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**Mothers, Daughters, Culture and Criticism:
An Examination of Eating Problems in Adolescent Girls**

by
Melissa Ritter

A dissertation submitted to the Graduate Faculty
in Psychology in partial fulfillment of
the requirements for the degree of Doctor of Philosophy,
The City University of New York

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THE CITY UNIVERSITY OF NEW YORK

MOTHERS, DAUGHTERS, CULTURE AND CRITICISM:
AN EXAMINATION OF EATING PROBLEMS IN ADOLESCENT GIRLS
by
Melissa Ritter

Advisor: Professor Paul L. Wachtel

Maternal domain-specific criticisms of daughter weight and attractiveness have been found to be significant variables with respect to the presence of a more serious eating problem in an adolescent daughter (Pike & Rodin, 1991). The current study of 47 mother-adolescent daughter dyads attempted to replicate and elaborate upon these findings by exploring 1) the relationship between domain-specific and global maternal criticism with respect to degree of daughter eating problem 2) the salience of "cultural criticism"--broadly defined as media messages about weight and body, as well as peer attitudes--in regard to the severity of a girl's eating problem and 3) the adolescent girl's perception of criticism, both maternal and cultural.

Pike & Rodin's (1991) finding that mothers of daughters with more serious eating problems were more critical of their daughters' weight, regardless of whether the daughters were actually overweight, was replicated ($p < .05$). However, in contrast to the findings of Pike & Rodin, the current study found the domain-specific criticism related to a daughter's eating problem was narrowly focussed on weight and did not extend to the domain of overall attractiveness.

Supporting the idea that a daughter can develop a mid-range eating problem without the presence of pervasive psychological difficulty in the mother-daughter dyad, no relationship was found between maternal global criticism and degree of daughter eating problem. It appears that maternal criticism may be limited to the domain of weight when found to relate to the development of a daughter eating problem.

Sensitivity to cultural criticism, in the form of attention and reactivity to media messages regarding weight and body, was found to be correlated with more serious eating problems ($p < .001$), as was self-reported belief that friends thought the subject should lose weight ($p < .001$). The daughters also reported the media's powerful influence on their conception of the ideal body.

The measurement of perceived criticism suggested that mothers and daughters communicate more clearly with respect to maternal weight criticism ($p < .01 - .001$) than criticism of overall attractiveness (ns). This is interpreted as syntonic with the salience of cultural proscriptions on the female body.

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I. Introduction

Many, if not most, women and adolescent girls have some degree of difficulty with issues related to eating and weight (Button & Whitehouse, 1981; Cooper, Waterman and Fairburn, 1984; Kagan & Squires, 1984; Kesges, 1983; Polivy & Herman, 1987). These eating problems span a broad range: from the clinical diagnoses of Anorexia Nervosa and Bulimia Nervosa, through Eating Disorder Not Otherwise Specified, to compulsive eating and/or dieting and obsessional weight preoccupation. The observation that--particularly for women--our cultural norm has become one of a disturbed relationship to food and body (Bloom et al, 1994; Polivy & Herman, 1987) only underscores the need to examine its aetiology with respect to both familial and sociocultural influences.

Within the clinical literature, a disturbed mother-daughter relationship is often implicated in the formation of eating problems (e.g., Bruch, 1979; Palazolli, 1981; Shainess, 1979; Sugarman, 1991). However, eating difficulties are so tethered to Western culture that more recent authors have suggested they be categorized as culture-bound syndromes (King, 1993). It is now quite common to find eating problems understood as at least partially engendered by cultural influences (e.g., Fursland, 1987; Garner et al., 1980; Polivy & Herman, 1987; Wooley & Wooley,

1982; Vandereycken, 1993). The bridge between these ideas is provided by feminist authors who theorize that cultural values are unconsciously passed on through and by the family (Benjamin, 1988; Chodorow, 1978; Orbach, 1984). Mothers-- who, after all, are women themselves and subject to the same proscriptions with respect to body and appetite visited upon their daughters--may identify with their daughters and unwittingly project onto them their anxieties about body size and eating behavior (Bloom et al, 1994; Orbach, 1986).

Self-criticism is a central concept with respect to understanding the form internalized proscriptions assume and thus key to sorting out the complex aetiology of eating problems. Susan Gutwill (1994) states one aspect of the case:

"...women must sculpt themselves into marketable objects to enhance their objective and subjective sense of security...to this end, a central requirement of women's social position is that they develop a critical, self-observing sense about themselves and their appetites...[women have] simply out of self-preservation...had to become hypercritical." (p.6).

To successfully raise a daughter requires that mothers transmit those values and characteristics most adaptive for a female in our culture (Orbach, 1986). Unfortunately, self-criticism is one of these characteristics.

Gutwill (1994) also suggests that culture may be introjected directly without parental mediation. That is, young women may internalize a critical attitude towards their bodies and appetite from the barrage of consumer

images relentlessly beamed at them by the media. This "culture mother" (Kogel as cited in Gutwill, 1994, p.18) may be as instrumental as human mothers in the transmission of eating problems.

While eating problems are clearly embedded in a cultural matrix, they may also represent individual responses to disturbed familial relationships (Bloom et al., 1994; Orbach, 1986; Steiner-Adair, 1986). Since women are enculturated to express a range of negative affect in the language of body dissatisfaction and eating problems (Bloom et al, 1994) it is not surprising that conflict within a mother-daughter dyad--conflict which may arise from an almost infinite variety of sources--would similarly express itself in bodily terms. More specifically, a mother's criticism of her daughter's appearance might be understood as a single manifestation of a more global difficulty within the dyad, as distinct from an unconscious communication about cultural expectation with respect to the feminine form.

Though the clinical literature has long assumed the salience of the mother-daughter relationship with respect to a girl's body image and eating attitudes, there has been surprisingly little research directed at measuring aspects of this relationship as correlates of disturbed eating patterns (Orbach, 1986; Wooley & Wooley, 1985). One of the studies recently attempting to address this paucity of

empirical data is that of Pike & Rodin (1991). Their research specifically targets the mother-adolescent daughter relationship as it intersects with eating problems.

Hypothesizing that mothers unwittingly "operate as society's messengers" (p.198) by applying direct pressure on their daughters to maintain a culturally prized thin physique, Pike & Rodin were able to discriminate five significant predictor variables in connection with the development of eating problems. Two of the five variables indicated that degree of maternal criticism towards daughters with respect to weight and appearance was significantly higher in dyads in which the daughter had an eating problem; two of the variables suggested that degree of maternal eating disturbance predicts the degree of the daughter's eating disturbance. Taken together, these variables point towards a model of intergenerational transmission wherein the mother's anxiety about food and body issues is expressed in domain-specific criticism of her daughter's appearance. In turn, the daughter develops an eating problem, a key feature of which is a harshly critical attitude toward her own body and eating behavior.

The current study intends to both elaborate upon and refine the findings of Pike & Rodin (1991) with respect to the multifaceted relationship between criticism and eating problems. There are three domains of investigation. The first relationship to be examined is that between domain-

specific and more global criticism. The aim is to determine if the critical attitude of the mothers of girls with eating problems found by Pike & Rodin (1991) is limited to the domains of weight and appearance or is part of a more general critical attitude towards their daughters. Any insight gained with respect to domain-specific vs. global criticism will help clarify whether eating problems can develop within a relatively conflict-free dyad in which mother unknowingly functions as a conduit for negative cultural messages about the female body by being critical of her daughter and modeling discomfort with her body and appetite; or whether eating problems are more likely to occur in dyads for whom food and body concerns are but one manifestation of more pervasive difficulty. The data should also clarify the relationship between severity of eating problem and the breadth of criticism within a dyad. It may be that more severe eating problems develop when a disturbed maternal relationship converges with pathological cultural values.

Secondly, the adolescent girl's experience of "culture mother" criticism will be examined. That is, to what extent do adolescent girls with eating problems perceive body and appearance criticism from their peers and the media, the adolescent cultural milieu. Peer criticism is analogous to maternal criticism in that it is here conceived as relatively direct and overt; media criticism is more

oblique, manifesting itself as the presentation of both idealized images of slenderness and methods for achieving this prized physical form.

The adolescent's representation of criticism is the final domain of investigation, encompassing those preceding as well as constituting a distinct area of inquiry. Pike & Rodin (1991) measured the mothers' critical attitude with respect to their daughters' weight and appearance; they did not assess the degree to which the daughters felt criticized. Recent research (Hooley & Teasedale, 1989) has found the perception of a critical attitude towards oneself by a spouse to be a more powerful predictor variable in the relapse of depressed patients than the rating of criticism within the dyad by a trained observer. While this is a narrow finding, it suggests that the internal representation of criticism may be the more potent influence on behavior (Diamond & Doane, 1994).

The investigation of perceived criticism has the potential to illuminate the relationship between maternal attitude and eating problems in two ways: 1) it will provide additional data with respect to the distinction between domain-specific and global criticism; 2) it will enable comparison of the variance accounted for by a mother's critical attitude versus her daughter's perception of that attitude.

Further, while there has been some empirical investigation aimed at measuring the quantity and content of cultural messages regarding body and appetite directed at females (ie, Anderson & Domenico, 1990; Ogletree et al, 1990; Wooley, 1994), there has been very little research focussed on the individual female's experience of this cultural communication, particularly as the reception of these messages converges with eating problems. The examination of perceived cultural criticism, in conjunction with that of perceived maternal criticism, should help to refine our current models of eating problem transmission, whether they feature a human mother, a "culture mother" or some combination of both.

II. Literature Review

Defining Eating Problems

The term "eating problem" is used throughout this study to describe a range of difficulties that include the clinical disorders of Anorexia, Bulimia and Eating Disorder Not Otherwise Specified, as well as compulsive eating patterns and obsessive body/weight preoccupations not currently included in our diagnostic nosology. The characterization of these distressing experiences and behaviors as "problems" and not "disorders" is a deliberate attempt to depathologize difficulties with which the majority of Western women struggle (Cooper, Waterman & Fairburn, 1984; Kagan & Squires, 1984; Klesges, 1983; Polivy & Herman, 1987). As Bordo (1993) points out, given the prevalence of body preoccupation and dieting in the female adolescent population, those who insist on employing terms like "illness" and "disease" (p.64) are effectively labeling a preponderance of adolescent girls as pathological.

Attempts to attenuate the pathologizing of Western female eating behavior are relatively recent. Much of the literature relevant to this study will refer to eating "disorders." Consequently, it is necessary to discuss the relationship between the three clinical classifications of eating problems. This is particularly so because while the literature generally--though not exclusively--attends to one

or the other of the two disorders known as Anorexia and Bulimia, this study will not make such a distinction. As will be outlined below, many of the symptoms are shared by both disorders and the differences, other than those at the most extreme end of the continuum, can be quite murky. This confusion is reflected in many of the instruments developed to assess one or the other disorder as they are commonly used merely to distinguish between disordered and non-disordered subjects without making a more refined diagnostic evaluation (eg. Eating Attitudes Test, Garner & Garfinkel, 1979; Eating Disorder Inventory, Garfinkel et al., 1983; Goldfarb Fear of Fat Scale; Goldfarb, Dykens & Gerard, 1985).

Efforts have been made to address this haziness, particularly with respect to the diagnostic criteria standardized in the DSM-IV (Walsh, 1992). However, while diagnostic categories and criteria have been amended, much overlap and imprecision remains. This continuing difficulty appears to support the notion that separate disorders as such do not exist despite the literature's tacit insistence.

The recently published DSM-IV (APA, 1994) includes two primary and one ancillary category of eating disorder. The major eating disorders are currently defined as Anorexia Nervosa (p. 539) and Bulimia Nervosa (p.545). Two subtypes of Anorexia have been distinguished: Restricting Type and Binge-Eating/Purging Type. These classifications are based

on the specific eating behavior manifested, with the former featuring self-starvation and the latter cycles of rapid, uncontrolled overeating followed by purging behavior (ie, vomiting, laxative use). Similarly, Bulimia has two subtypes: Purging Type and Nonpurging Type. The latter describes a disorder wherein the patient utilizes compensatory behaviors such as excessive exercise or fasting subsequent to binge-eating episodes. Both disorders are characterized by the undue influence of body shape and size on self-evaluation.

The introduction of these subtypes into the eating disorder nosology reflects the increasing evidence that the distinction between Anorexia and Bulimia is not clear-cut, but rather one of symptom primacy--many anorexics binge and purge; bulimics may have periods of dramatically restricted food intake (eg., Halmi, Falk & Schwartz, 1981; Mitchell & Pyle, 1982; Palmer, 1979; Thompson & Schwartz, 1982). It appears that the salient distinction between the two groups is that of body weight. A diagnosis of Anorexia is made when the various behavioral and ideational symptoms are present and body weight is 85% or less of normal weight; those suffering with Bulimia are typically at or above their optimal weight.

Eating Disorder Not Otherwise Specified, the third diagnostic category offered by the DSM-IV (p.550), further blurs the distinction between the primary eating disorder

classifications in that it applies to a variety of symptom configurations that are essentially subclinical expressions of either or both Anorexia and Bulimia. For example, Eating Disorder Not Otherwise Specified is diagnosed when:

"All of the criteria for Anorexia Nervosa are met except that, despite significant weight loss, the individual's current weight is in the normal range" (p.550).

The same diagnosis is made when:

"All of the criteria for Bulimia Nervosa are met except that the binge eating and inappropriate compensatory mechanisms occur at a frequency of less than twice a week or for a duration of less than three months [these being the frequency and duration criteria for Bulimia Nervosa]" (p. 550).

While much of the eating disorder literature typically attends to either Anorexia or Bulimia, it is apparent that these are not such neatly-packaged, discrete syndromes. Thus, in this review I will include material drawn from the literature on both disorders. In order to gain the most richly-textured perspective on what are certainly multi-determined difficulties, it seems wise to cull from all the clinical consideration and empirical data available.

Additionally, as Orbach (1986) contends and Bordo (1993) concurs, there is no precise criterion to distinguish between "normal" and "pathological" eating problems other than arbitrary cut-offs established by those bound to a medical model predisposed towards minimizing cultural context. In this study, eating problems will be conceived of as more or less severe on a continuum presumed relevant for the great majority of Western women. Since the subjects

in this study were recruited from a non-clinical population, this is particularly appropriate.

Mothers, Daughters & Eating Problems (theoretical/clinical literature)

Since one's earliest relationship to mother generally evolves in the context of feeding, it is not surprising that various eating problem theories focus on that which has gone awry between mother and child. Anna Freud (1965) was one of the first to make the infant's food = mother equation explicit and then link it with later eating disturbance. More recent authors have pointed to the particular vulnerability of girls to eating problems because mother and daughter are of the same gender and any difficulties which arise between them may be magnified by the intensity of identification (Bloom et al., 1994; Dana, 1987; Epstein, 1987; Orbach, 1986; Sands, 1991; Shainess, 1979).

Seminal Theoreticians

The thinking of some of the most influential of recent authors considering eating problems has its roots in systems theory. These views focus on the mother-daughter relationship to varying degrees, frequently emphasizing the familial, as opposed to dyadic, transaction. However, particularly in the cases of Hilde Bruch and Mara Selvini Palazzoli, their insight into the mother-daughter

relationship continues to inform research into and treatment of eating problems.

Bruch (1961, 1973, 1979) identifies an impaired capacity to differentiate between demands external to the individual, and one's own impulses, experiences and body awareness as a primary deficiency in both anorexia and compulsive eating. She locates the genesis of this boundary disturbance in the "inaccuracies..[of] the reciprocal feedback patterns in the transactions between mother and child." (1973, p.66). According to Bruch, there has been a failure to transmit essential information to the child with respect to correctly identifying bodily and affective states. More specifically, and simply, the child does not learn to recognize and respond appropriately to hunger.

Bruch discusses the "family frame" (1973, chap. 5) with respect to the aetiology of eating problems and conspicuously includes both parents, as well as siblings, in her consideration. The mother's particular contribution is viewed as largely a function of her customary role as primary caretaker, and thus the most likely to be the child's partner in transactional patterns surrounding food and feeding. For a variety of reasons, ranging from the desire to pacify a rambunctious infant to narcissistic preoccupation resulting in a complete disregard for the infant's appetitive needs, mothers may unwittingly redirect

and compromise the child's adaptive impulses and behavior towards eating.

Palazzoli (1981), who both expands upon and refines Bruch's theory, highlights the "psychopathological body experiences" (p.85) that distinguish both the aetiology and expression of eating problems, specifically anorexia. She suggests that the early caretakers--generally, mothers--of disordered women have impinged upon the child in such a way as to undermine the latter's ability to identify, conceptualize and satisfy her own body needs. The mother insinuates her own conceptions and needs into her daughter's body experience, affect, perceptions and attitudes. Consequently, as the daughter matures and seeks to differentiate herself, her body comes to serve many pathological functions--it is the battleground for the assertion of autonomy; it is identified with the bad object and is thus tormented and rejected; and it serves to concretize her self-loathing in the experience of profound and debilitating body shame.

Palazzoli (1981) later shifted her focus from the mother-daughter dyad to the entire family. Influenced by Jay Haley and his systemic model, Palazzoli came to view eating problems as symptomatic of a familial communication disorder. She did not abandon her earlier position, but rather expanded it to include other family members. This is

made most apparent by the fact that both perspectives are presented in the same volume (1981).

Minuchin (Minuchin, Rosman, Baker, 1978) is an exclusively systems theorist and considers anorexia only in a familial context. He enumerates the characteristics of "the anorexic system" (p.59) which features a highly enmeshed pattern of operation. He notes that the family focus on the identified patient's actions and experience serves to develop a vigilance within and about herself. The family is also highly self-conscious and sensitive to the evaluation of others, further compounding the daughter's watchfulness towards her own actions, as well as those of other family members. According to Minuchin et al, other aspects distinguishing eating problem families include a hidden spouse conflict, the use of the children to detour conflict, a coalition between the children and mother against the father and an overconcern with food.

While the present research is not directly linked to these three seminal theories, they are germane to the extent that they establish a connection between maternal anxiety, the feeding situation and eating problems (Bruch, 1973; Palazzoli, 1981). Minuchin et al (1978) point towards the salience of self-criticism in their description of the identified patient's attitude of vigilance. The self-conscious attitude they have observed in these adolescent girls may be understood as a form of internalized criticism,

while the family's emphasis on appearances suggests a critical attitude directed towards the daughter.

Feminist Perspectives

Since feminism is not a single viewpoint, but a heightened sensitivity to the role of feminine gender within the context of a particular theoretical (or political, critical, etc.) orientation, there is much diversity within the feminist literature with respect to the multidetermination and meaning of women's eating problems. Those perspectives reviewed here are largely influenced by a range of psychodynamic thought. Clearly some of these theories are more speculative than others. They are offered as representative of the variety and complexity of consideration that has been given to women and eating problems, not as empirically validated observations.

What I wish to underscore with respect to these theories is that despite their differences, they are bound by an emphasis on sociocultural expectations and pressures as contributors to the development and maintenance of eating problems. Further, while many include careful examination of the mother-daughter relationship, they strive to keep "mother-blaming" at a minimum and make an active effort to empathize with all parties. As some feminist authors frankly acknowledge (Bloom et al, 1994; Rabinor, 1994) mothers were once daughters themselves and the genetic

aetiology of eating disturbance can be traced back in a (theoretically) endless regression.

Susie Orbach, one of the most influential feminist thinkers currently considering eating problems, believes that the mother-daughter relationship is key to the understanding of these problems and details these views in her classic text on Anorexia, Hunger Strike (1986). Orbach considers the particular problems of eating behavior and body image to emerge within the broader context of women's culturally induced self-dislike, even "disgust" (p.78). She suggests that the mother's intensity of identification with her same-sexed infant inevitably results in the transmission of some negative feelings about being female; feelings which later find expression within the traditional feminine purview of food and body.

According to Orbach, it is primarily within the context of their relationship with their mother that daughters learn gender-appropriate social role. One salient facet of this role is the denial of one's own desire and Orbach argues that this aspect of feminine identity is transmitted to the daughter in both explicit and unconscious ways. Generally falling into the latter category, but sometimes frankly avowed, is the message that is communicated during feeding in infancy. Orbach cites both empirical and clinical evidence pointing towards a discrepancy between the amount male and female infants are fed and the quality of the feed.

Her references suggest that female infants are breast-fed less frequently, are provided shorter feed durations and are weaned earlier than male infants. Orbach links these early experiences of relative denial with accepted feeding patterns for adult females, suggesting that this early mother-daughter communication initiates the construction of a template for the restraint of physical appetite.

Obviously, this particular example of how females are indoctrinated into lives of self-restriction does not hold equally for all mother-daughter dyads. However, Orbach argues that very early on little girls get the message to restrain all manner of appetite, particularly that for food. In adolescence, this issue emerges with renewed intensity. As a mother has herself lived with food and body proscriptions, she is unlikely to feel comfortable with her own form or that of her developing daughter. Her concerns may be projected onto her daughter, translating to an anxious preoccupation with the younger woman's eating behavior.

Clearly influenced by Orbach, and largely in agreement with her views, Bloom et al. (1994) focus and expand upon the object relationships represented in women's connection to food. While much of their work echoes that of Orbach with respect to transmission, it includes some refined analysis with respect to symptom meaning. Bloom and her colleagues argue that one's relationship to food--what is

chosen to eat and how it is eaten--reflects early and ongoing internal object relationships. They write:

"Food represents caretaking in the client's earliest familial arena and in her peer and cultural milieu. How these relationships have been internalized in their primitive, fantasized, and real forms will determine how the client uses food: whether she devours it, spits it out, rejects, avoids, swallows, chews or enjoys it."
(p.97)

One of the key relationships that is represented by and through food is that with mother. Recalling Palazzoli's (1981) notion that the body becomes identified with the bad object, the impinging mother, Bloom et al. suggest that food can become the bad object, the aspect of mother that was unable to gratify or contain in any number of ways. Bloom et al. are more sympathetic in their portrayal of the mother than is Palazzoli. They are clearly attempting the tricky balance of cultural influence and the psychoanalytic.

Similarly straddling two schools of thought, Chernin (1985) presents a creative interpretation of eating problems--an admixture of feminist and Kleinian theory. She suggests that the recent epidemic of eating problems is a result of social change that has, at least superficially, enabled women's lives to widen with possibility. She believes that as women reach maturity and begin to surpass their mothers with respect to achievement and opportunity, they become guiltily aware of the limitations which with their mothers as women of a different generation have had to contend. In order to prevent themselves from surpassing

their mothers--from further damaging their mothers--some daughters develop eating problems to curb future accomplishment, as well as to punish themselves.

This view that eating problems may express an attempt to postpone adulthood and the fantasied betrayal of mother has been suggested in other theories as well (Perlick & Silverstein, 1994; Steiner-Adair, 1986). However, Chernin associates the adult female's current guilt with the guilt of her infancy. She goes on to suggest that women with eating problems have not surmounted the guilt they initially felt as an infant for their fantasied depletion of, and oral aggression towards, their mothers while nursing. The daughter, wishing to preserve her mother from further assault, later turns the aggression towards herself. While ostensibly sparing the mother direct attack, the eating problem symbolizes both the daughter's rage and her need-filled longing. Chernin asserts that male children need not resort to such self-destructive forms of expression because they are able to displace their mother-rage onto other women through acts of sexual domination and female suppression.

Dana (1987) also considers the anxiety accompanying the fear of destroying mother as a contributing factor to the development of eating problems. She suggests that in order to avoid this anxiety, as well as that which accompanies the fear of being abandoned by mother, a compulsive consumption of food is engaged as defense. The food = mother equation

facilitates the fantasy that in eating actual food, the mother as good, nurturing object is providing the care theorized as absent in the earlier stages of life.

This perspective again implicates the mother's identification with her young daughter: because they are of the same gender, a mother is more likely to assume she "knows" what her daughter needs--to over-identify--and thus she will not attend sufficiently to her infant's actual expression of need. This initial struggle with boundaries is later compounded by the fact that women, by virtue of being caretakers, frequently have their time and space controlled by others. That is, women don't often feel a sturdy boundary around themselves from which their families' needs can be appropriately excluded. Consequent to these experiences, women drive the needy part of themselves underground, initially in an attempt to preserve their relationship with mother and later as an accommodation to role expectation. Dana views the assorted eating problems as a spectrum of reactions to this deprivation.

In a view that reframes the connection between the wish to protect/preserve mother and eating problems, Rabinor (1994) asserts that daughters use the restraint of their bodies to maintain loyalty and connection to their mothers. Rabinor believes that daughters with eating problems are motivated by an unconscious desire to remain true to their mothers' values and lifestyles. Through modeling and

admonition the mothers transmit our patriarchal culture's message that a woman's body is her most effective tool with respect to gaining power. In her pursuit of a perfect body, the daughter with an eating problem mirrors her mother's bid for power. In this way the mother-daughter bond is strengthened--while the mother provides her daughter with a way to gain access to the limited power available to women, the daughter honors her mother's struggle. Rabinor agrees with Hancock (1989) that what the daughters want most is to create intimacy and connection with their mothers, as opposed to severing the relationship in a desperate bid for autonomy.

Taking a somewhat different tack than the preceding authors, Epstein (1987) focuses on women's anger as it expresses itself in eating problems. Her view is also distinct from others reviewed here in that it focuses on compulsive eaters who become overweight. She argues that our culture does not allow for the direct expression of female anger and thus women are encouraged to deny and suppress potent negative affect. While women with eating problems--particularly, compulsive eaters--may feel out of control with respect to food, Epstein believes the eating pattern is masking an affect experience which the woman feels even more unable to master: anger.

While not emphasizing the mother-daughter relationship in her analysis, Epstein does suggest that anger and envy

between mother and daughter may be expressed covertly through eating problems. More specifically, she believes that some compulsive eaters are using their fat to repudiate their mothers' demand that they conform to a cultural standard of body weight, while others use their weight to differentiate themselves from an enmeshed--and slim--mother. In agreement with most other authors reviewed here, Epstein believes that a mother may unwittingly act as a conduit for destructive cultural messages about the female body.

What many of these theories agree upon with respect to the mother's role in the transmission of eating problems is that she is not conscious of her impact on her daughter and that she herself has been victimized by cultural censure. Nonetheless, by virtue of identification and maternal concern, her gender-related experiences of anxiety and distress are frequently visited upon her daughter and all too often find expression in problems of food and body.

Mothers, Daughters & Eating Problems (Empirical Research)

As noted earlier, while much of the clinical and theoretical literature points towards some difficulty in the mother-daughter relationship with respect to the aetiology of eating problems, there have been comparatively few systematic, controlled studies of eating problems focussing on this relationship (Orbach, 1986; Wooley & Wooley, 1985).

However, when the data that do exist are pieced together, support for a relatively coherent view begins to emerge.

Infancy and Early Childhood

Much of the theoretical and clinical work just reviewed locates the genesis of later eating problems in a mother-infant feeding relationship that is complicated by gender-related difficulties (ie, over-identification) (Bloom et al, 1994; Bruch, 1961, 1973; Chernin, 1984; Dana, 1987; Orbach, 1986; Palazzoli, 1981). Charone (1982) in a review of work on mother-infant eating behavior and its possible link with adolescent and adult eating problems covers a variety of research that attends to the exquisite sensitivity of the infant within the feeding context. She includes such variables as gaze, holding, tempo and rhythm of the feed, and reciprocity, discussing how each may facilitate or disrupt the feeding experience. With respect to reciprocity, she reports on the finding that this variable differs with respect to infant gender--infant responsivity (orientation/alertness) is higher in females; reactivity (irritability/lability) is higher in males. This suggests that there is a gender-determined distinction in the relational template as it evolves during feeding activity.

Longitudinal data (Marchi & Cohen, 1990) gathered from youngsters ages 1 - 10 through 12 - 20 (a ten year study),

found that girls are more likely to display "picky eating" (p.114) as reported by their mothers and that this is a predictor of later symptoms of Anorexia, an eating disturbance that predominantly afflicts females. Taken with the related finding (Marchi & Cohen, 1990) that early childhood battles at mealtime are associated with elevated levels of food avoidance in adolescence, further support for a model of gender-distinct conflict and/or anxiety about food being related to the development of eating problems is provided.

It is a logical hypothesis that among those mothers with the highest degree of anxiety around mealtime are those with eating problems themselves. Studies of mothers with eating problems and their infant feeding behavior have shown that these mothers are more concerned about their infant's weight (Lacey & Smith, 1987; Stein & Fairburn, 1989); more intrusive and expressive of negative emotions during mealtimes (Stein, Wooley, Cooper & Fairburn, 1994); and may experience difficulties breast-feeding and keeping enough food in the house to provide adequate nutrition for their children (Stein & Fairburn, 1989). The infants in these dyads were observed to have a more negative emotional tone and more conflictual mealtimes (Stein et al, 1994) as well as being at risk for childhood eating problems like non-organic failure to thrive and obesity (Stein & Fairburn, 1989). While these authors do not report on differential

maternal behavior due to infant gender, they do contribute data pertinent to the understanding of the transmission of eating problems.

Though the data from these studies is limited, when taken together it bolsters a model of the early feeding relationship which asserts that it is differentially influenced by infant gender; extremely vulnerable and reactive to maternal behavior, particularly food-related anxiety; and associated with both childhood and adolescent eating problems.

Latency, Adolescence and Beyond

Much of the empirical literature on eating problems which considers maternal influence does not focus on the mother-daughter relationship, but embeds this variable in the context of the family. For example, Laura Lynn Humphrey has done a number of studies on the families of adolescent girls with eating problems. She has found that families in which a daughter has bulimia-anorexia appear to be less supportive and more conflicted than non-problem control families (1986a). She has also reported that a high level of complex and confusing communications characterize the bulimia-anorexia family (Humphrey, Apple & Kirschenbaum, 1986), as do put-downs and complaints (Humphrey et al, 1986). Humphrey (1986b) further concludes that both bulimics and anorexics view their parents as more

neglectful, blaming and rejecting of them as compared to normal controls. All of this points towards heightened criticism in these families, a topic to be taken up more specifically later in this review. However, none of these studies include a separation of data with respect to mother-daughter, father-daughter or sibling relationships. Additionally, criticism puts a family at risk for a variety of disturbances (Doane & Diamond, 1994); distinct categories of criticism need to be examined--global vs. domain-specific--in order to more completely understand the path of influence with respect to eating difficulties.

More recently, there have been a few studies specifically examining the mother-daughter relationship as it converges with eating behavior and problems. Gray (1994) has found that daughters are more likely to restrict their own caloric intake when their mothers are chronic dieters. Perdue (1990) reports that there are two distinguishable sets of women who binge: those whose mothers pressured them not to diet and those whose mothers pressured them to eat less. What seems significant here is that pressure with respect to eating behavior--regardless of the direction of that pressure--is linked with the emergence of eating problems. Finally, Amatea (1992) found that the overall level of mother-daughter hostility was not significantly related to eating problems in the daughter.

This last finding appears to be in contradiction to those of Humphrey (1986a, 1986b; Humphrey et al, 1986). However, in addition to the respective studies having different foci (mother vs. family), the Humphrey research studied clinical populations with frank eating disorders, while the Amatea project examined a non-clinical population. That is, on the continuum of eating problems, those at the most extreme end of severity may be determined by overall level of familial discord, in addition to conflict specifically related to food and body. Alternatively, extreme eating problems may themselves stress the family and generate the discord detected in these studies. The three studies that do concentrate on the mother-daughter relationship--all having collected data from non-clinical populations--combine to lend support to a model which specifies maternal, domain-specific anxiety, as opposed to more global conflict, as key to the development of less severe eating problems.

Costanzo & Woody

The domain-specific model for the parental transmission of particular problems in childhood is introduced by Costanzo & Woody (1985) in a comprehensive, four-part study of obesity proneness in children. They suggest that what may be most important with respect to the development of a

"deviant position" (p.425) in a youngster are within-parent patterns:

"...there is reason to argue that parents' impact on their children is not monolithic...it may be quite normative for a parent who is not otherwise overinvolved to become so in a particular domain of a child's functioning...under such conditions, the child would be likely to introject the concern..."
(p.428,430)

Costanzo & Woody believe that a parent may demonstrate an elevated level of concern and constraint in a specific domain of her child's life due to "child-irrelevant social values and concerns" (p.439)--they specifically conceive of this model as applying to the transmission of socialized attributes.

The studies of mothers, daughters and eating problems cited above fit quite neatly into this model. First, the mother's concern about food and body is documented in the studies of Gray (1994) and Perdue (1990). Gray makes an explicit association between the mother's food and body preoccupation and that of the daughter; Perdue highlights the salience of overinvolvement in a particular domain with respect to the transmission of eating problems. Amatea's data point to the specificity of the difficulty in the dyad--as Costanzo & Woody (1985) argue, there need not be a globally pathological mother-daughter relationship in order for a problem to surface.

For their part, Costanzo & Woody (1985) present data from a number of their studies on eating problems. In one

project (Costanzo & Woody, 1984, as cited in Costanzo & Woody, 1985) they interviewed the mothers of children aged 8 - 11 and found that there was a pervasive gender split with respect to the mothers' inferences about their children as related to weight. Mothers were more likely to be concerned about a daughter's weight problem (versus a son's) and to impose a higher degree of restraint on these daughters. Morgan & Costanzo (1985, as cited in Costanzo & Woody, 1985) found that college women with eating problems recollected higher levels of parental control--both instrumental and influence control--of eating while they were growing up. These data further support a gender- and domain-specific model.

Pike & Rodin

As outlined in the introduction, the present study intends to elaborate upon and refine the work of Pike & Rodin (1994) on mothers, daughters and eating problems. Pike & Rodin collected data from both mothers and daughters with respect to their degree of eating problem and their attitude towards their weight and appearance. They then explored the mothers' attitude towards their daughters' weight and appearance, as well as towards the general level of family functioning. They found five predictor variables for the daughter's eating problem. In descending order of significance they are: a) mother's rating of how much weight

her daughter should lose (more than control mothers thought their daughters should lose); b) age of mother at her first diet; c) the difference between mother's and daughter's ratings of daughter's attractiveness (mother rates her daughter less attractive than the daughter rates herself); d) mother's dissatisfaction with family cohesion; and e) mother's degree of eating problem.

The mother's domain-specific criticism is represented by variables a and c (though c is a somewhat surprising finding in that one of the hallmarks of an eating problem is self-criticism with respect to appearance; that the mother would be more critical of the daughter than the daughter is of herself is counterintuitive--this particular finding bears further exploration); the genesis of her criticism is suggested by variables b and e--her own anxiety about food and body. It is unclear where variable d fits into this model. The mothers of adolescent daughters with eating problems were desirous of a greater level of closeness within the family. While interesting, and perhaps indicative of a larger difficulty within the family, no apparent conclusions can be drawn from it.

As was highlighted earlier, there are sufficient data from this study--particularly when interpreted in the context of other recent research--to reasonably determine that maternal domain-specific criticism is a contributing factor in the aetiology of eating problems for adolescent

girls. However, it remains to be seen if this attitude is only directed at the daughters in this single domain as is suggested by the Costanzo & Woody (1985) model.

Cultural Contributions to Eating Problems

What the preceding studies document is the relationship between a mother's anxiety about food & weight--her own and/or her daughter's--and a daughter's eating problem. What is not addressed is the role of cultural values and pressure as they impact the dyad and, specifically, the daughter.

Cultural Context

One of the most compelling arguments for the implication of culture in the aetiology of eating problems is their comparison with the nineteenth century epidemic of hysteria and neurasthenia. As Bordo (1993) observes, with the passage of time it has become widely acknowledged that hysteria had its roots in Victorian culture, particularly in gender-related ideology:

"Victorian physicians, we should remember, lacked this perspective. It is only as hysteria has shed its symbolic, emotional, and professional freight, as it has become a historical phenomenon, that it has become possible to see it, in some ways, for the first time...from the perspective of the present, Victorian ideals of masculinity and femininity and the styles of behavior that regulated them seem *themselves* as dusty and distant as the disorder of the era." (p. 50)

Bordo likens eating problems to hysteria in that they both afflict females disproportionately and are "culturally and historically situated, in advanced industrial societies within roughly the past hundred years." (p.50). She believes that women continue to struggle with social contradictions, which in conjunction with specifically contemporary factors are responsible for the current prevalence of eating problems.

Bordo's reference to "advanced industrial societies" highlights another facet of the argument for the cultural aspect of eating problems; that is, their relative absence in non-Western societies. Eating problems, while not exclusive to the Western world, are comparatively rare in developing countries (King, 1993). Recent research has also shown that as other societies adopt Western values, eating problems also begin to emerge (Nasser, 1988; Pumariega, 1986).

Given our lack of distance--our difficulty in deconstructing the culture of which we are both part and product--there has been much resistance to according culture its primary role in the progress of eating problems. Nonetheless, even some of the pioneer clinicians working with eating problems have suggested, albeit tentatively and with minimal elaboration, that cultural factors appear to feature in the evolution of eating problems (Bruch, 1973; Palazzoli, 1981).

Predominant among the social conditions that have nurtured this outbreak of eating problems is the well-documented fetishization of an extremely slender female form (Bruch, 1973; Garner, Garfinkel, Schwartz & Thompson, 1980; Orbach, 1986; Seid, 1994; Wooley, 1994). The reasons offered for the contemporary vogue of thin women are varied and include the brutally ironic theory that just as women have begun to assert their presence in a wider range of professions and public positions, it is demanded that they quite literally take up less space (Bloom et al, 1994; Orbach, 1986; Wolf, 1994). Wolf (1994) explicitly links the historical events of women's emancipation, the reduction of their ideal weight and the resultant development of the diet industry as the realization of a "collective wish" (p.97):

"...Simply as a result of dropping the official weight one stone below most women's natural level, and redefining a woman's womanly shape as by definition "too fat," a wave of self-hatred swept over First World women; a reactionary psychology was perfected; and a major industry was born." (p.97)

What is suggested by these theorists, as well as others of a feminist viewpoint (eg, Fursland, 1987; Kilbourne, 1994; Rothblum, 1994; Wooley, 1994) is that women's passivity--the restriction of the female appetite for success, power, sex and, obviously, food--is the intent of this most recent incarnation of objectification. While some might take issue with these analyses of the motivation behind the current cultural pressure on women to be slim,

the fact of this pressure is more difficult to dispute. It is its transmission that is one of the foci of the present study.

The Media

It has been widely observed that women are bombarded with messages regarding their weight and appearance from all manner of media (Bloom et al, 1994; Bordo, 1994; Garner et al, 1980; Kilbourne, 1994; Orbach, 1986; Wooley, 1994; Wooley & Wooley, 1982). These messages present models for the ideal body, and present a challenge--even a demand--to achieve it through rigorous weight control. In a much-cited study, Garner et al (1980) found that in the twenty years prior to their research, the female form as represented by Playboy centerfolds and Miss America Pageant contestants had become significantly slimmer. Concomitantly, advertisements and articles promoting weight loss are found 10.5 times as frequently in women's magazines as in publications marketed for men (Anderson & DiDomenico, 1990). In a 20 year study of a magazine specifically marketed to adolescent girls, half the major nutrition-related articles included a weight-loss plan and 47% of the product claims in nutrition-related advertisements promised weight-loss as a benefit (Guillen & Barr, 1994). Even television commercials for children have been implicated--there is a significantly disproportionate percentage of appearance enhancement products marketed to a

female audience, combined with an emphasis on food products (Ogletree, Williams, Raffeld, Mason, & Fricke, 1990). Bordo (1994) has documented a range of media representations of women, noting subtle fluctuations of style--for example, willowy vs. athletic--that nonetheless always feature slenderness as key to beauty, success and happiness.

While the pathogenic character of these cultural communications and their subsequent expression in disturbed eating patterns has been the subject of much consideration (Bloom et al., 1994; Bordo, 1994; Freedman, 1984; Kilbourne, 1994; Mitchell, 1987; Orbach, 1986; Wolf, 1991; Wooley, 1994), there has been little empirical examination of the relationship. What has been found is that bulimic and anorexic women will more dramatically over-estimate their weight after exposure to an idealized body in a women's fashion magazine (Hamilton & Waller, 1993; Waller, Hamilton & Shaw, 1992). However, these studies were not designed to examine whether the images were causative agents with respect to the development of the eating problems. Hamilton & Waller (1993), while reporting that girls with more serious eating problems were more likely to overestimate their own body size after exposure to photographs of fashion models, concluded that these girls already had innaccurate body-concepts that were exacerbated--as opposed to caused--by the images. They further suggest that women with eating problems avoid publications that

portray idealized images of women as an aspect of treatment: if the girl absents herself from our culture, perhaps her health will be restored.

The influence of advertising, verbal messages, social models and social situations have all been shown to be salient for adolescent girls with anorexia (Toro, Salamero & Martinez, 1994). In the first and only attempt of eating problem researchers to evaluate sociocultural influence via questionnaire Toro et al find evidence of such influence in anorexic girls. Conducting their study in Spain, these authors found that anorexic adolescents are "...more perceptively, cognitively and emotionally subject to pressure by advertising that encourages slimming..." (p.150). This finding might be interpreted in much the same way that Hamilton & Waller (1993) understood their data: one of the symptoms of an eating problem is heightened susceptibility to media messages focussed on weight and appearance. Indeed, Toro et al suggest this as one interpretation of the data. However, they acknowledge that current thinking attributes a causal role to sociocultural factors and that further study is necessary to illuminate the question of antecedence.

Spare and inconclusive, the empirical literature investigating media influence on eating problems leaves a tremendous amount of room for further study. The field has only begun the attempt to verify what has become

increasingly held theoretically: eating problems must be understood in a cultural context.

Peers

Peers and the pressure they exert are compelling factors in the life of an adolescent (Berndt, 1992; Brown, Lohr & McClenahan, 1986; Connor, 1994) and have been found to play central roles in behavior related to substance abuse (Keefe, 1994; Webster, Hunter & Keats, 1994) and sexual activity (Duncan-Ricks, 1992).

In the present study peers are conceived of as potential mediators of cultural values in much the same way as a mother. That is, with perhaps less, and clearly different, influence, peers may express criticism of an adolescent girl's weight and body by exerting explicit or indirect pressure to conform to a socialized norm for appearance. In so doing, they inadvertantly contribute to the emergence of an eating problem. Unfortunately, this aspect of eating problems has received almost no attention in the empirical literature.

Further, there is some conflicting data in the literature that does exist. Gibbs (1986) and Toro et al. (1993) have found that the number of dieting female friends an adolescent girl has appears to be unrelated to her degree of eating problem. Pike (1989), on the other hand, reports that in 9th grade girls there is a concordance between a

girl's degree of eating problem and the degree of these problems among her friends. However, this association declines to an inverse relationship as the individual progresses through high school and reaches 12th grade. Gibbs (1986) found that the frequency of discussing dieting, weight and related issues does seem to be associated with eating problems. Here, Pike (1989) concurs, concluding that concern about weight within the "friendship system" which results in the exertion of pressure on a girl to lose weight is a risk factor for the development of an eating problem. This limited data suggests that modeling is not in itself potent enough to engender eating problems, but that the more interactive pathway of verbal communication between peers may contribute to their development. However, these studies only minimally attend to the individual's experience of her peers with respect to her weight and appearance: does the adolescent girl perceive pressure from her friends to conform to a socialized norm?

Criticism

Until this point, the discussion has centered on some of the people and institutions that transmit the cultural sanctions on food and body size: mother, peers and the media. What has not been addressed are the means by which the messages are conveyed. One of the salient media is criticism, direct or implied, conscious or unwitting. The

criticism of weight and body--veiled by concern, pop imagery, or other obscuring aspect--is then internalized, becoming the self-criticism that marks the configuration of eating problems so distinctly (Costanzo & Woody, 1985). Even oblique criticism is a potent force by which individuals are led to conform to social norms:

"...there is no need for arms, physical violence, material constraints. Just a gaze. An inspecting gaze, a gaze which each individual under its weight will end by interiorising to the point that he is his own over seer, each individual thus exercising this surveillance over, and against himself" (Foucault, 1977, as cited in Bordo, 1993).

Foucault's "inspecting gaze" is the critical eye of society (mom, media, peers) that, once trained upon the female body, glares relentlessly until appetitive and bodily restraint are, at the very least, attempted.

Expressed Emotion

Interestingly, criticism has not been the focus of much research with the exception of an atheoretical measure with its origins in the most extreme end of the psychopathological continuum. Expressed Emotion (EE), originally developed to evaluate the effect of family life on the vulnerability to relapse of schizophrenic patients (Brown, Castairs & Topping, 1958), has come to refer to the degree of criticalness and emotional involvement expressed in speech samples and interviews of family members of these patients (Gottschalk & Keatinge, 1993). The number of

critical comments--direct verbalizations of criticism-- uttered within a speech sample or interview is frequently used to determine EE level (Vaughn & Leff, 1976). As such, EE represents criticism in its most overt and global (vs. domain-specific) form.

The primary finding in seven independent studies of the population for which the concept of EE was originally developed, has been that high EE ratings in the relatives of schizophrenic patients predict high rates of relapse in those patients (Schwartz et al, 1990). Further research suggests that this highly critical familial communication antedates schizophrenic onset, as opposed to representing reactions to psychotic behavior in already schizophrenic children (Goldstein, 1985). More recently, EE research has broadened its focus to include affective disorders (Franks et al, 1992; Hooley, 1986), childhood disorders (Leff & Vaughn, 1981; Schwartz et al, 1990) and weight-loss maintenance (Fischman-Havstad & Marston, 1984). What all these studies found is that EE is correlated with a negative outcome; that is, the higher the degree of EE within a family or dyad, the more likely the identified patient is to, for example, relapse into depression, develop a childhood disorder or regain recently lost weight.

Traditionally, the assessment of EE has been unwieldy, requiring hours of interviewing and coding (Kazarian et al, 1990; Shields et al, 1992; Vaughn & Leff, 1976). Given its

lack of portability, this measurement of criticalness is scarcely used outside research specifically focussed on EE. Over the past few years a number of questionnaires have been developed to measure both criticalness and emotional involvement in a less time-consuming and labor-intensive way (Docherty et al, 1990; Kazarian et al, 1990; Shields et al, 1990). These measures have begun to make it feasible to incorporate criticism as a variable for exploration in a broader range of research.

Eating Problems & Expressed Emotion

Investigation of EE in the families of eating disorder patients was initiated a little over a decade ago and since then has been relatively limited (Hodes & Le Grange, 1993). One of the principal findings has been that the families of anorexic patients tend to demonstrate low levels of EE as compared with the families of schizophrenic patients (Goldstein, 1981; Van Furth et al, 1989), though mothers of anorexic daughters are more critical towards their offspring than are their fathers (Szmukler et al, 1987). The data on bulimic adolescents is less coherent: one study concluded that the relatives of bulimic daughters appear to have significantly higher levels of EE than those of anorexic girls (Szmukler et al, 1985) while another (Le Grange, 1989 as cited in Hodes & Le Grange, 1993) found very low levels of EE in both bulimic and anorexic patients.

While this research is clearly inconclusive, there is some data to suggest that EE may not be salient for families in which a daughter suffers from an eating problem. Further muddying the waters, is the research of Humphrey et al (1986a, 1986b), discussed earlier in this review, who, while not including EE in their conceptualization, nonetheless reported that high levels of criticism and blame characterize parental attitude towards girls with eating problems.

Within the EE literature, a variety of explanations have been offered with respect to the relatively low numbers of critical comments recorded in the families of patients with eating problems, and even lower numbers logged for those patients diagnosed with anorexia, as opposed to bulimia. These include the ideas that mothers of daughters with eating problems may admire, even envy, their daughters' restraint and that anorexics in particular are typically so rigid and predictable that their behavior by its nature may serve to reduce parental criticism (Hodes & Le Grange, 1993). The explanation not found in the current literature is that perhaps EE as a measure of global criticism is low because it is domain-specific criticism that is key to the aetiology of eating problems. It remains for a direct comparison to be made between EE and domain-specific criticism with respect to the development of eating problems.

With regard to the Goldstein (1981) and Van Furth et al (1989) studies, it is reasonable to assume that there is not the same degree of familial pathology in the families of those with eating problems as in those of schizophrenic patients--this may be a misleading comparison. Clearly further exploration is indicated and it remains to be seen if EE features in the mother-daughter dyads containing adolescent girls with the most extreme eating problems, or if there is a more contained realm of conflict that centers on the adherence to socialized norms of eating and appearance.

Perceived Criticism

EE refers to the degree of criticism observed to be directed towards an individual; perceived criticism (PC) represents the experience of criticism from that individual's point of view. While PC is currently being touted in EE research as an economical and highly predictive measure (Hooley & Teasedale, 1989), it has its roots in earlier investigations of the perception of parental attitudes.

Ausubel et al (1954) in a study of children's perception of their parents' attitudes as determinants of ego structure neatly highlight two justifications for focussing on one's *perception* vs. an observer's assessment of another's attitude:

"First, although parent behavior is an objective event in the real world, it affects the child...only to the extent and in the form he perceives it...Second,...children's perceptions of parent behavior and attitudes can be measured more validly than these latter phenomena themselves." (p.173).

Interestingly, this simple assertion contains a sophisticated juxtaposition of theoretical positions. On the one hand, the idea that perception is the most empirically valid measure of attitudinal or behavioral impact of one individual on another is heir to a behaviorist tradition of observation without inference. On the other hand, the acknowledgement that perception is indeed often different from the "objective event" suggests possible unconscious influence from a variety of sources. Depending on one's specific orientation, these include the actively evolving experiences and representations of others as described by interpersonal and integrative theorists (e.g. Sullivan, 1953; Wachtel, 1987); the internalized objects, wishes and fantasies detailed by other psychoanalytically informed authors (e.g. Klein, 1984; Winnicott, 1958); as well as the internal working models of attachment theory (e.g. Bowlby, 1977; Slade & Aber, 1992). While the current study does not assume a single understanding of the unconscious influence, it does suggest that the "perceived criticism" construct may be representative of complex processes that proceed largely out of awareness.

Exploring the notion that perceived parental attitude is a powerful correlate of behavior, van der Veen & Novak

(1971) found that disturbed adolescents felt their parents to be more negative towards them than did their normal siblings, who did not differ from normal controls on parent attitude variables. Harris & Howard (1978, 1984) studied adolescent perception of parental criticism and self-image. They concluded that the more criticism a teenager perceived for a specific behavior or attitude, the more likely she was to experience herself as being that way. The perception of harsh, accusatory and global criticism (ie, my mother/father thinks I am hard to get along with) was most productive of a negative self-image.

More currently, Hooley & Teasedale (1989) in an EE study of married dyads in which one of the pair was hospitalized for depression, found that the patient's perception of his or her spouse's degree of criticalness was even more predictive of relapse than EE levels assessed by structured interviews that were professionally administered and coded. It has been suggested that these results indicate the importance of representation with respect to critical attitude (Diamond & Doane, 1994), a point similar to that made by Ausubel et al (1954) in discussing the utility of measuring perception of experience.

For the purpose of the present study the measurement of PC from mother, media and peers will facilitate a closer view of the representational world of adolescent girls as it intersects with issues of food and body.

Summary

The rudiments of a model for the development of eating problems in adolescent girls are embedded in the preceding literature. There is ample evidence that both maternal and cultural influences are active in shaping a young woman's sense of her body and appearance, though to what extent each features is not clear. Additionally, there is support for the contention that a mother's concern and criticism with respect to her daughter's shape may stem from her own food and body preoccupations, as well as the admirable impulse towards aiding her daughter to successfully negotiate the demands of Western culture. At the same time, it must be acknowledged that idiosyncratic pathological trends within a mother-daughter dyad may also contribute to the development of an eating problem. Taken together, what emerges is a model in which the middle range of eating problems--those typically classified "sub-clinical"--may have a partial origin in cultural and/or maternal domain-specific criticism, while those eating problems at the more extreme end of the continuum may represent a convergence of global difficulty within the mother-daughter dyad and cultural context.

Criticism is viewed here as a powerful conduit for behavior altering messages. Self-criticism, one of the hallmarks of an eating problem, is understood as the internalization of the cultural censure of the female form.

Once taken in, this criticism becomes the foundation for the self-reproach which leads to disturbed eating patterns. Cultural criticism may be experienced from the environment via the media, or transmitted less directly by family members and peers. While maternal domain-specific criticism is implicated in the development of eating problems, it is the larger cultural context, not the mother who is herself subject to cultural proscription, which is ultimately marked as culprit.

It is a truism that any model is partial and evolving. What is offered here is a preliminary understanding of eating problems informed by both feminist thought and previous research findings.

Remaining Questions

Clearly, then, there are large gaps remaining in the eating problem literature. While feminists have discussed in great detail the various relationships between mothers, daughters and eating problems, as well as culture and eating problems, there has been comparatively little empirical evidence to support their generally compelling views. In addition to the attempt to replicate some of Pike & Rodin's findings, the present study endeavors to support some of these perspectives and the model they suggest by empirical investigation of the following question clusters:

- 1) Is the maternal domain-specific criticism of adolescent daughters with eating problems found by Pike & Rodin (1991) indeed limited to the realms of weight and appearance or is this critical attitude more global? To what degree is maternal critical attitude--domain-specific and/or global--related to mothers' own eating problems and the anxiety they generate?
- 2) What is the impact of the larger cultural milieu as represented by the media and peer relationships on the development of eating problems in adolescent girls? Do girls feel criticized by their "culture mother" with respect to weight and appearance? If so, is the intensity of this experience related to eating problems symptoms?
- 3) Is the daughter's subjective experience of maternal criticism more related to eating problems than is the degree of her mother's critical attitude? How does the representation of maternal criticism--either with respect to global or domain-specific criticism--relate to the development of eating problems?
- 4) What is the adolescent girl's experience of criticism from her mother vs. that of her culture mother? To whom might she attribute influence on her eating habits and body image? How are these factors associated with eating problems?

III. Methodology

Subjects

Subjects were 47 adolescent girls in grades 9 - 12 and their mothers. They were recruited by six adolescent girls hired as research assistants for this study. Subjects all attended public or private schools with predominantly upper middle class student populations. While there is some conflicting data in the literature with respect to the correlation between socioeconomic status and eating problems (Pope, Champoux, & Hudson, 1987), it has been long held that the upper socioeconomic classes are those in which eating problems are most prevalent (Bruch, 1973; Dornbusch et al., 1984; Morgan & Russell, 1975; Szmulker, 1985). Thus, it was decided to collect data from a subject pool which the majority of studies pointed towards as one with a likelihood of containing some individuals with more serious eating problems. This was done in an attempt to ensure the representation of a range of eating problems in the data. Details of the recruitment process will be presented in the "Procedures" section.

Demographic Characteristics. Tables 1 - 3 provide summary statistics on the subjects' demographic characteristics. As shown, the sample overwhelmingly identified themselves as Caucasian/European (85.1% of the daughters; 87.2% of the mothers). Those mothers reporting family income (almost 20%

of the sample did not complete this item) provided enough data to solidly place the sample in the upper percentiles with a median of \$100K per annum. Over 50% of the mothers completed graduate or professional education. The daughters ranged in age from 14 - 18 and were relatively evenly distributed among grades 9 - 12 with a slight skew towards the upper grades.

Table 1

FREQUENCIES AND PERCENTAGES FOR DAUGHTER
DEMOGRAPHIC VARIABLES

<u>AGE</u>	<u>Frequency</u>	<u>Percentage</u>
--14	2	4.2%
--15	6	12.8%
--16	13	26.5%
--17	13	26.5%
--18	13	26.5%
<u>GRADE</u>		
--9	7	14.9%
--10	13	26.5%
--11	11	23.4%
--12	16	32.7%
<u>ETHNICITY</u>		
--Caucasian/European	40	85.1%
--African-American	1	2.1%
--Latin-American	1	2.1%
--Asian-American	3	6.4%
--other	0	00.0%
--missing data	2	4.2%

Table 2FREQUENCIES AND PERCENTAGES FOR MOTHER DEMOGRAPHIC VARIABLES

<u>ETHNICITY</u>	<u>Frequency</u>	<u>Percentage</u>
--Caucasian/European	41	87.2%
--African-American	0	00.0%
--Latin-American	1	2.1%
--Asian-American	3	6.4%
--other	1	2.1%
--missing data	1	2.1%
 <u>EDUCATION LEVEL</u>		
--completed high school	5	10.6%
--completed college	14	29.8%
--completed grad/prof	26	55.3%
--missing data	2	4.3%

Table 3MEANS, ST. DEVIATIONS AND RANGES FOR MOTHER DEMOGRAPHIC VARIABLES

	<u>Mean</u>	<u>St.Dev.</u>	<u>Range</u>
<u>AGE</u> (in years)	46	3.8	39/54
<u>INCOME (family)</u> (per annum)	\$164K	\$172K	\$50K/\$800K

Materials

Demographic Information Survey (See Appendices A/1 & A/2). All subjects were asked to provide information on their age, grade in school and ethnicity. Mothers were also asked to provide information on their own education level and family income.

Weight and Appearance (See Appendices A/1 - A/3). A self-report questionnaire was used to gather data on weight and appearance. Each subject was asked to report her current weight in pounds, ideal weight in pounds and height in inches. The mothers were asked to provide this data for their daughters as well as for themselves. No objective measure of weight was taken because studies indicate that actual and self-reported weights are highly correlated (Attie & Brooks-Gun, 1989; Charney, Goodman, McBride, Lyon, & Pratt, 1976; Coates, Jeffrey, & Wing, 1978) and that weight preoccupation does not result in systematic body measurement error (Radke-Sharpe, Whitney-Saltiel, & Rodin, 1990). Following Pike & Rodin (1991), the mothers' assessment of their daughters' level of attractiveness in comparison to other girls their age, as well as the degree of difference between the mothers' report of their daughters' current and ideal weights were taken as measures of maternal domain-specific criticism (MDSC).

From the above data, a measure of body mass (Body Mass Index, BMI) was calculated according to the formula provided by the Statistical Bulletin ("Measurement of Overweight," 1984). The formula is: $BMI = \text{Weight (kg)} / \text{Height}^2 (\text{m}^2)$.

Following Pike & Rodin (1991), the subjects were asked to compare themselves with women or girls their same age in terms of attractiveness on a 5-point Likert scale anchored by "a great deal less attractive" and "a great deal more

attractive". Mothers were asked to compare their daughters as well as themselves on this scale. Pike & Rodin (1991) report a test-retest reliability of .89 for this measure.

Eating Disorder Inventory (EDI) (See Appendix B). The EDI is a 64-item, self-report, multiscale measure designed to assess both psychological and behavioral traits common in anorexia and bulimia (Garner et al., 1983). It does not establish a formal diagnosis, but identifies women at high risk for eating problems (Raciti & Norcross, 1987). The EDI consists of eight subscales, three of which measure attitudes and behaviors associated with disturbed eating: Drive for Thinness, Bulimia, and Body Dissatisfaction. The remaining five subscales measure psychological constructs that are thought to relate to the psychopathology of eating problems (e.g. Bruch, 1973, 1979; Palazolli, 1981): Ineffectiveness, Perfectionism, Interpersonal Distrust, Lack of Interoceptive Awareness, and Maturity Fears.

It has been suggested that while the three subscales which assess eating behavior and attitude towards weight and shape are specific to eating disorders, the five psychological dimensions measured are more reflective of an overall level of disturbance than of a configuration specific to eating problems (Cooper, Cooper & Fairburn, 1985; Hurley, Palmer, & Stretch, 1990). Olmstead & Garner (1986) found that women who report vomiting to control

weight may have high scores on the Bulimia, Drive for Thinness and Body Dissatisfaction scales, but low scores on the remaining subscales. They acknowledge that these women are likely to meet the diagnostic criteria for an eating disorder even though, as measured by the EDI, they don't display the ego deficits and interpersonal difficulties reported by some clinicians (e.g. Bruch, 1979).

For the purposes of this study, the Bulimia, Drive for Thinness and Body Dissatisfaction subscales were totaled to comprise the Disordered Eating Index (DEI) following the method of Pike & Rodin (1991). This total was used to assess degree of eating problem. Thus, only those scales that clearly measured behavior and attitudes directly related to eating problems were employed. Garner himself, in later research (Olmstead & Garner, 1986), acknowledged that "the specific attitudes that are characteristic of the syndrome of bulimia have been an area of some confusion" (p.695). In order to prevent this confusion from confounding the results of this study the five subscales addressing hypothesized dynamics were not administered.

Klemchuk, Hutchinson, & Frank (1990) provide a succinct adaptation of the Garner et al. (1983) subscale descriptions. The relevant three are presented as follows:

Drive for Thinness (DT):

Excessive preoccupation with weight and diet, and intense pursuit of thinness.

Bulimia (BU):

Tendency towards episodes of uncontrollable over-eating and self-induced vomiting.

Body Dissatisfaction (BD):

Dissatisfaction with the "maturational" areas of the body (hips, thighs).

Adequate levels of internal consistency have been demonstrated for the EDI (Eberly & Eberly, 1985; Ratici & Norcross, 1987). Cronbach's alpha ranged from .85 to .90 on the three relevant subscales (DT, BU, BD) for a criterion group of anorexic girls (N=113) and from .83 to .91 for a comparison group (N=577). Item-total correlation coefficients for these three subscales were moderately high: M = .64, SD = .14 (Garner et al., 1983; Garner & Olmstead, 1984). In a study of 49 anorexia patients correlations of clinician's ratings and the EDI were .53, .57 and .44 for the DT, BU, and BD subscales respectively. All coefficients were significant at the $p < .001$ level (Garner et al., 1983). The EDI was also able to discriminate between bulimic (N = 20) and control subjects (N = 20) with correlations for DT and BU significant at $p < .001$, and BD at $p < .01$ (Gross, Rosen, Leitenberg, & Willmuth, 1986).

Additional validation studies have included convergent and discriminant validation approaches. Among the findings reported by Garner et al. (1983): the DT subscale correlated significantly with Garner & Garfinkel's Eating Attitudes Test (N = 50, $r = .51$); the BU subscale was significantly correlated with Reid & Ware's measure of diminished self-

control ($N = 66$, $r = .53$); the BD subscale was significantly correlated with a modified version of Berscheid, Walster, & Hohnstedt's measure of overall body dissatisfaction ($N = 354$, $r = .69$); and none of these subscales correlated with Chapman, Chapman, & Raulins' measure of physical anhedonia. Further results of correlations between EDI subscales and established measures of both similar and dissimilar constructs are described in Garner et al. (1983).

Scoring the EDI/DEI. Subjects respond to the six point, forced choice items by indicating whether each statement applies "always," "usually," "often," "sometimes," "rarely," or "never." The most extreme "pathological" response is scored 3, the immediate adjacent response is scored 2, the next response 1, and the three remaining choices are scored zero. The items are then summed for a total score ranging from 0 to 69 (for the three subscales being used here). The EDI does not produce a single criterion by which to identify eating disordered individuals. The manual provides norms and a normative profile with the mean scale scores for eating disordered and nonclinical groups (Garner & Olmstead, 1984).

The EDI's 4-point scoring system was a transformation of an original 6-point scale (0,1,2,3,4,5). The transformation was performed so as to most conservatively distinguish between clinical and non-clinical groups of subjects (Garner & Olmstead, 1984). It has been suggested

(Schoemaker, van Strien, & van der Staak, 1994), however, that in using these transformed scores for a non-clinical population the variability of the EDI data is suppressed. These researchers report that the alpha coefficients for each subscale remain unchanged or improve with the use of untransformed scores.

One drawback of using the untransformed scores is that it precludes comparison to published norms for both clinical and non-clinical populations as the recommendation to score the EDI in this way is quite recent (1994). Despite this drawback, the increased variability afforded by the untransformed scores is of paramount importance to the current study, which examines the range of eating problems in their broadest conception. Since this project does not intend to distinguish between clinical and non-clinical eating problems and would clearly benefit from a continuous measure with sensitivity to subtle eating issues, untransformed scores (0 - 5) were used.

Perceived Criticism From Mother, Domain-Specific (PC-DS)

(See Appendix C). These are four, 5-point Likert scale items developed for this project with the purpose of determining the degree to which the daughters in the study perceive their mothers as critical of their weight and appearance. These items were administered in a pilot study to a sample of 14 ninth grade girls. Each item was administered two

times, with a week to ten days intervening. The responses at time 1 and time 2 were compared using a paired t-test and there was no significant difference between the two test times on any of the items. Correlational procedures were not used due to the small sample size.

Cuestionario de Influencias sobre el Modelo Estetico Corporal (CIMEC-26) (See Appendix D). The CIMEC is a 26-item, self-report, multifactor measure developed in Spain that is designed to evaluate the impact of a range of sociocultural influences on adolescent girls' attitudes toward their own bodies (Toro et al., 1994).

The CIMEC has been able to discriminate between anorexic (N=59) and comparison (N=675) groups of young women ages 12 - 24 ($t=5.11$, $df=103.6$, $p<.001$). Satisfactory internal consistency has been demonstrated for total scores in both groups with Cronbach's alpha of .93 for the anorexic subjects and .91 for the comparison women (Toro et al., 1994).

Structural validation of the questionnaire employing the varimax method of factorial analysis identified five primary factors, described by Toro et al. (p.148-149, 1994) as follows:

Factor I: distress because of body image. Includes all items that show anxiety when faced with situations that question the body itself, or envy of obvious models of slenderness (explained variance: 32.9%).

Factor II: influence of advertising. Includes 8 items, all related to the interest aroused by advertisements for slimming products (explained variance: 6.1%).

Factor III: influence of verbal messages. Includes items dealing with the interest aroused by articles, reports, books and conversations related to weight loss (explained variance: 5.1%).

Factor IV: influence of social models. Includes items related to the interest aroused by the bodies of actresses, fashion models and passers-by in the street (explained variance: 4.5%).

Factor V: influence of social situations. Includes items in which the experience of social pressure in eating situations is measured and the degree of social acceptance attributed to slenderness is assessed (explained variance: 4.1%).

An English translation of this instrument was agreed upon by three bilingual psychologists and administered in a pilot study to 9th grade girls (N = 14). Internal consistency was found in four of the five scales, with coefficient alphas of .75, .87, .90, .49, and .85 for factors 1 through 5 respectively.

As indicated by the above statistics, the subscale representing factor 4 was found to have low internal consistency. Closer examination of the data revealed that two of the four items clustered on this factor had skewed response distributions. Responses to item 9 ("When you are out on the street, do you look to see if people are fat or skinny?) were dichotomous with half the subjects responding "no, never" and half the subjects repoding "yes, at times." No one responded "yes, always." On item 24 ("Do pictures and advertisements featuring women in jeans, bathing suits

and lingerie appeal to you?") 64% of the subjects responded "no, not at all." The lack of variability on these two items likely accounts for the low coefficient alpha. When the subscale was run again on the larger study sample, the coefficient alpha increased to .52 (N = 47); with item 24 removed from the analysis, it increased to .65. The subscale was retained for analysis.

Perceived Criticism, Cultural (PCC) (See Appendix E). These six items were developed specifically for this project and are designed to measure aspects of sociocultural influence on eating behavior and body image not measured by the CIMEC-26. Four of the six items are 5-point Likert scales, the first two of which assess the experience of peer criticism with respect to weight, while the remaining two measure the degree to which a girl has peer models who are preoccupied with their weight. The final items are categorical and intended to determine to whom girls themselves attribute the most influence with regard to their eating habits and ideal body conception.

Test-retest analysis using paired t-tests (N = 14) on the first four items did not demonstrate significant difference between time 1 and time 2 except on item 1. Here the mean difference between the first administration of the item and the second administration was approximately half a

point. The remaining three items were shown to have adequate reliability.

The last two items are categorical and have eight possible responses each. This is too many categories for performing a t-test since the sample size was so small ($N = 14$) in the pilot study. Percentages were calculated which demonstrated the concordance between time 1 and time 2 for both items to be approximately .60. For descriptive purposes the eight categories of response remain as they are. However, they were collapsed for analysis. Since the primary distinction being made here is between cultural and maternal influence four categories were employed: mother/relative, friend/school, media and other.

Family Emotional Involvement & Criticism Scale (FEICS) (See Appendices F/1 - F/2). The FEICS is a 14 item, two scale self-report instrument based on Expressed Emotion Theory and designed to assess aspects of familial experience (Shields et al., 1992). The FEICS was developed to replace the Camberwell Family Interview (CFI), the original direct observation measure of EE which requires many hours of semi-structured interviewing and extensive training with respect to both administration and scoring. The two subscales, Perceived Criticism (PC) and Emotional Involvement (EI), are analogous to Critical Comments and Emotional Overinvolvement, the two key factors of EE assessed by the

CFI. The PC scale measures the degree to which the subject reports feeling criticized by her family; the EI scale measures the degree of emotional involvement the subject experiences with respect to her family. It is the PC scale that is primary for this study

The FEICS made its debut in the literature in 1992 and thus is a relatively new instrument. Shields et al. (1992) evaluated the psychometric properties of the scales and demonstrated that they achieve acceptable levels of reliability, construct and criterion validity. Cronbach's alpha for the PC scale was .82 ($M = 1.66$, $SD = 0.67$) for a sample of 101 cardiovascular patients receiving primary care at a family medical center; the EI scale had an overall alpha of .74 ($M = 3.05$, $SD = 0.91$).

Construct validity was demonstrated by comparing the FEICS with the Family Adaptability and Cohesion Evaluation Scales and the Interpersonal Support Evaluation List (Shields et al., 1992). Some of the findings reported include a negative correlation between PC and cohesion ($r = -0.44$) and adaptability ($r = -0.37$), demonstrating that subjects who perceived their families as critical of them also experienced their families as less close and less adaptable. Comparison with important criterion variables revealed a substantial bivariate correlation between PC and both depression and anxiety ($r_{PC, Dep} = .378$ $p < .001$; $r_{PC, Anx} = .352$ $p < .001$).

The authors do note that it is not known if the FEICS and the CFI are correlated, even though they are both based on the same theory. However, an even briefer measure of Perceived Criticism (Hooley & Teasedale, 1989) has been significantly correlated with overall EE level (low or high) as measured by the CFI.

The FEICS was adapted for this study of maternal criticism. Each item on the original FEICS asks the subject to report on her *family* with respect to experiences of criticism (for example, "my *family* finds fault with my friends"). The word *mother* was substituted in the form administered to the daughters ("my *mother* finds fault with my friends"). This was then used as a measure of perceived maternal non-domain-specific criticism. In a pilot study, this version was administered to 14 ninth grade girls, and internal consistency for the Perceived Criticism subscale was demonstrated (coefficient alpha = .75).

The version given to the mothers was modified similarly, with the word *daughter* replacing *family*. The mothers were also asked to report on their critical attitude towards their daughter, as opposed to their perception of criticism from their daughters. For example, the item "My mother is always trying to get me to change" appearing on the daughters' version became "I am always trying to get my daughter to change" on the mothers' form. This was used as a measure of non-domain-specific maternal critical attitude.

A pilot study of 12 mothers of adolescent daughters demonstrated adequate internal consistency for this adapted Criticism subscale (coefficient alpha = .83).

Scoring the FEICS. Each of the 14 items on this questionnaire uses a 5-point Likert scale with a range from almost never to almost always. PC and EI are presented here as continuous variables and thus no cut-off scores are provided.

Perceived Criticism Scale (PCS) (See last item in Appendices F/1 & F/2). The PCS is a 4 item self-report instrument that measures 1) how critical the subject considers a specified family member to be of them, and 2) how critical the subject considers themselves to be of that same family member (Hooley & Teasedale, 1989). In the current study, two of the four items were used. Daughters were asked to report the degree to which they feel criticized by their mothers; mothers were asked how critical they believe themselves to be of their daughters. The items use a 10-point, Likert-type scale anchored with the words *not at all critical* and *very critical indeed*.

Hooley & Teasedale (1989) have demonstrated some concurrent validity for this questionnaire by correlating it with overall EE levels (low or high) as measured by the CFI ($r(23) = .51, p < .02$). In their study, perception of spousal criticism was found to be the variable most powerfully

associated with relapse of hospitalized unipolar depressives within 9-months of discharge, indicating predictive validity for the construct of Perceived Criticism (PC*). All of the subjects in their study who assigned their spouse a 6 or higher on the PC* scale relapsed during the follow-up period.

Hooley & Teasedale (1989) report that when PC* was entered first and alone in a linear regression equation it predicted 38% (adjusted R²) of the total variance in patients' outcome as measured by relapse rate. Even with other variables already entered into the regression equation, PC* predicted a significant proportion of the outcome variance. Predictive validity of PC* has also been shown with respect to diabetic control of blood glucose levels (Klausner, 1993), with those subjects best able to control their glucose levels reporting low levels of PC*.

Analysis of the pilot study data from the daughters revealed that the PC* item was highly correlated with the PC subscale of the FEICS ($r = .74$). However, in order to ensure that this study's results were comparable to others in the field and because of its ease of administration, the PC* item was still included in the measures.

Procedure

Six adolescent girls were recruited as research assistants with the sole task of collecting data. Three of these girls gathered data from students attending public school in Westchester County, NY; one girl collected data from students enrolled at a private school in Brooklyn, NY; another recruited subjects from a competitive admissions public school in Manhattan, NY; the remaining research assistant enlisted subjects in attendance at both public and private schools in Pennsylvania.

All these girls were referred to me by colleagues in the field of Clinical Psychology. After obtaining their names, I interviewed them on the telephone and described my project. I then sent them a packet containing the following: 1) a letter outlining the procedure for recruiting subjects and the administration/distribution of the measures (see Appendix G); 2) initial recruitment handouts which introduced my project to prospective participants (see Appendix H); 3) envelopes containing a letter of introduction to the mother (see Appendix I) and a consent form requiring signature, name and address (see Appendix J); 4) packets for the daughters to complete (see Table 4 below for contents); and 5) packets for the mothers to complete (see Table 4 below for contents).

TABLE 4
RESEARCH PROTOCOL: ORDER OF PRESENTATION

<u>Daughter's Packet</u>	<u>Mother's Packet</u>
1) Introductory letter (Appendix K)	1) Introductory letter (Appendix L)
2) Demographic data	2) Demographic data
3) Weight & appearance items	3) Weight & appearance items (MDSC)
4) DEI	4) DEI
5) PC-DS	5) FEICS/PCS
6) CIMEC	
7) PCC	
8) FEICS/PCS	

The research assistants were instructed to give introductory handouts to fellow students and friends interested in the project. If a girl wanted to participate, she was given an introductory letter/consent form envelope by the research assistant and asked to have her mother read about the study and provide consent. Only after a girl returned the signed consent form to the research assistant was she given a packet of measures and asked to complete it. This she was asked to do without consulting her mother or friends about any of the items. Research assistants were requested to encourage subjects to complete the questionnaires as quickly as possible, preferably in the research assistant's presence. Subjects were instructed to place the completed questionnaires in the self-addressed

(addressed to me), stamped envelope provided, seal it and return it to the research assistant who was then responsible for mailing it to me. Research assistants then gave subjects a sealed questionnaire packet for delivery to their mother. Mothers were instructed to complete the measures and mail them directly to me in the addressed, stamped envelope provided.

Each research assistant kept a list of participants and their ID numbers. Daughter and mother packets had matching ID numbers so that should I receive a daughter packet, but not the mother packet (or vice versa) I was able to contact the responsible research assistant, give her the ID number and have her follow up on the missing data. In this manner, subject anonymity and confidentiality were preserved, while adequate tracking was maintained. The research assistants were paid \$10 for each mother-daughter dyad of data I received as a result of their recruitment.

After the data were analyzed and interpreted, a summary of the results (see Appendix M) was sent to each participant as a form of debriefing. As the names and addresses of the subjects were on the consent forms, a mailing was possible while still safeguarding subject confidentiality and anonymity.

Operationalized Research Questions

A) Pike & Rodin (1991) reported the finding that a mother's degree of eating problem was a significant predictor of her adolescent daughter's degree of eating problem. Other researchers (Attie & Brooks-Gun, 1989) have not found this relationship. In an effort to further investigate this key question, the current study asked:

1) Is mother's degree of eating problem as measured by the DEI related to daughter's degree of eating problem as measured by the DEI?

B) While Pike & Rodin (1991) found that mothers of adolescent daughters with eating problems were more critical of their daughters' weight and appearance, it was not determined if this critical attitude was limited to these specific domains. To explore the relationship between maternal domain-specific criticism, maternal global criticism and the daughters' degree of eating problem, the following was examined:

2) Is there a relationship between maternal domain-specific criticism as measured by the Pike & Rodin (1991) weight and appearance items and daughter's score on the DEI? (essentially a replication of Pike & Rodin, 1991)

3) Is there a relationship between maternal non-domain specific (global) critical attitude as measured by mother's score on the FEICS/PCS and daughter's score on the DEI?

- C) To explore the degree to which a maternal critical attitude--domain-specific and/or global--relates to a maternal eating problem and its attendant anxiety, this study asked:
- 4) Is there a relationship between maternal domain-specific criticism as measured by the Pike & Rodin (1991) weight and appearance items and mother's degree of eating problem as measured by the DEI?
 - 5) Is there a relationship between maternal non-domain specific critical attitude as measured by the FEICS/PCS and mother's degree of eating problem as determined by the DEI?
- D) The impact of contemporary culture on the development of eating problems in adolescent girls was investigated as follows:
- 6) Is there a relationship between an adolescent girl's degree of eating problem as measured by the DEI and her experience of cultural influences with respect to her weight and appearance as measured by the five factors of the CIMEC?
 - 7) Is there a relationship between an adolescent girl's degree of eating problem as measured by the DEI and her experience of cultural criticism as measured by the PCC items?
- E) The adolescent girl's subjective experience of maternal criticism as it relates to the development of eating problems was explored by asking:
- 8) Is there a relationship between a daughter's perception of her mother's global criticism as measured by the daughter's score on the FEICS/PC scale and the daughter's severity of eating problem as measured by the DEI?

9) Is there a relationship between a daughter's perception of her mother's domain-specific criticism as assessed by the PC-DS items and the daughter's degree of eating problem as measured by the DEI?

F) Finally, those factors found to have a significant relationship to the adolescent girls' degree of eating problem will be considered together in an attempt to determine which might be more influential with respect to the development of these problems:

10) What are the relative contributions to degree of daughter eating problem of those variables having a significant relationship to daughter DEI?

IV. Results

Description of Subjects' Eating Problems and Body Mass

DEI

The DEI as administered and scored for this study (which consisted of the BU, DT and BD subscales of the EDI; see Methodology for details) had a possible range of 0 - 115, with a score of 115 marking the least pathological end of the continuum. DEI scores of the daughters in the current sample had a range of 29 - 102 with a mean of 66.32 and a standard deviation of 18.29. The range of mother DEI scores was 35 - 103 with a mean of 74.04 and a standard deviation of 16.83.

As detailed in the Methodology section (see pp.53-54), these DEI statistics cannot be compared to published norms for nonclinical populations which are all based on transformed scores because untransformed scores were employed in this study in order to insure data variability. In fact, the scores from the current study may be considered as an initial contribution to the pool of data used to calculate norms based on untransformed EDI scores following the recommendations of Schoemaker et al. (1994).

Though normative comparisons are not possible, there are a few observations about the sample characteristics that should be noted. While both distributions (daughter and mother) were comparable in range and appeared to represent

good variability with respect to a wide mid-range of scores, the tails were flat, with the extreme ends of the eating problem continuum not represented. Apparently the most and least severe eating problems were not reported by subjects in this sample. With respect to the latter, in previous studies (eg Pike & Rodin, 1991) those scoring at the very highest end of the scale have generally been excluded from studies because a certain level of concern about weight and appearance is so normative as to raise questions about those reporting little or none (Pike & Rodin, 1991).

While the top 12 scale points, representing the least severe eating problems, were not present in either distribution, both were still slightly skewed towards this less troubled end of the continuum, with a greater number of scale points (28) missing from the other end of the spectrum, that representing the most serious eating problems.

BMI

The mean body mass reported by daughters in this study was 21.10 which is comparable to that of a similar sample of adolescent girls as reported by Pike (1989); the mean body mass reported by mothers was 23.75. Metropolitan Life ("Measurement of Overweight", 1984) reported that the body mass of the 10th - 65th percentiles of adult women ranged from 19 - 24. In the current sample, the 10th - 65th

percentile of mother body mass had a range from 19.89 - 23.90; the daughter range for the same percentiles was 17.99 - 21.63. The mother range was clearly comparable to that of Metropolitan Life. As the daughters were not fully-grown, mature women, the somewhat lower BMIs are expected and cannot be compared with the published statistics for adult women.

Metropolitan Life reported that those with body mass in the 10th - 65th percentiles had the lowest mortality rate and so were considered to be of optimal weight. By this criterion, 15 of the mothers (32%) were above and 4 (8.5%) were below optimal weight. The daughter percentiles could not be assigned from those published because, again, they were normalized on an adult population. Calculating percentiles from the daughter sample itself, 16 (34%) were above the 65th percentile and so might be assumed to exceed optimal weight, while 5 (10.6%) were below the 10th percentile and so may have been comparatively underweight.

Not suprisingly, both daughter and mother BMI were correlated with their respective DEI scores ($r = .35, p < .01$; $r = .49, p < .001$)--the greater a subject's BMI, the more likely she was to manifest an eating problem. The combination of this finding and the fact that no subject scored at the most pathological end of the DEI points to an absence of clinical-level anorectics in the sample. This may be true even given that 5 subjects were apparently below

optimal weight--none of these subject were sufficiently beneath the cutoff to meet the diagnostic criteria for anorexia, which requires a body weight 85% or less of normal weight. Given the low prevalence of Anorexia in the population (DSM-IV, 1994) and the nonclinical population from which subjects were drawn, this would not be unexpected. As was noted earlier, those with bulimic or non-specific eating disorder symptoms are frequently at or somewhat above weight; it appears subjects with these difficulties were well represented in the sample.

Analysis of Research Questions

Research Question (1):

The mother's degree of eating problem as measured by the DEI was not found to be significantly related to her daughter's degree of eating problem as measured similarly ($r = .20, ns$)¹. This finding appears to differ from that of Pike & Rodin (1991) who reported mother's EDI as a significant predictor variable of daughter's EDI in their discriminant analysis.

¹ Two-tailed Pearson R correlations were performed except where otherwise noted.

Research Question (2):

In clear agreement with Pike & Rodin's (1991) findings, a mother's criticism of her daughter's current weight was shown to correlate significantly with the severity of her daughter's eating problem ($r = -.45, p < .001$). Since actual daughter overweight was also shown to relate significantly to degree of maternal weight criticism ($r = .73, p < .001$), maternal criticism and daughter eating problem were examined controlling for daughter BMI. The relationship remained significant ($r = -.31, p < .05$) indicating that the mothers' critical evaluation of their daughter's current weight was not solely due to the daughters' actually being overweight.

With respect to Pike & Rodin's finding that mothers of girls with eating problems were more critical of their daughters' attractiveness than the daughters were of themselves, the current study found the converse relationship: mothers of daughters with more serious eating problems were less critical of their daughters' appearance than the daughters were of themselves. This was demonstrated by relating the results of two t-tests (see Table 5, Appendix O) comparing high and low daughter DEI groups on 1) maternal rating of daughter attractiveness and 2) daughter rating of her own attractiveness. It was found that mothers of daughters with more serious eating problems did not differ significantly from mothers of daughters with less serious eating problems with respect to their rating of

their daughters' attractiveness ($t = -1.44$, $df = 45$, ns). However, the daughters themselves differed, with those suffering with more serious eating difficulties rating themselves as significantly less attractive than those daughters with less severe eating problems rated themselves ($t = -2.09$, $df = 45$, $p < .05$).

Additionally, in contrast to the findings specific to judgments about weight, no significant relationship was observed between a mother's rating of her daughter's overall attractiveness and the daughter's score on the DEI ($r = -.04$, ns). However, daughter BMI was correlated with maternal rating of attractiveness ($r = -.28$, $p < .05$), indicating that the more a daughter exceeded her optimal weight, the more critical her mother was of her general appearance. These analyses were not reported on by Pike & Rodin (1991).

Research Question (3):

In a broadening of the Pike & Rodin (1991) study, maternal global criticism was examined with respect to its relationship to a daughter's DEI score. Here, no significant relationship was found between a mother's global criticism of her daughter--as measured by either the PC item or the FEICS scale--and the daughter's degree of eating problem ($r = -.15$, ns; $r = .02$, ns). A median split-half analysis was performed in addition to the Pearson in order

to determine if those daughters with DEI scores in the upper half of the sample range differed from those in the lower half with respect to degree of maternal global criticism. No significant difference was found in these t-test analyses when global criticism was measured by either the PC item or the FEICS scale (see Table 6 in Appendix O).

Research Question (4):

Moving to the consideration of the mother's degree of eating problem, a trend was observed with respect to the relationship between a mother's DEI and her degree of criticism of her daughter's weight when analyzed without control for daughter BMI ($r = -.26, p < .08$). However, this trend diminished when daughter BMI was held constant ($r = -.22, p < .13$). There is some indication that a daughter's actual weight was a critical variable with respect to the relationship between degree of maternal eating problem and maternal criticism of daughter's weight.

Maternal criticism of daughter attractiveness did not have a significant relationship to maternal degree of eating problem either with or without BMI held constant ($r = .06, ns$; $r = .10, ns$). Weight, as distinct from overall attractiveness, seems to have been salient for mothers with more serious eating problems when critically appraising their daughters.

Research Question (5):

The examination of the relationship between maternal degree of eating problem and maternal global criticism of daughter, yielded no significant relationship between a mother's DEI and her PC with or without control for daughter BMI ($r = -.13$, ns; $r = -.19$, ns). Similarly, there were no significant correlations between maternal FEICS and maternal DEI regardless of the presence or absence of control for daughter BMI ($r = -.03$, ns; $r = -.06$, ns). Thus, it appears that a mother's degree of eating problem is not related to her overall criticism of her daughter.

Research Question (6):

The second domain to be examined in this study was that of cultural context and the development of eating problems. Table 7 illustrates that an extremely strong relationship was found between all five sociocultural influence factors of the CIMEC and a girl's severity of eating problem.

Table 7
CORRELATIONS BETWEEN SOCIOCULTURAL FACTORS OF THE CIMEC AND
DAUGHTER'S DEGREE OF EATING PROBLEM

	<u>Factor 1</u>	<u>Factor 2</u>	<u>Factor 3</u>	<u>Factor 4</u>	<u>Factor 5</u>
DAUGHTER DEI	.80***	.58***	.63***	.48***	.58***

Factor 1 = Distress because of body image
 Factor 2 = Influence of advertising
 Factor 3 = Influence of verbal messages
 Factor 4 = Influence of social models
 Factor 5 = Influence of social situations
 * $p < .05$ ** $p < .01$ *** $p < .001$

These results are consistent with those of Toro et al. (1994) who reported on the administration of the CIMEC to two groups of Spanish adolescent girls, one a group of clinically diagnosed anorectics, the other a "normal" group. They found significant differences between these groups on each factor score. The subjects of the current study represented a range of eating disturbance found in the upper-middle class, predominantly Caucasian, East Coast American population. It appears that there is a similarity in the degree of engagement with sociocultural influences as they relate to an adolescent girl's eating problem between the two samples.

The results also indicate that Factor 1 (Distress Because of Body Image) is essentially equivalent with the DEI ($r = .80, p < .001$). This is confirmed by a face comparison of the DEI and Factor 1 items, some of which are quite similar. However, the high correlations found between the DEI and the remaining four factors are not attributable to duplication of items. Indeed, items resembling those of the CIMEC factors 2 - 5 are nowhere to be found on the DEI.

Research Question (7):

Sociocultural influence on eating problems was further explored with some items created specifically for this study. The first four PCC items (see Appendix E) were designed to measure various aspects of an adolescent girl's

experience of her friends' attitudes towards her weight and their own bodies. One item was shown to have a significant relationship to a girl's DEI score: a girl's perception that her friends believe she needs to lose weight was positively related to the degree of her eating problem ($r = .48$, $p < .001$). This relationship remained significant even after controlling for BMI ($r = .39$, $p < .01$). It appears that whether or not a girl was actually overweight, the more serious her eating problem, the more likely she was to believe her friends thought she needed to lose weight.

No relationship was found between a girl's eating problem and her report of the frequency with which her friends actually told her she should lose weight ($r = .12$, ns). It seems that girls with more serious eating problems attributed domain-specific critical thoughts to their peers while acknowledging that this perceived criticism remained unspoken.

The degree of friends' concern about their own weight as perceived by an adolescent girl did not appear to relate to her degree of eating problem ($r = .14$, ns); neither did her report of the frequency of her peers' discussion of weight-loss and related topics ($r = .15$, ns). However, this latter finding contradicted the results of CIMEC question 19, which asked about the number of friends the subject had who were concerned about their weight, and correlated significantly with a girl's degree of eating problem ($r = -$

.32, $p < .05$). There appear to be conflicting data with respect to the relationship between having weight-preoccupied friends and a more serious eating problem.

The last two PCC items were designed to measure an adolescent girl's attribution of influence with respect to the development of her current eating habits and conception of the "ideal body" respectively. Table 8 summarizes the results, which point to a difference between the attribution of influence with respect to eating habits (38.8% of the sample responded that "mother" had exerted the most influence) and conception of "ideal body" (48.9% attributed primary influence to one or another form of mass media).

Table 8
CATEGORICAL RESPONSE PERCENTAGES FOR THE
QUESTION OF INFLUENCE ON EATING HABITS AND CONCEPTION OF THE
"IDEAL BODY" AMONG ADOLESCENT GIRLS

	<u>Mother</u>	<u>Friend</u>	<u>Other</u> <u>Relative</u>	<u>Media</u>	<u>School</u>	<u>Other</u>
EATING HABITS*	38.3%	27.7%	4.3%	8.5%	0.0%	21.3%
"IDEAL BODY"*	6.4%	17.0%	0.0%	48.9%	6.4%	21.3%

*N = 47

While there appears to be a significant difference between the two distributions, this observation could not be confirmed statistically. It was not appropriate to perform a chi-square because in 14 of 16 cells the expected frequencies were less than five, which is the value needed

to justify this analysis. Further, the Fisher's Exact test, which allows the use of chi-square analysis when more than half the cells have an expected value of less than five is not appropriate for analyses that include more than four cells. Nonetheless, there is a clear difference between the distributions of attribution of influence which will be taken up in the Discussion section.

When the "Other" responses were further analyzed some additional distinctions between the distributions were noted. It was found that 19% (9 subjects) of those who selected this category in response to the question about their eating habits attributed primary influence to themselves, writing that they relied on "what feels good to me," "my own experiences of my body," and "how hungry I feel"; a single subject attributed influence here to "...a general social atmosphere".

In contrast to the distribution of "Other" responses for the eating habits question, 12% of the girls (6 subjects) attributed their conception of the ideal body to a cultural variable such as "society," "Barbie," or "dancers"; only 6% (4 subjects) identified their own sense of self as most important in their conception of a body ideal with statements like "my ideal is my comfortability (sic) with myself".

In order to determine whether degree of eating problem was associated with a particular attribution response within

the respective distributions, a 2X4 Chi-square analysis dividing the subjects into high DEI and low DEI groups was performed for each of the two items. The response categories were collapsed to diminish the degrees of freedom for the analysis, resulting in four new response groups: "mother" and "other relative" became response (1); "friend" and "school" became response (2); "television," "books & magazine articles," and "famous person" became response (3); and "other" was response (4). No significance was found in the distribution of attribution (see Tables 9 & 10 in Appendix O) between the two groups of daughters with respect to the development of eating habits ($X^2(3) = 3.45, ns$) or conception of ideal body ($X^2(3) = 1.19, ns$). It appears that the adolescent girls' attribution of influence to one or another source was independent of their degree of eating problem.

Research Questions (8) & (9):

Turning to the third domain considered in this study, the exploration of whether a daughter's perception of maternal criticism was significantly correlated with her degree of eating problem yielded a series of interesting relationships. First, no correlation was found between a daughter's perception of her mother's global criticism and the daughter's DEI. This absence of significant relationship was found for both the FEICS ($r = .11, ns$) and

PC ($r = .20$, ns) measures of daughter perception of maternal global criticism and provides further support for this project's finding that global criticism/EE is not significantly related to degree of eating problem.

Four items were developed to inquire into the daughters' perception of maternal domain-specific criticism of her weight and attractiveness (see Appendix C). Table 11 (see Appendix O) illustrates that no significant correlations were found between any of these items and a daughter's degree of eating problem. However, t-test analysis revealed that there was a trend towards a difference between the perception of maternal domain-specific criticism of daughters scoring in the upper half of the sample's DEI range (high DEI group) and those scoring in the lower half (low DEI group). Tables 12a - d (see Appendix O) show that daughter response to Perceived Criticism Domain-Specific (PCDS) item (3) ("my mother thinks I have a nice body") demonstrated the strongest tendency toward distinguishing between high and low DEI daughters: those girls with the more severe eating problems were more likely to experience their mothers as critical of their bodies. Given that the tails of the daughter DEI distribution are somewhat flat, the finding of a difference between the upper and lower halves is particularly worthy of note.

That girls with more serious eating problems appeared to experience their mothers as more critical of their bodies is consistent with the additional finding that a daughter's perception of maternal weight/body criticism correlated with her mother's self-reported degree of this criticism. This was demonstrated by the significant relationship between maternal criticism of a daughter's weight and daughter PCDS item (1) ("my mother thinks I should lose weight") ($r = .48$, $p < .001$), and PCDS item (3) ("my mother thinks I have a nice body") ($r = .34$, $p < .01$). Since mothers of daughter with eating problems were more critical of their daughters' weight, it follows neatly that these girls perceived their mothers as more domain-specific critical.

The clear significance of the relationships above is distinct from those characterizing the correlations between a mother's critical attitude towards her daughter's overall attractiveness and the daughter's perception of this critical attitude. While a strong trend was noted between maternal critical attitude in this domain and daughter perception as measured by PCDS item (4) ("Compared to other girls my age, my mother thinks I am...a great deal less...a great deal more attractive") ($r = .27$, $p < .06$); a much weaker relationship was found when daughter perception of maternal attractiveness criticism was measured by PCDS item (2) ("my mother thinks I am attractive") ($r = .22$, $p < .15$).

Research Question (10):

In order to pull together some of those findings most relevant to the issue of criticism--maternal and cultural-- as it relates to the development of eating problems, the following items, all of which were significantly related to daughter DEI, were entered into a stepwise multiple regression as independent variables: degree of maternal criticism of daughter's current weight; daughter report of likelihood of her friends' believing she needed to lose weight; and CIMEC factors 2 - 5 (factor 1 was not included as it was determined to be essentially equivalent to the DEI). As table 13 illustrates, 56% of the variance in daughter DEI was accounted for by CIMEC factors III (Influence of Verbal Messages) and V (Influence of Social Situations), and maternal criticism of daughter current weight. The first significant predictor was CIMEC factor III, followed by maternal criticism of daughter weight and CIMEC factor V. CIMEC factors II (Influence of Advertising) and IV (Influence of Social Models), as well as daughter belief that her peers thought she needed to lose weight did not emerge as significant in this equation.

Table 13

STEPWISE MULTIPLE REGRESSION ANALYSIS
PREDICTING DAUGHTER DEI

<u>Predictor</u>	<u>Multiple R</u>	<u>Beta</u>	<u>R²</u>	<u>Change R²</u>
CIMEC Factor III	.63	-.33	.39	
Maternal Wt. Crit.	.71	-.37	.50	.11
CIMEC Factor V	.75	-.32	.56	.06

$F(3,43) = 17.97, p < .001$

These findings support those of Pike & Rodin (1991) with respect to the relationship between maternal domain-specific criticism and daughter degree of eating problem. Perhaps more importantly, they point to the important role of cultural influence--the criticism of the "culture mother."

V. Discussion

Before beginning the discussion of the results of this study, a few words addressing the eating problem characteristics of the sample are necessary. This project was designed to examine eating problems as found in a non-clinical population of adolescent girls and their mothers. Eating "problems" were conceptualized as encompassing a spectrum of difficulties related to eating, including the most severe end of the continuum--what are currently diagnosed as clinical eating disorders--but additionally, and pointedly, referring to the undue influence of body shape and size on self-evaluation and the consequent contortion of eating behavior which pervades contemporary Western experience, particularly that of women.

As it turned out, none of the subjects who participated in this research appeared to have had the most extreme eating problems as represented by the highest scale points on the DEI, though there was solid representation of women and girls with a broad mid-range of eating problems--this was hardly a trouble-free sample. Given that the prevalence of clinical-level eating problems in assorted female populations as evaluated by a host of different diagnostic criteria has been variously estimated at anywhere between 0.9% (Whitehouse & Button, 1988) and 13% (Halmi, et al., 1981), and that the DEI does not provide a cutoff for

clinical-level disturbance, it is difficult to assess the representativeness of this sample.

Since the DEI is an abbreviated version of the EDI, which has a much stronger track-record of distinguishing serious eating problems (Garner et al, 1983; Norring & Sohlberg, 1988; Pike & Rodin, 1991; Welch & Hall, 1989) than it does of detecting the wide mid-range of eating difficulties, the absence of the most extreme problems within the sample was probably not due to measurement insensitivity.

The possibility must also be considered that the method of administration, which had peers distributing and collecting the assorted questionnaires from the daughter subjects, inhibited frankness of response. While the daughter subjects were provided both anonymity and confidentiality, they were required to trust that their peer who collected the data would not open the sealed envelope they returned to her with the completed questionnaires inside (for details of the procedure, please refer to the Methodology section). However, this procedure differed for the mother subjects, who mailed their material directly to the primary investigator. Since neither mother nor daughter group included subjects with the most extreme eating problems, it does not seem likely that this absence of data points was an artifact of the collection method.

Although the range of eating problem severity represented in this sample did not include the most extreme end, it was more than sufficient to perform meaningful analysis. However, as discussed below, the specific nature of the sample does require consideration with respect to the interpretations and generalizations that can be made.

Relationship Between Mother and Daughter Eating Problems

The results of this study found that there was not a significant relationship between mother and daughter degree of eating problem. At first glance, this appears to be a failure to replicate the findings of Pike & Rodin (1991), and consequently a point of doubt in the argument that maternal anxiety about her own weight and body is one of the starting points for the transmission of eating problems to the daughter. However, consideration of a recent paper (Rosenthal, 1995) on the determination of significance for empirical research in psychology tempers this conclusion.

Rosenthal (1995) has offered a comprehensive and persuasive argument for the reexamination of clinical research with an emphasis on meta-analysis and cumulation. He believes that clinical psychology has been too rigid with respect to the interpretation of results and so has often underestimated the significance of research findings. One of his points, quite simply put, is that "...10 p's of .10

are stronger evidence...than 5 p's of .05 [given that the effect is in the same direction]" (p.146).

Pike & Rodin reported that mothers of girls with disordered eating were significantly ($p < .02$) more eating disordered than the mothers of girls without eating disorders. Attie & Brooks-Gun (1989) found a relationship in the same direction, reporting that mothers' EAT-26 score approached significance ($p < .10$) as a predictor of daughters' EAT-26 score. However, in accordance with the conventional practice of reporting results as non-significant if $p > .05$, Pike & Rodin stated that the findings of Attie & Brooks-Gun contradicted their own and suggested that future studies seek to reconcile these seemingly disparate findings. However, reexamined with Rosenthal's recommendations in mind, the findings of Pike & Rodin (1991) and Attie & Brooks-Gun (1989) are consistent in suggesting that a relationship does exist between degree of maternal eating problem and that of the daughter, albeit of moderate magnitude.

The findings of the current study were the result of a 2-tailed Pearson R, had a $p < .18$, and thus were reported as not significant. However, if the less conservative 1-tailed Pearson had been performed, the probability would have decreased to .09, indicating a clear trend consistent with the results of both Pike & Rodin (1991) and Attie & Brooks-Gun (1989) and further substantiating the existence of a

meaningful relationship. To be sure, the findings of the present study alone do not provide very strong evidence for such a relationship; but it would be a misrepresentation of the study's findings only to report that no significant relationship between mother and daughter degrees of eating problem was found. It seems reasonable to argue that the current findings are within proximity to those previously published; at the very least the results are inconclusive.

**Domain-Specific Criticism and Eating Problems
(Replication of Pike & Rodin)**

Pike & Rodin's (1991) finding that maternal criticism of daughter weight significantly relates to a daughter's degree of eating problem, even after controlling for the influence of a daughter's actual weight, was solidly confirmed by the results of the current study: whether or not a daughter with a more serious eating problem was actually overweight, her mother was likely to be more critical of her weight.

Additional analyses performed for the present study, but not included in the work of Pike & Rodin, suggested that maternal criticism of a daughter's weight also tended to relate to her own degree of eating problem, particularly when the daughter was actually above optimal weight. Here we have preliminary evidence for the notion that maternal concern about her own weight results in criticism of her

daughter's weight, though the magnitude of these findings indicated a trend, as opposed to a clearly significant relationship and as such requires further study.

It appears that the relationship of maternal criticism to degree of daughter eating problem was domain-specific to weight and did not extend to mother's overall assessment of a daughter's attractiveness; no significant relationship was found between maternal rating of daughters' attractiveness and daughters' degree of eating problem. Nor did maternal criticism of a daughter's attractiveness relate significantly to degree of maternal eating problem. Taken together, these findings indicate that the maternal criticism which related to both maternal and daughter eating problem was narrowly focussed on weight and body and did not generalize to overall appearance.

Pike & Rodin's (1991) somewhat surprising finding that mothers of girls with more serious eating problems were more critical of their daughters' attractiveness than the girls were of themselves was not replicated. In the present study the daughters with more serious eating problems were more critical of their own attractiveness than were their mothers. These findings are consistent with a number of other indications in the literature. One of the key features of an eating problem is generally thought to be self-criticism with respect to appearance (eg, Bruch, 1973; Garner et al, 1983; Palazzoli, 1981). If the mothers were

more critical than the daughters were of themselves, it would suggest that either 1) the daughters had a low level of self-criticism, which would be entirely inconsistent with their having a more serious eating problem or 2) the mothers were so extremely critical of their daughters' appearance that they outstripped their daughters' level of self-criticism. If the Pike & Rodin finding was not in fact an artifact, the latter explanation seems more likely. Given that Pike & Rodin compared clinical and non-clinical groups, their finding may describe the mothers of daughters with the most serious eating problems, daughters not represented in the current study. Based on the eating problem severity distribution of the present study, it was not reasonable to expect such an elevated and pathological degree of domain-specific criticism with respect to attractiveness. In fact, maternal criticism of attractiveness was not shown to feature in any of the relationships examined in this study.

As reviewed earlier, there are a variety of theories with respect to the genesis of maternal concern and anxiety about a daughter's weight and the behavior it generates. These include the mother's intensity of identification with her same-sex child (Bloom et al, 1994; Orbach, 1986) and her unconscious mediation of cultural values (Pike & Rodin, 1991). The current study confirms the existence of this anxious expression of domain-specific criticism, suggests it is circumscribed in content--focussed only on weight, as

oposed to both weight and overall attractiveness as reported by Pike & Rodin (1991) --and relates it to both the mother's and daughter's degree of eating problem.

Domain-Specific vs. Global Criticism (EE)

The results of this study support the idea that a globally critical attitude on the part of a mother is not a significant variable with respect to the development of a mid-range eating problem in the daughter. Consistent with the model offered by Costanzo & Woody (1985), all the data point toward a maternal critical attitude limited to the specific domain of weight, as opposed to a more general phenomenon.

Since the EE measures used in this study were assumed to assess a global criticism representative of a more pervasive difficulty within the dyad, the results suggest that it is possible for a daughter to develop a mid-range eating problem without having had widespread disturbance in relationship to her mother. If this is true, it is then possible to de-pathologize maternal motivation: the domain-specific criticism may be understood as a response to accurately perceived cultural proscription and an expression of a mother's wish to facilitate her daughter's success, as opposed to just one of many symptoms in a trouble-laden relationship. Of course, this interpretation is necessarily

preliminary as the limited nature and number of measures employed in this study preclude broad conclusions.

Some previous research has found evidence for more global difficulty in the families of girls with eating problems. However since the majority of this work has focussed on clinical populations, it may be that the familial and/or mother-daughter problems observed (eg, Humphrey, 1986a, 1986b) are only manifest in those families with daughters at the most extreme end of the eating problem continuum within which intra-familial conflict shares equal billing with cultural context. The results of the current study are consistent with those of Amatea (1992) who found that mother-daughter hostility was not significantly related to a daughter's eating problem in a non-clinical population. As this research sample did not appear to include daughters with a clinical degree of difficulty, a comparison between clinical and non-clinical groups was not possible.

As reviewed earlier, the research specifically focussing on the variable of global criticism towards daughters with clinical eating problems is inconsistent. While there is some evidence that EE levels are generally low in the families of these girls, the published studies are almost exclusively focussed on anorexia (eg, Le Grange, 1989; Van Furth, 1989). Bulimic-daughter families have actually been found to have higher levels of EE (Szmukler et al, 1985) and it may be that at the clinical end of the

spectrum, pervasive conflict is expressed differently in the respective families--EE may be an appropriate measure for the families with a bulimic daughter, but not for those (few) with anorexic daughters. Though the data is inconclusive, it clearly raises questions about what kind of criticism--domain-specific and/or global--characterizes the families of girls with the most serious problems. Nonetheless, there is solid evidence that only domain-specific criticism with respect to weight features in the maternal attitudes towards daughters with a broad mid-range of eating problems.

Perception of Maternal Criticism

The question of whether or not a daughter's perception of her mother's critical attitude--domain-specific and/or global--would be more strongly related to her degree of eating problem than a mother's self-report of her critical attitude was answered in the negative. There were no significant relationships found between a daughter's perception of maternal global or domain-specific criticism and her degree of eating problem, while, as discussed earlier, a strong relationship was observed between a mother's self-report of her criticism of her daughter's weight and her daughter's degree of eating problem.

The findings with respect to global criticism were consistent with this study's other findings regarding global

criticism--it does not appear to have been a meaningful variable. That a daughter's perception of maternal domain-specific criticism, particularly with respect to weight, did not correlate with her degree of eating problem suggests that perception of criticism (vs. measurement of maternal expressed criticism) was not the potent variable Hooley & Teasdale (1989) found it to be in their research; in the current study, representation of maternal attitude did not feature as a correlate of degree of eating problem.

Of course, the next question is: if the mothers of girls with more serious eating problems were found to be more critical of their daughter's weight, weren't the daughters aware of this criticism? There appear to be data suggesting that these daughters were indeed cognizant of their mothers' attitude. While the detection of a correlational relationship between degree of daughter eating problem and perception of maternal weight criticism appeared to be obscured by the skewed shape of the distribution, t-test analysis did reveal a relationship: it was found that daughters with eating problems in the more serious half of the distribution tended toward experiencing their mothers as more critical of their bodies than did the daughters in the less serious half of the distribution ($p < .10$). There were also significant correlations between a daughter's perception of her mother's criticisms of her weight and body and her mother's reported criticism of her daughter's

weight--it appears that within the dyad there was clear communication along this channel.

The data with respect to the daughters' perception of her mother's critical attitude toward her overall appearance was inconclusive. T-test analysis comparing high DEI and low DEI daughter groups on items assessing daughter perception of this aspect of maternal criticalness had 2-tailed probability levels of .12 and .16, which are not significant. However, as noted earlier, the sample distribution was comparatively flat at the tails and so the detection of a difference was relatively difficult. Thus, it is likely that in a more well-distributed sample, a real difference would have been observed.

While degree of eating problem (more serious/less serious) cannot be conclusively described as relating to perception of maternal critical attitude towards overall appearance, the results do show a correlational relationship between a daughter's perception and mother's self-report of that attitude irrespective of degree of eating problem: daughters tended to have an accurate representation of their mothers' critical attitude toward their appearance. However, these results were trends, as opposed to significant findings.

Overall, it appears that communication between mother and daughter with specific respect to weight was more accurately perceived by the daughter, as well as more

related to her degree of eating problem, than was communication about general appearance. It may be that weight concerns are so salient in our culture that within mother-daughter dyads there is a hyper-attunement to this criticism which does not generalize to other domains. Further, weight is often mistakenly perceived as something one can easily change, whereas general attractiveness is typically viewed as less mutable. It may be that mothers feel more freedom to criticize their daughters' weight because there is the perceived possibility of improvement. There may also be greater variance with respect to what and who one deems "attractive"; while weight--which in our culture is obsessively tracked by numbers (pounds, clothing sizes, body measurements) to ostensibly provide objective assessment--is seemingly less open to subjective evaluation. Thus, a mother may be less inhibited with respect to criticizing her daughter's weight, believing herself to be more objectively correct in her assessment.

Cultural Criticism

The findings of this study clearly indicate that criticism from sources other than mother is a meaningful variable with regard to an adolescent girl's eating problem. First, all five factors of the CIMEC had strong correlations with a daughter's degree of eating problem. As mentioned earlier, Factor I (Distress Because of Body Image), which

measured the extent and effect of believing oneself to be overweight, was found to be essentially equivalent to the DEI, specifically those DEI items from the Body Dissatisfaction subscale which assessed self-criticism of different body areas (hips, buttocks, stomach). However, Factors II - V, which did not have the same content overlap with DEI items, still demonstrated a strong relationship with a daughter's degree of eating problem.

As assessed by the CIMEC, advertising, verbal messages from the media, and social models like actresses and fashion models, all had more of an impact on the food & body experiences and attitudes of girls with more serious eating problems. Clearly, these results beg the question of antecedence: is receptivity to cultural influence a symptom or a cause of eating problems? This was largely a correlational study and so it hardly requires stating that causation could not be determined. Nonetheless, the issue merits further exploration.

This project assumed that the "influence" described by Toro et al (1994) can be understood as cultural criticism. That is, when an advertisement promises a slender figure, there is an implicit criticism of figures that are not slender; when a magazine describes a quick weight-loss program, there is a clear criticism of those with a few "extra" pounds; and the pencil-thin form required of models is a barely-disguised reproach to those whose bodies differ.

What the girls with more serious eating problems who participated in this study reported was that they were both more attentive and behaviorally reactive to this criticism.

Some have argued (Hamilton & Waller, 1993; Waller, Hamilton & Shaw, 1992) that as a part of their symptom configuration, girls with eating problems have a cognitive orientation towards issues of weight and body which expresses itself in a heightened attention to those aspects of our culture. This interpretation of the data, which suggests a relationship between attention to media messages and presence of eating problem, while plausible in that it frankly acknowledges the limitations of correlational research, nonetheless flies in the face of reasonable understanding. The most compelling argument against taking this view as the only explanation for the data is offered by those studies which have underscored the likelihood that eating problems are culture-bound syndromes (King, 1993; Iancu et al, 1994; Pumariega, 1986). If vulnerability and attentiveness to media messages, which are here understood as direct manifestations of cultural attitude and value, are viewed as only a symptom of eating problems, would we not expect to find similar problems in the female populations of all societies regardless of whether or not their culture was similarly saturated with cultural criticism? At the very least, one must acknowledge a reciprocity between individual

and culture; a reciprocity which perpetuates or exacerbates the eating problem.

Future research should attempt longitudinal examination of the ages at which girls become 1) attuned to cultural criticism and 2) eating problem symptomatic. This recommendation is made with the specific goal of teasing stronger evidence of cultural culpability out of the confusion of reciprocal interaction that characterizes the adolescent girl's relationship to cultural criticism.

"Culture Mother" vs Biological Mother

Multiple regression analysis of those variables found to have a significant correlation with degree of daughter eating problem revealed that CIMEC Factors III (Influence of Verbal Messages) and V (Influence of Social Situations), along with maternal criticism of daughter weight accounted for 56% of the total variance of the daughter DEI score. This appears to be solid evidence that both culture and biological mother attitude are relevant variables with regard to a daughter's eating problem.

As just noted, longitudinal research is required to assign causal impact of either maternal or cultural criticism on eating problems. However, the data do seem strongly suggestive of causality. It is important to note that the maternal weight-criticism data was collected from the mother. If it had only been the daughter's report of

her mother's weight criticism which had correlated with a more serious eating problem, then one might argue that these daughters' perceptions of their mothers as weight critical was yet another symptom of their eating problem (this in an argument similar to that of Hamilton & Waller (1993)): eating problems are characterized by a perception of maternal criticism, as they are also characterized by heightened attention to media messages). However, the data make it almost certain that the mothers actually were critical--it is difficult to explain how this maternal self-reported criticism can be understood as a symptom of the daughter's eating problem; it seems quite likely that the maternal attitude was, in fact, a contributing aspect to the development of the eating problem.

That a similar claim cannot be made with respect to cultural criticism does not automatically discount its influential role. Cultural criticism cannot be measured in the same way as maternal criticism--there is not an individual to whom questions might be addressed; the criticism must be measured obliquely. That it is more difficult to assess does not equate to an absence of causal influence.

That both biological and culture mothers do have authority for daughters is strikingly illustrated by the data on the girls' attribution of influence with respect to the formation of their eating habits and conception of the

ideal body. Here, causation--or, what also might be categorized as perception of cultural criticism--was directly probed and the girls revealed an intriguing dichotomy between the two influence sources, with mothers overwhelmingly cited as the key figure with respect to the development of eating habits (38.3%) and the media held as arbiter of body perfection (48.9%). (These results were irrespective of degree of eating problem: because there were six categories of response to these questions, it is likely that the sample size was not large enough to detect a difference in attribution between girls with more and less serious eating problems.)

One explanation for the extent of the split noted in attribution of influence--only 6.4% of the girls attributed primary influence on their conception of the ideal body to their mother; 60.9% attributed primary influence to the media or other cultural variable (48.9%, media; 12%, other cultural variable)--may be that mother is more closely associated with food and feeding, as well as with the instructional aspects of nutrition and weight maintenance, while the notion of "ideal body" (vs. ideal weight) has a sexual connotation typically underscored in the media, but perhaps avoided in the mother-daughter relationship, the daughter's conscious representation of that relationship, or both. It is also likely that the data accurately reflect the extreme degree of body-related media inundation

experienced by these girls and the profound influence it has on their body conceptions.

Not all girls reported their mothers as the most influential with respect to their eating habits; a substantial portion of the sample cited their own experiences of hunger and satisfaction as the guiding aspect of their eating habits. Fewer girls made this attribution to self with respect to body ideal. This is not surprising as the very notion of an "ideal body" is culture-bound and thus tied to external markers; eating in its most natural state is the behavioral result of the internal experience of hunger, not the influence of the exterior world of fashion and value.

Peers

There were a number of findings with respect to peer criticism. First, friends were also reported as influential in the domains of eating habits and ideal body conception, though they were cited somewhat more frequently with respect to the former (27.7% vs 17%). In fact, after "mother," "friend" was the most common category of attribution with respect to influence on eating habits. Peers clearly have some perceived influence on adolescent girls' attitudes toward food and body.

The contradictory findings with respect to the relationship between having weight-preoccupied friends and

reporting a more serious eating problem are difficult to explain. The data indicate that while a girl with a more serious eating problem did not experience her friends as either more troubled about their own weight or more often discussing the topic, she did report having more friends who were concerned about their weight than did girls with less serious eating problems. While these are all clearly related aspects of the issue, it appears that the specific characteristic queried with respect to the peer relationship made a difference. When asked about the the intensity of her friends' concern or the frequency of their weight-related discussion, daughters with both more and less serious eating problems reported similarly. However, when the number of friends with these concerns--regardless of the intensity of their concern or the frequency of its expression--was investigated, it was found that girls with more serious eating problems reported having more friends with similar anxieties. This latter finding is consistent with a previous study (Pike, 1989) which found that a girl's disordered eating correlated with the number of similarly disordered friends she had.

Gibbs (1986) reported that frequency of weight-related discussions with friends was related to more serious eating problems. While this seems to counter the current findings, there is actually a subtle difference between the item in this study which asked how often the subject's friends

engaged in these discussions and the Gibbs study which asked about the frequency of the subject's participation.

Perhaps, what the present study most clearly demonstrated is that, while adolescent girls do experience the attitudes of their friends as influential with respect to the development of their own attitudes about food and body, the kind and quality of peer impact on the development of eating problems is not so clear. Further investigation, more thoroughly exploring the question of peer influence, is indicated.

The most interesting finding with respect to peer criticism was that the girls with more serious eating problems perceived their friends as more critical of their weight, while acknowledging that these friends did not actually tell them they needed to lose weight. Since these results were found when the actual weight of the subjects was held constant, the girls with more serious eating problems perceived their friends as weight-critical even when they were not above optimal weight. Thus, we might conclude that the results describe a process in which girls with more serious eating problems project their own self-criticism onto their peers or displace maternal and/or culture criticism onto their friends. That the girls in this study reported their friends did not actually tell them of their criticism, though culturally syntonetic in that we typically temper the expression of weight-related criticism

in social situations, may provide further evidence that the girls' perception of this attitude was more dynamically determined.

It is also possible that, despite the contradictory findings of this study, the friends of girls with more serious eating problems had more serious eating problems themselves and thus their hyper-critical attitude towards their own weight was generalized to those around them and then accurately perceived by their friends, who were the subjects in this study with more serious eating problems. The explanation for the friend weight-criticism data would then be similar to that already put forth with respect to maternal weight criticism: anxiety about one's own weight and body leads to criticism of others. In this view, both mothers and friends would be understood as (unconscious) mediators of cultural criticism.

The findings on peer criticism are less coherent than those for other aspects of this study. It is apparent that more thorough, detailed exploration of peer relationships as they relate to eating problems is necessary.

Actual Weight as a Key Variable

There were various findings reported in the Results section that, when examined as a group, highlight the importance of a subject's actual weight with respect to degree of eating problem and maternal domain-specific

criticism. The domain of actual weight was not originally targeted for investigation, but the data clearly indicate a relationship to eating problems, and underscore the consequence of being above optimal weight in our culture. As such, they merit some attention.

First, both mother and daughter degree of eating problem were significantly correlated with BMI: the heavier a subject, the more serious the degree of eating problem she reported. As mentioned earlier, contrary to popular wisdom, many females suffering with eating problems are at or above optimal weight (Bloom et al, 1994; DSM-IV, 1994). The ideational aspects of eating problems--particularly the self-criticism--are likely compounded for women who actually exceed the narrow parameters of accepted female body size.

It is not just self-criticism which features for these subjects, but maternal criticism as well. Both maternal criticism of daughter weight and of attractiveness were significantly correlated with daughter BMI. The larger a daughter, the more critical her mother was in both these areas, regardless of whether the daughter reported a more serious eating problem. Not surprisingly, overweight in our culture relates to criticism.

Post-hoc analysis further revealed that these daughters accurately perceived their mothers' critical attitude towards their weight as measured by the PCDS items (1) ($r = .45, p < .001$) and (3) ($r = .36, p < .01$), but did not perceive

the maternal criticism of overall attractiveness as measured by PCDS items (2) ($r = .07$, ns) and (4) ($r = .12$, ns). This is consistent with the data related to eating problems discussed earlier: there appears to be clear communication between mother and daughter with respect to weight criticism, while expression of maternal attitude towards overall attractiveness appears to be less frank. Of course one might interpret the data as pointing towards a defensive inability to perceive maternal criticism of overall attractiveness on the part of the daughters. This does not seem likely: social critics have recently observed that our culture sanctions the criticism of weight and body in a way that is not tolerated if the criticism is in any other domain (eg, Bordo, 1993). These data appears to substantiate those observations.

Summary & Conclusion

This study of middle and upper-middle class, primarily Caucasian, adolescent girls and their mothers lends support to the idea that maternal anxiety about her own weight and body, as well as concern for a daughter's success in our weight-obsessed culture, result in an expression of extremely focussed domain-specific criticism of a daughter's weight, which in turn, contributes to the development of a mid-range eating problem in the daughter. This process may occur within a relatively criticism-free dyad and thus may

represent a localized area of anxiety and conflict as opposed to a symptom of a more global difficulty between the pair. However, this sample did not appear to include girls with the most serious degree (clinical-level) of difficulty. Further research is required to more completely and clearly discern the relationship between global criticism (EE) and extreme eating problems.

Further, within the theory broadly tested in this study, cultural criticism was believed to be internalized directly from the media and peers--the adolescent cultural milieu--without maternal mediation and thus able to contribute independently to the development of a girl's eating problem. This, too, was supported by the data, though there were some unclear findings. Areas for future research include longitudinal study of the emergence of eating problems with particular emphasis on the influence of culture, and more thorough investigation of the apparently complex relationship between peer criticism/influence and eating problems.

There were a variety of findings within the domain of perceived criticism. In general, it appeared that perception of maternal weight criticism by a daughter was accurate. However, results with respect to perception of maternal criticism of overall attractiveness were inconclusive. No relationship was found between perception of global criticism and daughter eating problem. Taken

together, these findings suggest that, in the area of eating problems, perceived criticism is not the key variable found in earlier research on depression (Hooley & Teasedale, 1989).

Overall, the findings of this study point toward the importance of undertaking psychoeducational efforts to 1) underscore and deconstruct the cultural aspect of the notions women have with respect to weight, body, appetite and desire, 2) depathologize the mother-daughter relationship in dyads within which the daughter has an eating problem and 3) spotlight the behaviors--like maternal weight-criticism--known to correlate with a daughter's eating problem, uncover their cultural genesis and present alternatives for confronting and overcoming female anxiety about the meaning of weight and body shape in our culture.

Appendix A/1

ID# _____

1) Your date of birth _____

2) Your ethnicity (please circle one): Caucasian/European

African-American Latina-American Asian-American

Other (please specify) _____

3) Your grade in school (please circle one):

9th 10th 11th 12th

4) Your height _____

5) Your current weight _____

6) Your ideal weight _____

Please circle the number that most closely corresponds to your experience:

Compared with other girls my age, I am:

1	2	3	4	5
a great deal less attractive		equally attractive		a great deal more attractive

Appendix A/2

ID# _____

- 1) Your date of birth _____
- 2) Your ethnicity (please circle one): Caucasian/European
 African-American Latina-American Asian-American
 Other (please specify) _____
- 3) Your highest educational degree (please circle one):
 elementary school high school college
 graduate/professional school
- 4) Your approximate annual family
 income _____
- 5) Your height _____
- 6) Your current weight _____
- 7) Your ideal weight _____

Please circle the number that most closely corresponds to
 your experience:

Compared with women my own age, I am:

1	2	3	4	5
a great deal less attractive		equally attractive		a great deal more attractive

Appendix A/3

ID# _____

- 1) Your daughter's height _____
- 2) Your daughter's current weight _____
- 3) Your daughter's ideal weight _____

Please circle the number that most closely corresponds with your experience:

Compared with girls her age, my daughter is:

1	2	3	4	5
a great deal less attractive		equally attractive		a great deal more attractive

Appendix B

ID# _____

Please read each question carefully and circle the response that most closely corresponds to your experience.

1) I eat sweets and carbohydrates without feeling nervous
always usually often sometimes rarely never

2) I think my stomach is too big
always usually often sometimes rarely never

3) I eat when I am upset
always usually often sometimes rarely never

4) I stuff myself with food
always usually often sometimes rarely never

5) I think about dieting
always usually often sometimes rarely never

6) I think that my thighs are too large
always usually often sometimes rarely never

7) I feel extremely guilty after overeating
always usually often sometimes rarely never

8) I think my stomach is just the right size
always usually often sometimes rarely never

9) I am terrified of gaining weight

always usually often sometimes rarely never

10) I feel satisfied with the shape of my body

always usually often sometimes rarely never

11) I exaggerate or magnify the importance of weight

always usually often sometimes rarely never

12) I have gone on eating binges where I felt I could not
stop

always usually often sometimes rarely never

13) I like the shape of my buttocks

always usually often sometimes rarely never

14) I am preoccupied with the desire to be thinner

always usually often sometimes rarely never

15) I think about bingeing (overeating)

always usually often sometimes rarely never

16) I think my hips are too big

always usually often sometimes rarely never

17) I eat moderately in front of others and stuff myself when they're gone

always usually often sometimes rarely never

18) If I gain a pound, I worry that I will keep gaining

always usually often sometimes rarely never

19) I have the thought of trying to vomit in order to lose weight

always usually often sometimes rarely never

20) I think my thighs are just the right size

always usually often sometimes rarely never

21) I think my buttocks are too large

always usually often sometimes rarely never

22) I eat or drink in secrecy

always usually often sometimes rarely never

23) I think my hips are just the right size

always usually often sometimes rarely never

Appendix C

ID# _____

Please circle the number that most closely corresponds to your experience:

1) My mother thinks I should lose weight:

all the time	frequently	sometimes	rarely	never
1	2	3	4	5

2) My mother thinks I am attractive:

all the time	frequently	sometimes	rarely	never
1	2	3	4	5

3) My mother thinks I have a nice body:

all the time	frequently	sometimes	rarely	never
1	2	3	4	5

4) Compared with other girls my age, my mother thinks I am:

a great deal less attractive attractive	somewhat less attractive	equally attractive	somewhat more attractive	a great deal more attractive
1	2	3	4	5

Appendix D

ID# _____

Please circle the response that most closely corresponds to your experience:

1) When you are watching a film, do you watch the actresses with special attention to whether they are overweight or slim?

yes, always yes, at times no, never

2) When you eat with other people, do you pay particular attention to the amount that each of them eats?

yes, always yes, at times no, never

3) Do you envy the bodies of ballet dancers and gymnasts?

yes, a lot yes, somewhat no, not at all

4) Do you get upset when you put on clothing that is too small or too tight?

yes, a lot yes, somewhat no, not at all

5) Do television commercials that advertise weight-loss products catch your attention?

yes, always yes, at times no, never

6) Do store displays of weight-loss products catch your attention?

yes, always yes, at times no, never

7) When you see or hear an ad for diet soda, do you find yourself wanting one?

yes, always yes, at times no, never

8) Because you see yourself as fat, are you both drawn to and disgusted by your image in the mirror?

yes, a lot yes, somewhat no, never

9) When you are out on the street, do you look to see if people are fat or skinny?

yes, always yes, at times no, never

10) Have you ever gone on a diet?

yes, more than 2 times yes, 1 or 2 times no, never

11) Do weight-loss advertisements in magazines catch your attention?

yes, always yes, at times no, never

12) Do you envy fashion models because they are slim?

yes, always yes, at times no, never

13) Would you get upset if someone called you "full-figured" or spoke of your healthy appetite even if they meant it in a positive or affectionate way?

yes, a lot yes, somewhat no, not at all

14) Are you drawn to conversations about weight, calories, women's figures, etc.?

yes, all the time yes, sometimes no, never

15) Are you distressed by weight-loss commercials?

yes, a lot yes, somewhat no, not at all

16) Are you drawn to books, magazine articles and advertisements that talk about calories?

yes, a lot yes, somewhat no, not at all

17) Do you get upset about the coming of summer because you have to wear lighter clothes and a bathing suit?

yes, a lot yes, somewhat no, not at all

18) Are you interested in articles and reports about weight-loss diets?

yes, a lot yes, somewhat no, not at all

19) Do you have a female friend who is distressed or very worried about her weight or shape of her body?

yes, more than 2 yes, 1 or 2 no, none

20) Does seeing or hearing ads for weight-loss products make you want to use those products?

yes, always yes, at times no, never

21) Are you envious of the willpower of those able to follow a diet?

yes, a lot yes, somewhat no, not at all

22) Are you tempted to try a slimming cream when you see the ads for them?

yes, always yes, sometimes no, never

23) Do you believe that young women who are thin are more accepted than those who are not thin?

yes, certainly yes, probably no, I don't believe this

24) Do you look at pictures and advertisements featuring women in jeans, bathing suits and lingerie?

yes, a lot yes, somewhat no, not at all

25) Do laxative commercials catch your attention?

yes, a lot yes, somewhat no, never

26) If you're invited out to eat with others, do you worry about the amount of food you may be expected to eat?

yes, a lot yes, somewhat no, never

Appendix E

Please circle the number that most closely corresponds to your experience:

1) My friends think I should lose weight:

yes	probably	maybe	unlikely	no, they don't
1	2	3	4	5

2) My friends tell me I should lose weight:

almost always	frequently	sometimes	rarely	never
1	2	3	4	5

3) My friends are concerned about their weight:

almost always	frequently	sometimes	rarely	never
1	2	3	4	5

4) My friends talk about dieting, weight-loss and related topics:

almost always	frequently	sometimes	rarely	never
1	2	3	4	5

5) My eating habits have been most influenced by (circle one):

- | | |
|--|------------------------------------|
| 1. my mother | 2. other relative |
| 3. my friends | 4. things I've learned in school |
| 5. television | 6. books and magazine articles |
| 7. famous person
(model, athlete,
actress, etc.) | 8. other (please specify)
_____ |

6) My conception of the "ideal body" has been most influenced by (circle one):

- | | |
|--|------------------------------------|
| 1. my mother | 2. other relative |
| 3. my friends | 4. television |
| 5. movies | 6. magazines |
| 7. famous person
(model, athlete,
actress, etc.) | 8. other (please specify)
_____ |

8) My mother approves of my friends

almost never/once in a while/sometimes/often/almost always
 1 2 3 4 5

9) I often know what my mother is thinking before she tells me

almost never/once in a while/sometimes/often/almost always
 1 2 3 4 5

10) My mother complains about what I do for fun

almost never/once in a while/sometimes/often/almost always
 1 2 3 4 5

11) If I am upset, my mother gets upset too

almost never/once in a while/sometimes/often/almost always
 1 2 3 4 5

12) My mother is always trying to get me to change

almost never/once in a while/sometimes/often/almost always
 1 2 3 4 5

13) If I have no way of getting somewhere, my mother will take me

almost never/once in a while/sometimes/often/almost always
 1 2 3 4 5

14) I have to be careful what I do or my mother will put me down

almost never/once in a while/sometimes/often/almost always
 1 2 3 4 5

How critical do you think your mother is of you?

1 2 3 4 5 6 7 8 9 10
 not at very
 critical critical

Appendix F/2

ID# _____

Please circle the number that most closely corresponds to your experience.

1) I am upset if my daughter is upset

almost never/once in a while/sometimes/often/almost always
 1 2 3 4 5

2) I approve of most everything my daughter does

almost never/once in a while/sometimes/often/almost always
 1 2 3 4 5

3) I know what my daughter is feeling most of the time

almost never/once in a while/sometimes/often/almost always
 1 2 3 4 5

4) I find fault with my daughter's friends

almost never/once in a while/sometimes/often/almost always
 1 2 3 4 5

5) I give my daughter money when she needs it

almost never/once in a while/sometimes/often/almost always
 1 2 3 4 5

6) I tell my daughter I don't approve of how she handles money

almost never/once in a while/sometimes/often/almost always
 1 2 3 4 5

7) I know what my daughter is thinking before she tells me

almost never/once in a while/sometimes/often/almost always
 1 2 3 4 5

8) I approve of my daughter's friends

almost never/once in a while/sometimes/often/almost always
 1 2 3 4 5

9) My daughter knows what I am thinking before I tell her

almost never/once in a while/sometimes/often/almost always
 1 2 3 4 5

10) I tell my daughter that I disapprove of what she does
 for fun

almost never/once in a while/sometimes/often/almost always
 1 2 3 4 5

11) If my daughter is upset, I get upset too

almost never/once in a while/sometimes/often/almost always
 1 2 3 4 5

12) I am trying to get my daughter to change

almost never/once in a while/sometimes/often/almost always
 1 2 3 4 5

13) If my daughter has no way of getting somewhere, I will
 take her

almost never/once in a while/sometimes/often/almost always
 1 2 3 4 5

14) I have to be careful not to put my daughter down

almost never/once in a while/sometimes/often/almost always
 1 2 3 4 5

How critical do you think you are of your daughter?

1 2 3 4 5 6 7 8 9 10
 not at very
 critical critical

Appendix G

Dear _____:

Here's the data collection material for my project. I've enclosed: # introductory handouts; # consent form letters for moms; # questionnaire packets for daughters; and # sealed (more on this later) questionnaire packets for moms. The procedure is as follows:

- 1) you speak to a girl and give her the handout
- 2) if she's interested, you give her consent form letter for her mom
- 3) If her mom approves and signs the form, the girl returns it to you--you hold on to consent forms and mail to me later
- 4) you then assign the girl and her mom ID#s, a record of which you keep--this is **very** important for follow-up
- 5) you give girl the packet with her ID#
- 6) she completes it (hopefully this happens right away; encourage girls to fill out the questionnaires right then and there while still affording them some privacy--we can talk about this)
- 7) you take questionnaire in sealed envelope from girl and mail to me
- 8) girl is given packet for her mom with matching ID# -- mom sends completed questionnaires to me (hopefully)
- 9) when I receive both mom and daughter data in the mail, you get \$10

Any number of things can go wrong with this procedure: girl can lose/forget to bring mom consent form; girl can be lax in returning completed questionnaires to you; mom can neglect to return her questionnaires. I will need your help in trying to move things along, remind/cajole volunteers, etc. Finally, the mother packets are sealed because I don't want the daughters looking at the moms' questionnaires if at all possible. While I think it's a good idea for you to look at the packet for the daughters and be familiar with it, it is probably best that you don't know what's in the mother packets either. This way if any of your friends ask, you can honestly say you don't know. In reality, there is not much difference between the two packets. The mother packet is smaller, but quite similar to the daughter packet--it's OK to say that much about it to your friends. I'm just trying to provide as much privacy for each volunteer as possible, as well as attempting to prevent contamination of my data.

So, let's talk as soon as you get all this so we can discuss any problems or questions.

Appendix H

**NEEDED: HIGH SCHOOL GIRLS (AND THEIR MOMS)
FOR RESEARCH STUDY**

Would you like to participate in a study of high school girls and their experience of family, culture and themselves? It will only take about 15 minutes of your time and about 10 minutes of your mom's time, you will be making a contribution to the field of psychology AND you will probably find the project interesting (if I do say so myself). Here's the deal:

I am a doctoral student in Clinical Psychology at City College. One of the requirements for earning a PhD is the completion of a substantial research project known as a dissertation. My dissertation is about teenage girls and their relationship with their families, their friends, their bodies and the media. I can't be too specific about the study because if you participate you should not be biased. That is, if you know what I am looking to find, it might influence the way you respond to some of the questions I ask. However, after the study is over, I will tell you all about it and what I found.

If you would like to participate _____ will give you a letter and consent form for you to bring to your mom. If she agrees to participate, please return the signed consent form to _____. She will then give you a packet of questionnaires to complete. When you have returned them to her (in a sealed envelope-- everything is totally confidential), she will give you a packet for your mom. Your mom will mail her completed questionnaires directly to me. That's all there is to it.

If _____ is unable to answer a particular question you may have, please feel free to call me at (212) 799-4861.

THANK YOU!! THANK YOU!! THANK YOU!!

Appendix I

Dear Parent :

I am a doctoral candidate in Clinical Psychology at the City College of New York currently working on my dissertation. My research is on adolescent girls and aspects of their family and cultural experience. I am particularly interested in how these experiences relate to attitudes towards food, eating and body image.

I am looking for adolescent girls and their mothers interested in taking part in this study by completing some questionnaires. Your participation will further enhance scientific understanding of issues of concern to adolescent girls and only about 10 minutes of your time will be required. It will take somewhat longer for your daughter to complete her questionnaires, approximately 15 - 20 minutes. Total **anonymity** and **confidentiality** will be provided for you both.

If you would like to volunteer, please sign the attached consent form and have your daughter return it to _____ . She will then be given a packet of questionnaires to complete and another packet to bring to you. Your packet will have a self-addressed, stamped envelope into which you can place your completed questionnaires to be mailed to me. Your packet will only be identified by an ID# matching that of your daughter.

When I have collected and analyzed all the data, I will contact you with a summary of my findings. Should you have any questions, please feel free to contact me at (212) 799-4861.

Thank you very, very much for your help.

Sincerely,

Melissa Ritter

Appendix J

CONSENT FORM

I hereby consent for both myself and my daughter to participate in a study on adolescent girls' family and culture experiences as they relate to attitudes toward food, eating and body-image. The research is being conducted by Melissa Ritter as partial fulfillment of the requirements for a Doctor of Philosophy in Clinical Psychology at The City College of New York.

My and my daughter's involvement will consist of completing questionnaires. I understand that anonymity and confidentiality is ensured and that my name will not be affiliated with the results of this study. I also acknowledge that my and my daughter's participation in this study is voluntary and I or my daughter may withdraw from this research at any time without consequence. Further, I understand that there are no direct benefits to be expected from participation in this study, and that the risks involved are minimal or non-existent. The study has been explained to me and if I have any questions during the study, I may contact Melissa Ritter at (212) 799-4861.

Daughter's name (please print)

Mother's name (please print)

Address (please print)

Signature of Mother

Date

Appendix K

Dear Volunteer:

First, let me thank you for taking the time to help me with my study. By doing so you are making a contribution to the further understanding of the concerns of adolescent girls like yourself.

The attached questionnaires should not take very long to complete. They include questions about different kinds of eating habits and feelings about your body, as well as a few items about your relationship with your mother. Some of the questions may apply to you, some may not. What is most important is that you are as honest as possible--remember, everything is **anonymous** and **confidential**--and that you answer every question.

When you are done, please seal all the questionnaires in the self-addressed, stamped envelope provided and give it to _____ . She will then mail it to me and give you a packet to give to your mother. Please try not to talk to your mom about your questionnaires until after she has completed hers. This is because I want to know how each of you feel about things independent of one another. When the results of this study are in I will send a summary of the findings to you and your mom. Of course if you have questions for me, please don't hesitate to ask (212-799-4861).

Sincerely,

Melissa Ritter

Appendix L

Dear Volunteer:

First, let me thank you for taking the time to help me with my study. By now your daughter has completed her packet of questionnaires and it's your turn--your participation is much appreciated.

The attached questionnaires should not take very long to complete (about 10 minutes). They include questions about different kinds of eating habits and feelings about your body, as well as a few items about your relationship with your daughter. Some of the questions may apply to you, some may not. What is most important is that you be as honest as possible--remember everything is **anonymous** and **confidential**--and that you answer every question.

When you are done, please put all the questionnaires in the self-addressed, stamped envelope provided and mail it to me as soon as is convenient. Finally, please try not to talk to your daughter about these questionnaires until both of you have completed them. This is because I'd like to know each of your experiences independent of one another. When the results are in I will send you and your daughter a summary of my findings. In the meantime, should you have any questions for me I encourage you to call at (212) 799-4861.

Thanks again for your help!

Sincerely,

Melissa Ritter

Appendix M

April, 1996

Dear Mother and Daughter Study Participants:

My study of adolescent girls and their eating and body issues is completed and the results are in. Without your generous participation it would not have been possible, so once again, thank you. What follows is an overview of the findings:

47 mother-daughter pairs completed the questionnaires. Most of these women were from NYC and Westchester, though there was a group from Pennsylvania as well. The majority of participants identified themselves as Caucasian and middle to upper-middle class. This is important to know as the findings cannot be generalized to other populations. That is, women of color may have very different experiences than those found in this study, as may women of lesser financial means.

Both the mother and daughter groups included a wide range of difficulties with eating and body issues: some participants reported a high degree of satisfaction with their bodies and minimal concern about what and how they ate; while others expressed much anxiety, self-criticism and overall unhappiness with respect to the same issues. Those in the latter group were described in the study as having more serious "eating problems."

In this study, eating problems were conceptualized as including what are currently known as clinical eating disorders, as well as the more common phenomenon of women disliking their bodies, restricting or otherwise monitoring their food intake, and, perhaps, occasionally resorting to vomiting, laxative use, or fasting in order to control their weight. It did not appear that anyone participating in this study had a clinical eating disorder, though definitive diagnosis could not be made from the information gathered. In our culture, many women suffer with great unhappiness about their bodies without actually having a clinical eating disorder. It is this kind of difficulty that was of central interest in my research.

The findings of the study indicated that adolescent girls with more serious concerns about food and body are more sensitive to, and influenced by, cultural messages

about food and body. Advertising of weight-loss products, magazine articles about dieting, and other forms of cultural criticism of the female body are upsetting to these girls and may actually have contributed to the initial development of their eating problem. It was quite clear that the majority of girls, whether or not they had a more serious eating problem, experienced the media as having a powerful influence on their conception of what constitutes an attractive female form.

A mother's difficulty with food and body issues was also found to be a meaningful variable with respect to a daughter's eating problem. It appeared that mothers who were more distressed by issues regarding food and body tended to have daughters with similar worries. More specifically, mothers who were more concerned about their daughters' weight--even if those daughters were not actually overweight--seemed to have daughters more concerned about weight and eating. Taken together, these findings suggest that a mother's worry over her own food and body issues gets extended to her daughter.

What is important to note is that this finding does not suggest a mother is somehow at fault with respect to her daughter's eating problem. Mothers want their daughters to be successful, and in our culture being thin is (unfortunately) considered to be very important for women. A mother who is more sensitive to this pressure may have a higher degree of concern about her own body size and that of her daughter. The daughter, immersed in media messages about the way she should look and eat, as well as feeling her mother's concern, may then develop an eating problem.

Cultural and maternal attitudes are only two of what are certainly many contributing factors with respect to a daughter developing an eating problem. What this study alerts us to is the importance of becoming aware of the degree to which cultural messages about weight and body influence our attitudes about ourselves.

This has been a brief review of my study and some of its findings. Should you have questions or comments of any kind, please contact me at the above phone number or address. I would be happy to speak with you.

Thanks again for your participation.

Sincerely,

Appendix O

Table 5a-b
T-TESTS COMPARING HIGH AND LOW DAUGHTER DEI SCORE GROUPS ON
MATERNAL RATING OF DAUGHTER ATTRACTIVENESS AND
DAUGHTER RATING OF HER OWN ATTRACTIVENESS

Table 5a -- T-Test for Maternal Rating of Daughter
Attractiveness

	<u>Cases</u>	<u>Mean</u>	<u>St.Dev.</u>	<u>t-value</u>	<u>df</u>	<u>2-tail</u> <u>Prob.</u>
Low	23	3.74	.81	-1.44	45	.16*
High	24	4.04	.62			

*not significant

Table 5b -- T-test for Daughter Rating of Daughter
Attractiveness

	<u>Cases</u>	<u>Mean</u>	<u>St.Dev.</u>	<u>t-value</u>	<u>df</u>	<u>2-tail</u> <u>Prob.</u>
Low	23	2.87	.82	-.209	45	.04**
High	24	3.29	.55			

**significant

Table 6a-b
T-TESTS COMPARING HIGH AND LOW DAUGHTER DEI SCORE GROUPS ON
MATERNAL PC ITEM AND FEICS SCALE MEASURES OF GLOBAL
CRITICISM

Table 6a -- T-Test for PC Item

	<u>Cases</u>	<u>Mean</u>	<u>St.Dev.</u>	<u>t-value</u>	<u>df</u>	<u>2-tail Prob.</u>
Low	23	4.70	2.03	.73	45	.470*
High	24	4.25	2.15			

*not significant

Table 6b -- T-test for FEICS Scale

	<u>Cases</u>	<u>Mean</u>	<u>St.Dev.</u>	<u>t-value</u>	<u>df</u>	<u>2-tail Prob.</u>
Low	23	2.62	.26	.04	45	.970*
High	24	2.63	.45			

*not significant

Table 9
CHI-SQUARE ANALYSIS OF ATTRIBUTION OF INFLUENCE ON
EATING HABITS

	<u>High DEI</u>	<u>Low DEI</u>
Mother & Other Relatives	12 60.0% 52.2%	8 40.0% 33.3%
Friends & School	7 53.8% 30.4%	6 46.2% 25.0%
Media	1 25.0% 4.3%	3 75.0% 12.5%
Other	3 30.0% 13.0%	7 70.0% 29.2%

$\chi^2(3) = 3.45, P > .05$

Note: Cell entries are *n*'s, row percentages, and column percentages.

Table 10
CHI-SQUARE ANALYSIS OF ATTRIBUTION OF INFLUENCE ON
CONCEPTION OF IDEAL BODY

	<u>High DEI</u>	<u>Low DEI</u>
Mother & Other Relatives	1 33.3% 4.3%	2 66.7% 8.3%
Friends & School	5 45.5% 21.7%	6 54.5% 25.0%
Media	13 56.5% 56.5%	10 43.5% 41.7%
Other	4 40.0% 17.4%	6 60.0% 25.0%

$X^2(3) = 1.19, P > .05$

Note: Cell entries are n's, row percentages, and column percentages

Table 11
CORRELATIONS BETWEEN DAUGHTER DEI AND HER PERCEPTION
OF MATERNAL DOMAIN-SPECIFIC CRITICISM

	<u>Item (1)</u>	<u>Item (2)</u>	<u>Item (3)</u>	<u>Item (4)</u>
DEI	.16 P=.28	-.08 P=.57	-.19 P=.21	.16 P=.30

Item (1): "My mother thinks I should lose weight"

Item (2): "My mother thinks I am attractive"

Item (3): "My mother thinks I have a nice body"

Item (4): "Compared with other girls my age, my mother thinks I am **a great deal less...a great deal more** attractive"

Tables 12a - d
T-TESTS COMPARING HIGH AND LOW DAUGHTER DEI SCORE GROUPS
ON PERCEIVED MATERNAL DOMAIN-SPECIFIC CRITICISM ITEMS

Table 12a -- T-Test for Item 1
 ("My mother thinks I should lose weight")

	<u>Cases</u>	<u>Mean</u>	<u>St. Dev.</u>	<u>t-value</u>	<u>df</u>	<u>2-tail Prob.</u>
Low	23	2.57	1.04	1.52	45	.14*
High	24	2.04	1.30			

*not significant

Table 12b -- T-test for Item 2
 ("My mother thinks I am attractive")

	<u>Cases</u>	<u>Mean</u>	<u>St. Dev.</u>	<u>t-value</u>	<u>df</u>	<u>2-tail Prob.</u>
Low	23	2.00	.853	1.58	45	.12*
High	24	1.63	.770			

*not significant

Table 12c -- T-test for Item 3
 ("My mother thinks I have a nice body")

	<u>Cases</u>	<u>Mean</u>	<u>St. Dev.</u>	<u>t-value</u>	<u>df</u>	<u>2-tail Prob.</u>
Low	23	2.48	1.16	1.67	45	.10*
High	24	1.92	1.14			

*not significant

Table 12d -- T-test for Item 4
 ("Compared with other girls my age, my mother thinks I am
 a great deal less... a great deal more attractive")

	<u>Cases</u>	<u>Mean</u>	<u>St. Dev.</u>	<u>t-value</u>	<u>df</u>	<u>2-tail Prob.</u>
Low	23	3.74	.752	-1.44	45	.16*
High	24	4.08	.881			

*not significant

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