectation – in a wide range of work, financial, or interpersonal situations – that things will ultimately fall apart. Usually	
Punitiveness (PU)	The belief that people should be harshly punished for mistakes. Involves the tendency to be angry, intolerant, punitive, and impatient with those people (including oneself) who do not meet one's expectations or standards. Usually includes difficulty forgiving mistakes in oneself or others, because of a reluctance to consider extenuating circumstances, allow for human imperfection or empathize with feelings.	

Appendix P  
 Coding  
 Andrea  
 Anorexia Nervosa

Category	Definition	Participant Statement
<p>Abandonment/Instability (AB)</p>	<p>The perceived instability or unreliability of those available for support and connection. Involves the sense that significant others will not be able to continue providing emotional support, connection, strength, or practical protection because they are emotionally unstable and unpredictable, unreliable, or erratically present; because they will die imminently; or because they will abandon the patient in favor of someone better.</p>	<p>A fear of losing a family member. Him not loving me, no caring about me. And just that sense of rejection. Always a feeling of rejection.</p> <p>I was in seventh grade and a family friend that went to school with us, his parents were friends of my parents, made jokes about me being adopted and that I wasn't loved and I was given up and I was found in a dumpster.</p> <p>It had a profound affect on me that I wasn't loved. I started questioning my place in the world and trying to understand why anybody would want to give you up and not understanding.</p> <p>Not knowing what to expect. Not knowing how I would react to them or how they would react to me and the fear of being rejected. Because that to me would horrifying.</p> <p>I was hurt. I was hurt cause I really felt rejected.</p>

		<p>So that is where a lot of this whole rejection came into play. Abandonment and not love and trying to find my place although I always had a place. That one incident in middle school caused me to – it had a profound effect on me. That kid telling me I wasn't wanted.</p> <p>Because I didn't want to loose them. I didn't want them to not love me. So I had to be there for him at all costs. At all costs.</p> <p>I couldn't understand why he would want to go away to school and not be here with me.</p> <p>So I feel like she, when I call her up and she doesn't want to talk to me. I feel like she is rejecting me.</p>
Defectiveness/Shame (DS)	The feeling that one is defective, bad, unwanted, inferior, or invalid in important respects; or that one would be unlovable to significant others if exposed. May involved hypersensitivity to criticism, rejection, and blame; self-consciousness, comparisons, and insecurity around others; or a sense of shame regarding one's perceived flaws. These flaws may be private (e.g. selfishness, angry impulses, unacceptable sexual desires) or public (undesirable physical appearance, social	I started questioning my place in the world and trying to understand why anybody would want to give you up. Then I started believing that she didn't love me, I wasn't good enough

	awkwardness).	
Dependence/Incompetence (DI)	Belief that one is unable to handle one's everyday responsibilities in a competent manner, without considerable help from others (e.g., take care of oneself, solve daily problems, exercise good judgment, tackle new tasks, make good decisions). Often presents as helplessness.	
Emotional Deprivation (ED)	Expectation that one's desire for a normal degree of emotional support will not be adequately met by others. The three major forms of deprivation are: A. deprivation of Nurturance: Absence of attention, affection, warmth, or companionship. B. Deprivation of Empathy: Absence of understanding, listening, self-disclosure, or mutual sharing or feelings from others. C. Deprivation of Protection: Absence of strength, direction, or guidance from others.	They were always proud of me but never wanted to tell me that.
Enmeshment (EM)	Excessive emotional involvement and closeness with one or more significant others (often parents), at the expense of full individuation or normal social development. Often involves the belief that at least one of the enmeshed individuals cannot survive or be happy without the constant support of the other. May also include feelings of being smothered by, or fused with, others or insufficient	I was that girlfriend that I had to be with him 24/. My world revolved around him. I would give up anything and everything to make sure that I could be with him.  I continued because he wasn't here. And I had nothing for myself. Everything was around him, and everything was around my parents.



	individual identity. Often experienced as a feeling of emptiness and floundering, having no direction, or in extreme cases questioning one's existence.	
Entitlement (ET)	The belief that one is superior to other people; entitled to special rights and privileges; or not bound by the rules of reciprocity that guide normal social interactions. Often involves insistence that one should be able to do or have whatever one wants, regardless of what is realistic, what others consider reasonable, or the cost to others; or an exaggerated focus on superiority (being among the most successful, famous, wealthy) in order to achieve power or control (not primarily for attention or approval). Sometimes includes excessive competitiveness toward, or domination of others: asserting one's power, forcing one's point of view, or controlling the behavior of others in line with one's own desires – without empathy or concern for others' needs or feelings	
Insufficient Self Control (IS)	Pervasive difficulty or refusal to exercise sufficient self-control and frustration tolerance to achieve one's personal goals, or to restrain the excessive expression of one's emotions and impulses. In its milder form, patient presents with an exaggerated emphasis on discomfort-	

	<p>avoidance: avoiding pain, conflict, confrontation, responsibility, or overexertion—at the expense of personal fulfillment, commitment, or integrity.</p>	
<p>Mistrust/Abuse (MA)</p>	<p>The expectation that others will hurt, abuse, humiliate, cheat, lie, manipulate, or take advantage. Usually involves the perception that the harm is intentional or the result of unjustified and extreme negligence. May include the sense that one always ends up being cheated relative to others or “getting the short end of the stick.”</p>	<p>But he was very abusive growing up. To my mom physically and verbally. Verbally and emotionally to me.</p> <p>He knew that was one way to get to her.</p> <p>So I refused to live like that, I refused. The biggest impact was that I would go an get my education and I wouldn't have to rely on anybody to take care of me. I would be able to support myself no matter what and that was the most important thing to me.</p> <p>I don't trust too many people because somewhere along the line they are going to hurt me. They going to reject me.</p> <p>What my dad did to my mom. What he put me through. I don't trust my dad, even today. I don't trust him. I don't trust he will always be that way.</p>
<p>Subjugation (SB)</p>	<p>Excessive surrendering of control to others because one feels coerced – usually to avoid anger, retaliation or abandonment. The two major forms of subjugation are:</p>	

	<p>A. Subjugation of Needs: Suppression of one's preferences, decisions, and desires.</p> <p>B. Subjugation of Emotions: Suppression of emotional expression, especially anger. Usually involves the perception that one's own desires, opinions, and feelings are not valid or important to others. Frequently presents as excessive compliance, combined with hypersensitivity to feeling trapped. Generally leads to a build up of anger, manifested in maladaptive symptoms (e.g., passive-aggressive behavior, uncontrolled outbursts of temper, psychosomatic symptoms, withdrawal of affection, "acting out" substance abuse.</p>	
Social Isolation/Alienation (SI)	The feeling that one is isolated from the rest of the world, different from other people, and/or not part of any group or community.	
Self Sacrifice (SS)	Excessive focus on voluntarily meeting the needs of others in daily situations, at the expense of one's own gratification. The most common reasons are: to prevent causing pain to others; to avoid guilt from feeling selfish; or to maintain the connection with others perceived as needy. Often results from an acute sensitivity to the pain of others. Sometimes leads to a sense that one's own needs are not being adequately met and to resentment of those who are taken care of. (overlaps with	<p>I was the person he dumped on. I was the person call at 5:00 in the morning every time he was allowed to use the telephone I was that person.</p> <p>Q: When your brother was call from jail you said you were the one he called but you were also the one who answered, so did you struggle at all placing boundaries around his taking advantage of you. A: Oh absolutely. I had no boundaries.</p> <p>I sacrificed my education to try and be there for my</p>

	sense of co-dependency)	<p>family.</p> <p>I had nothing I had lost all my goals, I had lost everything. Everything was around everyone else.</p> <p>And of course that was probably one of my biggest fears is that my parents would be hurt. The last thing I wanted was to hurt them.</p> <p>At first I was very understanding because I was really trying to put myself in her place because that is the only way I am going to get through this without having a heart attack. And I kept thinking how she must feel. What she might think. That what would she want. So I was really trying to think of it from her perspective.</p> <p>And I didn't want her to feel to much of the emptiness because I didn't want to scare her away.</p>
Emotional inhibition (EI)	The excessive inhibition of spontaneous action, feeling or communication – usually to avoid disapproval by others, feelings of shame, or losing control of one's impulses. The most common areas of inhibition involve: (a) inhibition of anger & aggression, (b) inhibition of positive impulses (e.g. joy, affection, sexual excitement, play); (c) difficulty expressing	

	vulnerability or communicating freely about one's feelings, needs, etc., or (d) excessive emphasis on rationality while disregarding emotions.	
Failure to achieve (FA)	The belief that one has failed, will inevitably fail, or is fundamentally inadequate relative to one's peers, in areas of achievement (school, career, sports, etc). Often involves beliefs that one is stupid, inept, untalented, ignorant, lower in status, less successful than others, etc.	
Unrelenting standards/Hyper-criticalness (US)	<p>The underlying belief that one must strive to meet very high internalized standards of behavior and performance, usually to avoid criticism. Typically results in feelings or pressure or difficulty slowing down; and in hypercriticalness toward oneself and others. Most involve significant impairment in: pleasure, relaxation, health, self-esteem, sense of accomplishment, or satisfying relationships.</p> <p>Unrelenting standards typically present as (a) perfectionism, inordinate attention to detail, or an underestimate of how good one's own performance is relative to the norm; (b) rigid rules and "shoulds" in many areas of life, including unrealistically high moral, ethical, cultural, or religious precepts; or (c) preoccupation with time and efficiency, so that</p>	<p>I need to be perfect.</p> <p>So I had to in my mind create the perfect letter.</p> <p>And so it took me probably three days to write the letter. And I literally wrote, and wrote, and re-wrote and I threw away and it had the perfect paper, it had to be the perfect pen, the handwriting had to be perfect.</p> <p>For the next two years I spent every time the phone I became obsessed with who was calling. If I was unavailable I always answered it. It was an obsessed with who was calling. If I was unavailable I always answered it. If it was a number I didn't know I answered it. If they hung up on me I would go online and research trying to find them. I went as far as to find where they lived, how far that</p>

	more can be accomplished.	would be from me. Was it possible that they could have been who it was. It was insane. It was awful. Every birthday I just knew she was going to call.)
Vulnerability to harm (VH)	Exaggerated fear that imminent catastrophe will strike at any time and that one will be unable to prevent it. Fears focus on one or more of the following: (a) medical catastrophe: e.g., heart attacks, AIDS; (b) emotional catastrophes e.g., going crazy (c) external catastrophes; e.g. elevators collapsing, victimized by criminals, airplanes crashes, earthquakes.	<p>I was always very careful. ...I did not want to have to go through what they went through. Because I think my dad was abusive to them physically now that I look back at it as an adult.</p> <p>...because I was scared to do anything wrong. So I tried to be the model child.</p> <p>I was determined to never be involved with anybody like him. I would not date anybody who would drink to access or I felt my boyfriend ever got intoxicated.</p>
Approval-seeking/Recognition-seeking (AS)	Excessive emphasis on gaining approval, recognition, or attention from other people, or fitting in, at the expense of developing a secure and true sense of self. One's sense of esteem is dependent primarily on the reactions of others rather than one's own natural inclinations. Sometimes includes an overemphasis on status, appearance, social acceptance, money, or achievement – as mean of gaining approval, admiration, or attention (not primarily for power or control). Frequently results in major life decisions that are inauthentic or	<p>Because she was going to judge me based on this.</p> <p>I continued to battle with eating because it was still that he is trying to live his life and do what he wanted to do and he still wasn't take care of me the way I wanted him to. If I gained weight he would want me.</p>

	unsatisfying; or in hypersensitivity to rejection.	
Negativity/Pessimism (NP)	A pervasive, lifelong focus on the negative aspects of life (pain, death, loss, disappointment, conflict, guilt, resentment, unsolved problems, potential mistakes, betrayal, things that could go wrong, etc) while minimizing or neglecting the positive or optimistic aspects. Usually includes an exaggerated expectation – in a wide range of work, financial, or interpersonal situations – that things will ultimately fall apart. Usually	
Punitiveness (PU)	The belief that people should be harshly punished for mistakes. Involves the tendency to be angry, intolerant, punitive, and impatient with those people (including oneself) who do not meet one’s expectations or standards. Usually includes difficulty forgiving mistakes in oneself or others, because of a reluctance to consider extenuating circumstances, allow for human imperfection or empathize with feelings.	

## Appendix Q

## Auditor Background Information

I have been a counselor for the past five years and have been licensed in the State of Florida as a Mental Health Counselor for approximately 2 years (LMHC # 9747). My work has included serving as a counselor for the Counseling Center at the University of South Florida Polytechnic, as Adjunct Professor with the College of Education also at the University of South Florida Polytechnic and now currently as a private practitioner.

My knowledge of eating disorders is modest. I did however, during the course of my master's work conduct community based research into the accessibility for treatment for eating disordered individuals within the Polk County vicinity.

I have no personal interest in the outcome of Ms Hurley's research. My association with her stems from working together within the Counseling Center.

This is my first experience for an auditor for a dissertation

Sincerely,

Cara M. Hewett, Licensed Mental Health Counselor



## Appendix R

## Letter of Attestation

February 20, 2010

To Whom It May Concern,

My instruction was to assume the responsibility of auditor for the dissertation of Susan Hurley, doctoral candidate with the Division of Psychological and Social Foundations, Division of Counselor Education in the College of Education at the University of South Florida. My role as auditor was to ensure dependability, confirmability, and credibility of the findings in this doctoral dissertation. Ms Hurley's study focused on maladaptive schema associated with anorexia nervosa, bulimia nervosa and compulsive overeating resulting in obesity.

My roles and responsibilities as auditor of this dissertation were: 1) to review and verify the data gathered from the research participants and 2) to attest to having done so.

The steps I followed in the audit process were as follows:

- Familiarized myself with the study by reading Chapter Three of the dissertation proposal.
- Familiarized myself with the responsibilities of an auditor by meeting with Ms Hurley to discuss her expectations.
- Developed an understanding of the Young's (2003) maladaptive schema and coding criteria established by Ms Hurley.
- Read the interviews of the 10 research participants.
- Ensured dependability by examining the process of inquiry, i.e., the questions asked of each participant, responses by the researcher, as well as the product, i.e., data, findings, and interpretations of the researcher.
- Ensured confirmability by, examining analytical techniques used by the researcher, agreeing upon appropriateness of coding labels, discussing interpretations of the participant's responses, and assessing for researcher bias. Made notes while reading the interviews and shared notes with Ms Hurley.
- Ensured credibility by providing peer debriefing to the researcher. We talked on the phone and in person on several occasions exploring her findings, clarifying interpretations of the data, and discussing the overall process of her study.

I was able to find and confirm dependable the research findings that Ms Hurley reported. No inconsistencies, illogical inferences, or researcher bias were found during the course of this study therefore, making the research credible.

Sincerely,

Cara M. Hewett, Licensed Mental Health Counselor

## About The Author

After graduating from USF with a Master's Degree in Counseling, Susan Hurley accepted a position as Coordinator of the Division of Education at the University of South Florida Polytechnic (USFP). As she began working on campus she became aware of a lack of counseling services for students attending classes at USFP. She found an open office on the campus, and made a proposal to the administration to provide counseling services to students on campus. One of the first clients to seek counseling was a young woman diagnosed with Anorexia Nervosa. Through the process of helping her, Susan became very aware of the difficulties of treating disordered eating. Thus began her interest in researching possible treatment options in order to offer this student the best possible treatment available. This dissertation is the culmination of her research and effort to add to the body of research in the field. Her hope is that the information found in this dissertation will help her and others pursue better treatment options for disordered eating.

Susan continues to work at the University of South Florida Polytechnic. Over the course of eight years she has developed the counseling center, moving it from a quarter time position to a full time position with two mental health counselors seeing students with mental health, substance abuse and other issues. Recently she was named as the Program Director of Student Health and Wellness.