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**SELF-UNDERSTANDING AND DEPRESSION AMONG ANOREXIC AND NON-  
ANOREXIC ADOLESCENT GIRLS: A SELF-IN-RELATION APPROACH**

by

**KIM A. GALLELLI**

**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**

**2003**

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Abstract

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By

Kim A. Gallelli

Advisor: Professor Tracey A. Revenson

Using an integrative model that bridged developmental and self-in-relation theories, this study examined how self-understanding in girls with anorexia nervosa was distinctive from girls without anorexia nervosa. Forty-seven adolescent girls, ranging in age from 13-21 years, with a DSM-IV diagnosis of anorexia nervosa were compared to twenty-five girls without a diagnosed eating disorder.

All participants completed the following measures: the eating disorder and major depressive disorder modules of the Diagnostic Interview Schedule for Children (DISC-IV-R); Eating Attitudes Test (EAT); Beck Depression Inventory (BDI); a modified version of Damon and Hart's Self-Understanding Interview (SUI); and Higgins' Selves Questionnaire. The narratives from the self-understanding interview were coded using Damon and Hart's (1988) coding scheme, which was expanded for this study to include the relational context, as well as constructiveness (positive or negative statements) of the girls' self-statements. In addition, three representative narratives were analyzed a second time using Brown and Gilligan's Reader's Guide (1992).

Analyses of variance compared three groups on all measures: girls with anorexia nervosa and co-morbid depression (AN-ND group, n = 26); girls with anorexia

nervosa without co-morbid depression (AN-ND group, n = 21), and girls without anorexia nervosa or major depressive disorder (NAN group, n = 25). The AN-D group had significantly higher discrepancy scores between their actual-ideal selves, and actual-ought selves than either AN-ND or NAN girls.

Differences were found between anorexic and non-anorexic girls in type and developmental level of self schemas they utilized. The data indicated that the anorexic girls were more self focused than relationally focused, made significantly more negative self-statements, and had less developmentally advanced self conceptions. However, the analysis of a select set of narratives using self-in-relation theory contradicted these findings, as anorexic girls were extremely relational, with their self-image shaped by perceptions of what others thought of them. Furthermore, there were distinctions in self-understanding between anorexic girls with and without clinical depression: Depressed girls had more negative self-conceptions. This dissertation demonstrates that not only are there important differences in self understanding between anorexic and non-anorexic adolescents, but also that the particular theoretical and methodological approach influences the interpretation of data.

## Acknowledgements

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With the support, encouragement and cooperation of the Child and Adolescent Psychiatry and Adolescent Medicine departments at Schneider Children's Hospital, I was able to develop and implement my research ideas. I thank the faculty at the Eating Disorders Center for their willing participation and excitement about this project. Most particularly, I am grateful for the mentorship of Dr. Mary Solanto—for her faith in the competence of a very young researcher and her ideas—and Dr. Neville Golden—for his training in the nuances of the medical condition of eating disorders as well as for his cooperation and enthusiasm in this project.

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My friends and family offered me emotional respite throughout the desperate years of this dissertation process, making me laugh when I wanted to cry and making me see my intelligence when I felt brainless. I especially thank my mother and my sister, for standing by me and continually reminding me of the person I wanted to become. I also thank my amazing friends, for reminding me that sunsets and laughter are as essential to life as breath and water. I am forever indebted to my aunt, Joan Heaney, who graciously provided me with the physical and emotional space necessary to think and create in peace and serenity.

Most importantly, I thank the many girls who shared their private thoughts, feelings, hopes and dreams. It was through what they said, both with their voice and body, that I came to understand the depth and complexities of their self-beliefs. I feel privileged that these young women took my hand and led me on a tour of their psyche and its connection to relationships, exposing both joy and sorrow—hope and despair. It was on this journey that I not only gained an intimate sense of who these girls were—what they knew and did not know about themselves, their world and their place in it—but most surprisingly, I came to know who I was as well.

Dedicated to the loving memory of my father and godfather,  
two star-bright gulls,  
whose own extraordinary journeys taught me to fly.

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## CHAPTER 1: INTRODUCTION

Anorexia nervosa (AN) is an illness diagnosed primarily among adolescent girls and young adult women. Prevalence rates for anorexia among adolescent girls range from .2 to .5% and are reported as rising (Lucas, Beard, O'Fallon, & Kurland, 1991; Whitaker, 1989; Davies, Shaffer, Johnson, Abrams & Walsh, 1989). In addition, recent survey studies have documented that many of the behaviors associated with eating disorders are alarmingly common in the adolescent population at large. According to Wolf (1991) 60% of all American college women will struggle with some type of eating disorder, and up to one-fifth of female students in the U.S. are struggling with different extremes of anorexia. In a study of non-referred high school girls, Whitaker and colleagues (1989) found that 81% desired to lose weight, 42% perceived themselves as overweight (though within normal weight range). Seventy-two percent of high school senior girls reported rates of lifetime dieting and an average weight loss of 10 to 12 pounds on a diet. Seven percent of high school girls reported having binged, 8% report inducing vomiting, and 2% reported using laxatives.

Current theories on the etiology of AN view it as a multidetermined disorder with various individual, cultural and familial predisposing factors (Garfinkel & Garner, 1982). One of the dominant themes crossing divergent theories on AN is that deficits or developmental delays in the patient's self-concept are central to the etiology and maintenance of the illness. Surprisingly, there exists little empirical research examining self-concept in this population. Among the few studies that do exist, there is wide variability in how "self-concept" is defined and measured, with little or no application of

developmental and multidimensional models of self-concept. It appears necessary, given the large void in the empirical literature, to examine how self development may be different in anorexic girls and women, utilizing a clearly defined and relevant conceptual model of self.

In addition to the pivotal component of a problematic self-concept, difficulty with interpersonal relationships and acceptance of cultural values of thinness also are core features of anorexia and considered to be related to the development of the self (Bruch, 1985, 1988; Steinhauser & Volrath, 1993). An appropriate model of self development should address these theoretical constructs. However, a review of the literature on self-concept suggests that there is not simply one existing theory that incorporates all of these "key" features, but instead several theories that include one or two of these features (Avants, Margolin, & Singer, 1994; Damon & Hart, 1988; Jordan, Kaplan, Miller, Stiver, & Surrey, 1991).

Of the existing theories on self development, those from developmental and feminist psychology best address issues specific to AN. Developmental deficits or delays in self-concept formation are considered central to the etiology of AN, indicating the importance of utilizing a developmental approach. Additionally, although social development is considered to be an important component of many developmental models, the connection between interpersonal relationships and self-concept is often not made explicit or elaborated fully. Given that interpersonal relations are seen as problematic to the anorexic girl (Bruch, 1988; Polivy & Herman, 2002; Wechselblatt et al., 2000), it is necessary to use a theoretical model that examines the self (and its various components) in the context of relationships.

Using an integrative framework that bridges developmental and feminist approaches, the proposed research has three related aims. First, I will compare the structure and content of self-concept in girls with AN to self-concept in girls without eating disorders. Second, self conceptions in the context of interpersonal relations will be compared between the groups. Third, in addition to the comparison of self-concept deficits in the two different populations, the phenomenology of the experience of the anorexic girl will be explored through qualitative analyses. A general psychoanalytic interpretation of anorexia is that the anorexic's dissatisfaction about her self and life is transposed to her body; rather than speaking with her voice about her despair and emptiness, her anorexia speaks for her (Bruch, 1988; Swift et al., 1986). By listening to the narratives of the anorexic girls and women--hearing what they are voicing/saying as well as what they are not saying or are silencing--we may gain some insight into the phenomenology of this embodiment of distress.

Damon and Hart's (1988) developmental model of self-understanding serves as the structural foundation for this work. It provides the working definitions of subjective and objective subcomponents of the self, as well as a hierarchical framework that identifies age appropriate levels of self development. Self-in-relation theory provides the feminist theoretical approach. Emerging from feminist critiques of traditional models of development, self-in-relation theory suggests that, as a result of cultural and socialization influences, a girl's sense of self is organized and developed in the context of important relationships (Surrey, 1991). Thus, the critical context of interpersonal relationships will be fused with Damon and Hart's developmental approach.

A semi-structured interview on self-understanding and standardized questions on self-concept, and anorexic and co-morbid symptoms will be obtained from 70 adolescent girls (45 anorexic girls and 25 asymptomatic girls). Interview narratives will be coded for developmental levels of functioning across multiple domains of the self-concept. These multiple self domains fall into two broad categories, the subjective and objective self. All of these self-conceptions will be examined in the context of relationships. Scores on the standardized questionnaires will be used to calculate if levels of self-understanding vary with co-morbid symptoms. Overall, I expect to find both qualitative and quantitative differences in self-understanding between anorexic and non-anorexic girls. It is hypothesized that anorexic girls will have a developmentally lower level of self-understanding than non-anorexic girls. In addition, the prevalence of subjective and objective self references will differ between the anorexic and comparison groups. For example, anorexic girls will use more self descriptions that fall into the physical self domain, and less psychological and agenic self descriptions than the non-anorexic girls.

Using an integrated theoretical approach has several advantages. First it affords a richer understanding of girl's self development and its connection to interpersonal relationships. Second, by listening to the interview narratives for what girls *are* and *are not* saying, I will gain insight into the literal "embodiment of distress", an understanding of the stories these girls are telling with their bodies versus their words. Third, this integrated model will also contribute to a reframing of traditional ways of viewing anorexia, shifting the theoretical groundwork from "pathology to normalcy"

(Miller, 1991) and approaching the anorexic's problems as "different" instead of "deficient".

## **BACKGROUND**

The literature review will first detail the diagnostic and descriptive characteristics of anorexia nervosa (AN). This literature emphasizes the importance of co-morbid symptoms and diagnoses, specifically the co-existence of depression among girls with anorexia. Given the breadth of research on co-morbidity, it is important to review this area briefly as well as delineate the significance of co-morbid disorders in order to place the research questions in an illness context. Next, relevant developmental and feminist theories will be reviewed. I will then propose how developmental and feminist perspective on the self can be integrated into a unified model. Finally, a review of existing empirical research on the role of the self and self-concept in anorexia will be presented.

## **CHARACTERISTICS OF ANOREXIA NERVOSA**

Anorexia Nervosa (AN) is a psychological and physical illness mostly diagnosed in adolescent girls and young adult women. According to the Diagnostic and Statistical Manual of the American Psychiatric Association (DSM-IV-Revised, 1994) diagnostic characteristics of the disorder include weighing 15% below ideal body weight, extreme fear of fat and gaining weight, body image distortion, and loss of menses in females. Anorexia nervosa is one of the most lethal psychiatric disorders with a mortality rate of 20 % -30 % (Johnson et al., 1992; Theander, 1985).

Recent studies have documented that many of the behaviors associated with eating disorders, such as dieting, bingeing, purging, and poor body image, are quite

common in the adolescent population at large (Roger et al., 1997, Whitaker et al., 1989). In a study of high school girls, Whitaker et al. (1989) found that 81% desired to lose weight and 42% perceived themselves as overweight (though within the normal weight range). Seventy-two percent of high school senior girls reported having been on a diet at some point in their life and an average weight loss of 10 to 12 pounds on a diet. Seven percent of high school girls reported having binged, 8% reported having induced vomiting and 2% reported using laxatives (Whitaker et al., 1989). Additionally, a Gallup poll found that as many as one million teenage girls are afflicted with eating disorders whereas other studies have estimated that 10 percent of American women and 20 percent of women on college campuses are anorexic or bulimic and nearly 2/3 of young girls have distorted body images (Tolman & Debold, 1994). These statistics are important in showing the widespread prevalence of unhealthy and dangerous behaviors that could develop into a life threatening illness.

The etiological focus of eating disorders has changed over the years, moving from a view that the illness is triggered by sexual maturity fears, and considered to occur only in upper socioeconomic classes, to a more current emphasis on developmental, neuroendocrine, and personality vulnerabilities (Comerci, 1992; Pirat et al., 1988). Recent studies have documented that eating disorders and related symptoms are *not* only associated with the upper social classes (Whitaker et al., 1989). Thompson (1994) argues that the bias that anorexia occurs only in white, middle-class, professional, “achievement-oriented” women actually masks its presence among working class women of all races. She critiques the often cited findings of anorexia as a white, middle class disease to be a result of studies biased by their sampling from hospitals, private high schools and

colleges—restricting the survey of women of color, less educated, older and poorer. Current etiological theories view AN as a multidetermined disorder with various individual, cultural, and familial predisposing factors (Garfinkel & Garner, 1982). Depression, obsessive-compulsive disorder and other anxiety disorders, avoidant behaviors, family dysfunction, and cultural beauty ideals for females of thinness are suggested as having various etiological roles in AN (Comerci, 1992; Pirat, et al., 1988). In addition, clinicians have suggested that certain developmental processes involved in identity formation, self-concept, autonomy and agency—as well as how these factors are affected by individual psychopathology and family dysfunction—appear to be related to the etiology of AN (Bruch, 1973, 1988).

The average onset occurs in middle to late adolescence with reports of a bimodal distribution of age of onset that peaks at 14 and 18 years (Halmi et al., 1979). However, AN has been noted to occur in prepubertal children as well as in middle aged adults (Gallelli et al., 1997; Johnson et al., 1992). Interestingly, 90-95 % of anorexics are females (Garner & Garfinkel 1980; Hsu, 1990). Although the incidence of men with eating disorders is rare, many researchers agree that eating disorders in men involve greater pathology than for females, are more difficult to treat, and involve greater psychosexual conflict—with a disproportionate amount being homosexual (Schneider 1991).

Although the diagnostic criteria remain constant across ages and gender, it has been suggested that etiological factors may differ among individuals and across developmental stages. For example, although anorexics at age 8, 13, and 20 years may describe the same constellation of symptoms, family stressors may be the primary trigger

for the 8-year old, the pressures of adolescence may be a primary trigger for the 13-year old, and personality characteristics may be the precursor for the 20-year old (Sargent, 1992). However, there have been no empirical studies, to date, documenting different predictors at different developmental levels. Patients also vary in their psychosocial functioning, socioeconomic status and varying types and degrees of co-morbid symptoms and disorders, described next.

### **CO-MORBID SYMPTOMS AND DISORDERS**

Much of the clinical literature on anorexia focuses on associated problems and co-morbid disorders. The person with an eating disorder often is described as having interpersonal difficulties with peers and family (Sargent, 1992) and as having difficulty identifying and articulating internal states (Bruch, 1988). In addition, families are described of anorexics as enmeshed, controlling, and rigid (Minuchin et al., 1978). It is thought that psychological growth in the areas of self expression and autonomy are not encouraged in anorexic families (Bruch, 1973).

There also exists a large literature citing the high incidence of eating-disordered women who have also been victims of sexual abuse (Wooley, 1991). Many studies confirm that between 1/3 and 2/3 of women who have eating disorders have been sexually abused (Thompson, 1994). Kearney-Cooke (1988) found that 59% of women attending an inpatient bulimia program had been victims of incest, childhood molestation, or rape. Thompson (1994) found in a study of 18 women that two-thirds—across race, class and sexual orientation—were survivors of sexual abuse. It is important to note that these findings of high incidence of sexual abuse were reported in studies, or disclosed by the victims, when they were adult women. We do not know, from such studies exactly

when the victims first disclosed their abuse, but from many studies, it appears that women are more likely to disclose abuse in comparison to children or adolescents—who still may be experiencing the abuse or are in more vulnerable and fearful positions. However, as Thompson (1994) points out, sexual abuse does not necessarily result in an eating disorder, and not all people with eating disorders have been sexually abused.

The psychological and psychiatric literature is saturated with conflicting theoretical and empirical accounts regarding the prevalence, type and role of specific comorbid disorders. These associated disorders, by definition considered to be secondary to AN, are important to consider when looking at the etiology and psychological sequelae of AN. In other words, although AN constitutes the primary diagnosis, other psychological disorders may influence its course, presentation, and effects. For the most part, the empirical literature focuses on the associated role of anxiety disorders (such as obsessive compulsive disorder) and mood disorders (such as major depressive disorder and dysthymia) in the onset and maintenance of AN (Cantwell, 1977; Fornari et al. 1992; Szmulker, 1987). Moreover, there has been a great deal of controversy as to whether AN is a variant of depressive disorders, or whether depressive symptoms are secondary to the anorexia (Hinz and Williamson, 1987; Szmulker, 1987). Major depressive disorder (MDD) is characterized by depressed mood, loss of interest or pleasure (or in adolescents, the presence of irritability) lasting for at least two weeks or more. Four of seven additional symptoms must also be experienced to warrant a diagnosis of MDD: increase or decrease in weight or appetite; sleep disturbances, increases or decreases in psychomotor activity; decreased energy; feelings of worthlessness or guilt; difficulty concentrating or making decisions; recurrent thoughts of death or suicidal ideation

(DSM-IV-Revised, 1994). Kegan (in Kroger, 1989) suggests that depression may be characterized by feelings of loss of one's own needs, wants, or personality, being constrained, controlled, deprived; feelings of loss associated with loss of relationship which results in feelings of abandonment or betrayal; or low self esteem characterized by a failure to live up to the expectations people hold for themselves. Many of these characteristics overlap with the symptoms and experiences of the anorexic patient.

There are diverging perspectives concerning the relationship between depression and AN. Some researchers hold fast to the notion that AN is simply a variant or subtype of depression, an atypical affective disorder (Cantwell, 1977; Devlin & Walsh, 1989) or an "opportunistic" illness, made possible by the preceding presence of depression (Szmukler, 1987). A second perspective suggests that the onset of depression occurs at specific times in relation to the onset of the anorexia. Within this perspective there are conflicting views: some theorists argue that the onset of depression occurs *concurrently* with the anorexic symptoms, whereas others suggest that the onset of depression occurs *after* the anorexic symptoms have emerged (Szmukler, 1987). A third perspective argues that individuals may be at risk for both disorders because of genetic, psychological and biological mechanisms that are shared between both disorders (Devlin & Walsh, 1989; Silverstone, 1990). Yet a fourth perspective suggests that depressive symptoms in AN patients may be a direct result of malnutrition and starvation effects (Devlin & Walsh, 1989).

In an expansive 10-year follow up study, Halmi et al. (1991) evaluated 62 anorexic women and found a greater lifetime prevalence of major depressive disorder and dysthymia compared to women without AN. Similarly, Ratsam (1992) found that 86% of

anorexic girls reported depressed mood or the presence of affective disorders compared to 14% of normal controls. In contrast, Solanto et al. (1996) found lower rates of Axis I co-morbid disorders in 37 adolescent anorexics when utilizing strict diagnostic criteria, in comparison to the findings of Halmi (1991) and Ratsam (1992). Fourteen percent of girls with anorexia met DSM-III-R criteria for major depressive disorder, excluding the symptoms that exist in both anorexia and depression (i.e., loss of weight, irritability, low energy and concentration), and an additional 1% met criteria for dysthymia.

In a meta-analysis examining depression and eating disorders, Hoffman and Halmi (1993) concluded that approximately 40% of anorexics at presentation will have symptoms that can be diagnosed as major depressive disorder, and that the lifetime prevalence of MDD in AN is between 40% and 68%, compared to 25% in the general female population. These findings suggest that depressive symptoms can precede, appear simultaneously with, or follow the onset of the eating disorder.

It is important to note that only a small percentage of depression-prone individuals develop eating disorders. Strober and Katz (1987) argue that neither the findings of high lifetime rates of affective disorders in patients with eating disorders or increased rates of affective disorders in their families provide a sound basis for inferring a direct, causal relationship between the two disorders. Devlin and Walsh (1989) cite findings that bulimic patients, most of whom are normal weight, and underweight anorexic patients have comparable rates of depression. This seems to disprove the theory that depression in anorexia is a result of malnutrition or starvation effects.

Much of this literature can be critiqued for its wide variability in how co-morbid disorders and symptoms are measured. With the exception of a few studies, most

assessments of depression are based on self-report checklists of symptoms, or retrospective case analyses. Such methods do not provide for a valid diagnosis of depression based on DSM criteria. The lack of consistency in measures used across studies and the lack of clear diagnostic criteria for reporting co-morbid disorders contributes to the often contradictory reports of associated disorders in AN. In addition, as pointed out by Strober and Katz (1987), not all depressed girls develop eating disorders and not all eating disordered girls meet criteria for depression. Given the inconclusive findings, it seems difficult to accept the hypothesis that eating disorders and depression are variants of one another *or* that they share the same biopsychosocial causal mechanisms.

At the same time, a relationship may exist between the two disorders, although anorexia nervosa is quite distinct from clinical depression. There is an overlap of symptoms between AN and depressed patients, such as low self-esteem and problematic interpersonal relationships, but the anorexic clearly manifests such problems in a different manner--through distinct body image distortion, fear of fat, and emaciated figure.

### **SELF-CONCEPT, DEVELOPMENT, AND ANOREXIA**

Although understanding the relevance of co-morbid disorders and depression to the etiology of anorexia is important, it can be argued that this knowledge is not central to the phenomenology of the illness itself. The role of the self-concept is arguably one of the most dominant themes in the clinical literature. Clinicians and researchers alike suggest that deficits or developmental delays in the patient's self-concept are central to the etiology and maintenance of this illness (Bruch, 1988; Casper et al., 1981; Garner &

Garfinkel, 1980; Levitt & Hart, 1991; Pipher, 1995; Steiner-Adair, 1990; Surrey, 1991; Swift et al., 1986;). Hilde Bruch, one of the foremost experts on anorexia, considered disturbances in self-concept and how interpersonal experiences are perceived and interpreted to play a significant role (Bruch 1973, 1988). Bruch, a psychiatrist, emphasized the importance of looking at the developmental origins of problems with self-concept and identity formation. Anorexia was described as "an illness of inner self-awareness, of inner feelings of relatedness, and of feelings of fulfillment. The real problem isn't the weight and food; the problem is the sense of inner worth and well-being" (Bruch, 1988).

Surprisingly, there exists little empirical research examining self-concept among people with anorexia. Among the few studies that do exist, there is wide variability in how "self-concept" is defined and measured, with little or no application of developmental models.

### **Developmental Theories of the Self**

A vast literature on the concept of the self exists across the social sciences. The "self" crosses such constructs as "self-concept", "self-esteem", "self-understanding", and "identity" and these terms often are used interchangeably. Theories of the self that have been generated within developmental psychology have some common underlying premises, but also focus on distinct aspects of self development. Much of the developmental literature suggests that the nature of self understanding or self representations shifts from concrete descriptions of behavioral and social characteristics to more abstract descriptions of one's psychological and spiritual interior as children develop (Harter, 1990). The changes in how one represents or understands the self are

directly linked to cognitive development. For example, preoperational children may describe themselves in terms of physical and behavioral characteristics, belongings and membership categories (I have red hair; I can run fast; I have a sister). Concrete operational children shift to describing themselves in terms that include more internal or conceptual notions (I am pretty, sad, or smart). With formal or abstract reasoning, most often occurring with adolescence, the self is described in terms of psychological and abstract self descriptions such as beliefs, wishes, moods and emotions (I am a sensitive, moral person; Harter, 1990).

The Multidimensional Model of Self-Understanding. Damon and Hart's (1988) theory of self-understanding will be used as the structural framework for the dissertation. Thus, it will be described first and in detail. Damon and Hart's theory was developed to incorporate much of the existing research on self development across the life span. The model divides self-understanding into two groups: *self-as-subject* and *self-as-object*. The self-as-object grouping is comprised of the following categories: physical, active, social and psychological sense of self. The self-as-subject grouping is comprised of the subject's sense of continuity, agency and volition. In addition to building their model to reflect the wide array of developmental findings on self-concept and other related constructs, Damon and Hart based the structural aspect of the model on William James' (1890) definition and categories of the self. James understood the nebulous construct of the "self" as having two important dimensions: the subjective self and the objective self, or the "I" and the "me". He defined the self-as-object, or "me" as being comprised of the following components: the physical self, material self, social self, psychological self, and spiritual self. James defined the self-as-subject, or "I" as a sense

of agency, continuity, volition and reflection. Although Damon and Hart modified some of James' notions, the structural aspects of their model directly reflect James' theory.

An early awareness of self is based on physical activity and the results of such activity. There is an early awareness of physical categories of self like gender and size and there exists an age-related shift from defining oneself through external characteristics (the physical and material) to internal qualities (the psychological and spiritual). Self statements do not simply become more abstract with age as is suggested by much of the developmental literature. Instead, with age, there is an increasing ability to move back and forth between various levels of self-understanding. Each of the objective and subjective self components change with cognitive development. It is important to emphasize that Damon and Hart do not believe that children move developmentally in a linear manner—that is, they do not move from the physical to active to social and psychological conceptions of self. Instead each of the self categories undergoes developmental change with maturation. Increased hierarchization in each of these categories, or the development of more advanced self conceptions, may not occur simultaneously—and children of all ages have some level of conceptualization in all of these categories.

Indeed, Damon and Hart believe that earlier levels of each of the components of self understanding become part of later ones, although they appear in a new form. For example, self-understanding of the "me" is always categorical, but more developed levels employ the categorical self in a new manner. For example, a young child may describe herself as having red hair, whereas at an older age she may describe herself as having red hair, which is unique because none of her friends have that color. Earlier forms of

self-understanding continue to function at more developed levels, rather than disappear. There are four critical developmental levels with corresponding characteristics for each of the components of the subjective and objective self. Figure 1, reprinted from Damon and Hart (1988) depicts these levels. Level 1 is considered characteristic of early childhood, where self understanding is organized around categorical identifications. At Level 2, or middle and late childhood, self understanding is organized around comparative assessments. During Level 3 or early adolescence, inter-personal implications for self understanding emerges, and during Level 4, or late adolescence, systematic beliefs and plans emerges for each of the self categories.

Because Damon and Hart's theory conceptualizes the self as multidimensional, with objective and subjective components, it will provide a structural framework with which to examine and measure self-concept in girls with AN. As encompassing as Damon and Hart's model appears to be, however, important aspects of the self are missing from this model, as will be described later.

Self-Discrepancy Theory. E. Tory Higgins, a social psychologist, also developed a multifaceted, dynamic theory of the self. Higgins' self-discrepancy theory proposes that the self is comprised of numerous self-representations, including one's perceived current self (*actual self*), the person one would like to be (*ideal self*) and the person that one feels one should or ought to be (*ought self*). Higgins suggests that discrepancies between these self-representations are associated with certain negative emotional states (Avants et al., 1994; Higgins, 1989, 1987). A discrepancy between what, one *is* (actual self) and what one would *like to be* (ideal self) is associated with feelings of dejection or depression; a discrepancy between the actual and ought self is

characterized by feelings of failure to fulfill responsibilities and duties, which produce anxiety. In Higgins' theory, behavior is seen as being driven or "motivated" by the goal of reducing discrepancies between actual and internalized referent states, such as one's ideal or ought self.

Hart, Field, Garfinkel, Singer and Anderson (1997) argue that there is considerable precedent for considering mood and emotion as being regulated by representations of self and other. Markus and Nurius' (1986) work on "possible selves" found that positive judgements about the future were related to mood; the more positive characteristics persons use to describe their past and future selves, the more positive lifetime history of moods are reported. Self-esteem is related to various self-representations. Block (1985) argues that self-esteem is simply the distance between the ideal and actual self whereas Olgivie and Clark (1987) argue that self-esteem is related to the proximity between the actual and undesired self. Markus and Nurius (1986) found that positive judgments about past and future selves were related to high self-esteem. Higgins' model has also been applied to the study of drug abuse, eating disorders (anorexia and bulimia nervosa), migraine headaches, indigestion, and muscle cramps. These studies have successfully demonstrated the link between physical and mental health symptoms and self-representations (Deaux, 1992).

Both Damon and Hart's multidimensional model of self-understanding and Higgins' self discrepancy theory emphasize the multidimensional nature of the self. Both assess an individual's various representations of the self. However, there are differences: Damon and Hart's model goes beyond individual representations by placing representations in a developmental-structural framework. At the same time, Damon and

Hart's method of assessing self-understanding does not include asking the subject how she thinks she *ought* to be like, whereas Higgins' does.

The perception of one's "ought self" may be an especially problematic area for the anorexic patient. Clinical descriptions of anorexics have suggested that they are abnormally influenced by what they feel they ought to be or what they should be like (Higgins, 1990). Self-discrepancy theory has been used in one study of anorexic and bulimic girls (Higgins, 1990). In this study, discrepancies between the actual and ought selves were more strongly related to anorexic symptomatology, whereas actual-ideal discrepancies were associated with bulimic symptomatology.

### **Self Development During Adolescence**

In attempting to understand the relationship between anorexia and self, it is important to highlight the developmental literature pertaining to the adolescent period. Most researchers have found that adolescent self-understanding shows an increasing use of psychological and social relational concepts for describing the objective self and a strong belief in one's agency and volitional ability in self-formation. However, as Harter (1990) points out, this newfound ability to describe the self more abstractly, representing more advanced cognitive structures, allows for self representations to be far removed from concrete behaviors, thus allowing for the potential for distortion and behavioral maladaptation. Harter's observations lend some understanding as to why the adolescent period has been described as a time wrought with emotional turbulence, and considered to be a time where many behavioral and emotional disorders are first expressed.

With development comes a shift in the types of social relationships that affect self- understanding and self perceptions. Rosenberg (1979) has suggested that for

younger children, parents are most important for critical feedback of the self; in adolescence there comes a reliance first on feedback from peers, and ultimately, on self reliance. Adolescents have been shown to utilize different self-representations depending upon whether they are describing the self with father, mother, close friends, classmates, and boyfriend/girlfriend (Harter, 1990). Middle adolescence, in particular, is a critical period with great social pressure to experiment with different roles such as friend, daughter, student, and girlfriend (Erikson, 1968). With the emergence of new roles comes conflict between the various ways in which one perceives oneself. Harter (1986) points out that at the same time as adolescents are faced with multiple roles and "selves", cognitive developmental factors push them towards developing a coherent sense of self.

This notion of diverse self-representations expressed in the context of social relationships is not addressed by Damon and Hart's model of self-understanding. Although Damon and Hart's model does address the importance of social influences on self development (and does assess self-understanding of one's "social self"), neither the theory nor the methodology explicitly addresses how self understanding may vary across different social contexts. Feminist self-in-relation theory can address.

### **Feminist Theory on Self Development**

Although Damon and Hart's theory asserts the notion that self-consciousness about one's physical appearance and an emphasis on peer acceptance becomes increasingly important with adolescence, it does not address these issues with respect to gender. It has been suggested that adolescent girls report more emotional conflict and more contradictory self attributes than do boys (Debold, et al., 1999). Depression is more prevalent in prepubertal boys than girls, but in adolescence, girls develop depression at

much higher rates and report lower levels of self-esteem and overall self worth. Preadolescent girls speak freely of feelings, values and conflict, but in adolescence this strength of self definition appears to be lost (Brown & Gilligan, 1992; Gilligan et al., 1990)

One explanation for the gender differences in adolescent emotional experience can be found by examining the differing societal expectations for girls and boys. It has been suggested that girls and women develop their sense of self through maintaining and developing relationships and that separation and individuation are not equally central developmental tasks for both girls and boys (Miller, 1991; Surrey, 1991). That is not to say that autonomy and individuation are not important to girls; instead girls develop their sense of autonomy and identity *through* their experiences in relationships, by changing one's relations with friends and family. This *self-in-relation theory*, or relational theory (Miller, 1991; Surrey, 1991), argues that separation actually impedes female self development. Thus the primary developmental task of female adolescents is argued to be one of "self differentiation within the context or relationships, having a distinct and unique sense of self but still be connected to others" (Steiner-Adair, 1990, p. 164).

Feminist theorists argue that because of the gender-specific importance of relationships, the development of a sense of self or self-concept in girls and young women is not captured by existing models of development (Brown & Gilligan, 1992; Miller, 1991). Traditional theories are critiqued as being male-oriented and based on Erikson's (1968) notion that the primary task of adolescence is individuation and separation: Striving towards separation should be the focus of adolescents' psychological energy; from this effort a sense of agency or self-efficacy is developed. Relational

theory, in contrast, suggests that girls' developing internal representations of themselves is not based on separation, but a more complex sense of their own abilities within relationships (Miller, 1991). Girls gain a sense of their agency and internal representation of the self in *relation to others*.

Adolescent girls are often described by feminist theorists as being at a "crossroads" (Brown & Gilligan, 1992). Adolescent girls struggle for independence and individuation from the family, but they do so in the context of, or with a goal for, further developing, maintaining and renegotiating relationships. Thus, relational theory redefines the primary developmental task of female adolescents as individuation within relations. Such emphasis on relationships, and its attendant lack of emotional separation should not be interpreted as an immature level of development, or even a defense against true individuation. Instead, individuation within relations is an elegant, sensitive management of the paradoxical values that the developing female confronts. This important role that relationships play in influencing self development and maintaining self-esteem is not measured in existing scales of self-concept and self-esteem.

Many feminist theorists argue about the conflicting messages an adolescent girl confronts in our society. Negotiating the "crossroads of adolescence"—the attempt to establish mature and valued interpersonal relations while attempting to develop one's individual wants, needs and desires-- is a tricky tightrope for girls to walk (Brown & Gilligan, 1992). In order to travel this "tightrope" to adulthood, the sacrifice of self development or individuality is offered unknowingly by the girl, in an effort to maintain socially valued relationships. Thus adolescent girls lose their relationships with themselves in an effort to maintain relationships with others (Debold, 1995; Gilligan et

al., 1990; Steiner-Adair, 1990). It is at this same developmental period that we see an alarmingly high percentage of girls suffering from damagingly low self-esteem, eating disorders and depression (Brown & Gilligan, 1992).

Pipher (1995) examines this difficult developmental period for girls from a different perspective. Like Harter (1990), Pipher discusses the true versus the false self. She argues that painful and confusing cognitions and emotions are dealt with in ways that are either true or false to the self. Girls who integrate such conflict from the perspective of their "true" self, challenge and incorporate information as it fits in with their scheme or sense of who they "truly are"--their chosen values, beliefs, and goals. On the other hand, girls who operate from their false self reduce the world to a less complicated place by distorting reality or ignoring their own beliefs. Pipher even suggests that perhaps some girls become anorexic in an attempt to reduce all the complexity in life to a single issue--weight. Pipher suggests that one can determine the distinction between true and false selves in girls by looking at and listening to the surface structure or behavior of their speech and actions in comparison to the deep or "true" structure they talk about. However, Pipher's theories have yet to be tested empirically.

Similarly, Miller (1991) points out that many studies indicate that adolescence is a time where girls "contract rather than expand". Girls silence their true selves and seem to lose the assertive and opinionated self that they acquired through girlhood. In contrast, boys have been shown to "open up" with adolescence or continue to develop a strong sense of who they are and what they value. Self is defined as an "active agent"--the context of acting within a relationship and for the relationship--and is changed by an intense pressure at adolescence that girls must defer the desires of their own self to that of

others needs or desires. With this pressure the girl gives up her relationship with herself--her ability to maintain true to her self, her values and her desires--in an attempt to satisfy the needs of others and maintain other relationships--but at cost to her own self development.

As discussed earlier, it is considered "normative" for adolescent girls to be preoccupied with their appearance and weight, engaging in various weight-loss, diet and fashion seeking behaviors. Brown and Gilligan (1992) interpret what the "normal" adolescent concern with physical appearance may mean to girls and how such concerns are tied to sociocultural values. They propose that pubertal changes "visually disconnect" girls from their childhood selves and force them to identify with an adult woman. With their new "adult" female bodies come certain expectations and associations of what it means to be female, and a great concern about what others say about them and their appearance. Adolescent girls not only attempt to modify their appearance to match societal standards, but they change the way they speak and relate to others, in accordance with the perceived feminine ideal. It is in this struggle to meet societal definitions of womanhood that adolescent girls can easily become "disconnected" from their own wants and desires, looking to others to define those needs for them. Fine and Macpherson (1994) suggest that the body becomes an arena where struggles for social control are played out--"social anxieties load onto the bodies of adolescent women" (p. 224). Perhaps it is with and through the body that the adolescent girl may express the difficulty she has navigating the challenges of adolescence, speaking with her body--rather than voice--about the complex standards and ideals she feels forced to emulate.

In sum, feminist psychology points to the importance of the relational context in which self development occurs for females, and the enormous challenge adolescent girls face in attempting to negotiate the conflicting societal message they internalize. The loss of prepubertal girls' "voicing" of their own wants and desires that occurs with puberty make adolescent girls vulnerable for loss of their "true self", which, in turn, can affect their overall self-worth and emotional state. The importance of the societal pressures and values for girls is not considered in traditional self development models.

Many current treatment and research approaches to AN echo the themes of relational theory. Problems with interpersonal relationships, lack of self-ownership of wants and desires, and lack of self-awareness are themes that not only relational theory emphasizes as problematic for girls, but are also considered central features of AN in the clinical literature as well (Bruch, 1988). Because of this theoretical overlap, it seems essential to incorporate relational theory within existing developmental theories on self development in order to gain an authentic picture of the self-concept in girls with AN.

### **BUILDING THEORETICAL BRIDGES**

Given the lack of a single conceptual framework that addresses the central psychological issues of anorexia (problematic self-concept development and impaired interpersonal relations), a new integrative framework is needed to build a bridge between more traditional developmental theories and feminist theories. A traditional developmental perspective provides the structural framework or working definitions for this integrated model; the component of "interpersonal relations" will be contributed by feminist theories. How girls view themselves will be tied to how relationships with

significant others are experienced. By integrating self-in-relation theory, one can begin to re-conceptualize traditional developmental theories of self-concept.

Damon and Hart's (1988) multidimensional, developmental theory of self understanding seems most appropriate to serve as the foundation for this theoretical bridge. The model identifies multiple levels of functioning of objective and subjective self structures, and has already been applied to a study of self in girls with anorexia (Levitt & Hart, 1991). This foundation will be strengthened by mixing in constructs from social and feminist theories of the self (e.g. Harter, 1990; Higgins, 1987; Miller, 1991). This will enrich Damon and Hart's model to address the impact of interpersonal relationships and sociocultural values on self development in girls.

Some of this bridge building requires the addition of methodological innovations to the basic structure. Self-in-relation theory utilizes an interpretive method, which categorizes girls' self-descriptions into subjective and objective self conceptions. However, relational theory emphasizes explicitly how concepts of the self are tied into interpersonal relationships, which is not a focus of Damon and Hart's method. This is not to say that Damon and Hart did not address the issue of social relationships to self development. Indeed, they assert that examining the context of self development is one of their primary goals (given that they base their model on "social interactionist" theory). Although their clinical interview methodology has left room for the interpersonal context to emerge and its influence to be noted, their interview does not specifically ask about relationships. In speaking with girls one needs to be more explicit in getting at how relationships with others connects with self understanding nor does the method directly assess girls' self-representation of significant others' values, or the "internalized other".

To assess the impact of relationships on self-values and expectations, Damon and Hart's method will be augmented with Higgins' (1987,1989) notion of the "ought self", or what the girl perceives she ought to be like, and with self-in-relation theory (Miller, 1991; Surrey, 1991).

Before using this new integrated model as a framework to ask new questions and modify methodology about the self development of anorexic girls, I will briefly review existing empirical studies examining the self among anorexic girls.

### **Empirical Studies Testing Damon and Hart's Theory**

Damon and Hart developed and tested their model of self-understanding on healthy children and adolescents ranging in age from 4 to 17 years. These normative studies confirmed that levels of self-understanding could be divided into four developmental levels (early childhood, middle and late childhood, early adolescence, and late adolescence) and seven categories (physical, active, social, psychological, continuity, distinctness, and agency). Damon and Hart's model also has been used to examine self conceptions among children and adolescents with conduct disorder (Milker, 1986), adolescent girls with eating disorders and scoliosis (Levitt & Hart, 1991), and children and adolescents living in a rural, agrarian, Puerto Rican fishing village (Lucca, 1988). Across these studies, differences in developmental levels were found to vary with age, and developmental delays or lags were found in specific aspects of self-understanding in anorexic girls, and boys with conduct disorder, in comparison to norms. Given the relevance of the Levitt and Hart's study of self-understanding in anorexic girls to the proposed research project, the findings will be discussed in some detail.

Levitt and Hart (1991) utilized the Damon and Hart model of self

understanding to compare the subjective and definitional sense of self in girls with anorexia nervosa, scoliosis (curvature of the spine), and healthy girls. Differences in the volitional aspects of the self-concept (control over one's life) were found among the three groups, with the largest difference found between the girls with anorexia and healthy girls. Levitt and Hart found that anorexic girls differed from non-anorexic girls in their developmental conceptions of volition, not in the evaluation of their magnitude of experienced volition. Anorexics' sense of volition was viewed in terms of observable consequences in which the self role is predetermined. This immature conception of control fits the anorexics' experiences where they assert their volitional efforts in physical and active arenas such as the control over the body through dieting and exercise behaviors. Anorexics do not feel they are lacking control—because they are indeed exerting a great deal of control, just applying it in inappropriate and unhealthy arenas.

Contrary to their hypotheses, Levitt and Hart (1991) found no significant differences among the three groups for developmental levels of individuality or continuity. Most interestingly, and again contrary to their hypotheses, they also found no differences in the self-as-object areas (physical, active, social, psychological) and in the sense of distinctness. However, when the context of the anorexic in relation to her mother was provided, the results demonstrated that anorexics described themselves significantly less often in terms of their communicativeness than did healthy adolescents girls. As the authors pointed out, no significant differences were found on the definitional aspects of the self when the social or relational context was unspecified.

Levitt and Hart's (1991) study is important because it demonstrates that Damon and Hart's theoretical framework can be successfully applied to an anorexic

population. However, the proposed research project will expand upon Levitt and Hart's work by considering how depression, a disorder highly associated with eating disorders, may also affect self development. In addition, self-understanding will be studied from a relational perspective, examining self development in the context of all significant social relations, not just the mother-daughter relationship.

### **Empirical Studies of Self-Concept in Anorexia**

Several studies using other approaches have explored the self-concept in girls with eating disorders. It is important to clarify that the study of self-concept is distinct from the wide array of studies looking at self-esteem in eating disorders. Self-esteem is best defined as the value or overall positive or negative feelings one has about one's self. The self-concept is not necessarily assessing the valence of ones' feelings about the self but attempting to directly assess how one describes different aspects of one self. However, even within studies that assess "self-concept", there is wide variability in how the term is defined.<sup>1</sup>

Three sets of studies will be reviewed briefly. First, studies that compare samples of anorexic girls to girls with eating disorders or to girls without eating disorders will be reviewed. Largely atheoretical, these studies aim to document psychopathology and eating behaviors and attitudes. Next, studies utilizing a cognitive psychology framework will be reviewed. Cognitive psychology focuses on the study of internal

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<sup>1</sup>This review will not include studies that simply examine how one feels, rates or values the self, i.e. self-esteem studies. Additionally, there exists a wealth of literature that focuses on body image and related disorders in the eating disorder population. Although body image is theorized as a component of the self concept, it is just one aspect of the entire self.

mental representations, beliefs, and attitudes. Finally, studies examining how sociocultural values influence eating disorders will be discussed.

### Eating behaviors and related psychopathology

Most studies of self-concept in anorexia utilize standardized self-report questionnaires to document the subject's assessment of herself on various dimensions. A number of studies have used the Offer Self-Image Questionnaire (OSIQ; Casper et al., 1981; Steinhauer & Volrath, 1993; Swift et al., 1986). The OSIQ is a standardized, reliable measure of the subjective sense of self, consisting of 130 self-referential items in 11 domains (impulse control, emotional tone, body image, social relationships, vocational and educational goals, sexual attitudes, family relationships, mastery of the external world, psychopathology and superior adjustment). Swift et al. (1986) found the adolescent anorexic's self-concept to be characterized as a "mixed pattern" in comparison to normal controls. Anorexics were found to have "good" adjustment in the areas of morals, impulse control, educational goals and "poor" adjustment in emotional tone, body and self-image and sexual attitudes. Casper et al. (1981) assessed self image in 30 acutely ill adolescent anorexics, ranging in age from 13-19, and found higher levels of distressed affect, warped body image and self concept, inadequacy in social relationships, and feelings of social inadequacy as compared to girls without eating disorders. However, anorexic girls exhibited better adjustment in other areas--impulse control, morals, family relations and educational goals. Steinhauer and Volrath (1993) assessed 40 German adolescent anorexic girls and found that they had lower scores than healthy controls on the following subscales: impulse control, emotional tone, body image, social relationships, sexual attitudes and psychopathology. With the exception of lower scores

of impulse control, these findings corroborated those of the two American studies just described. Interestingly, the authors suggest that these findings contradict clinical beliefs about anorexia because the girls expressed—rather than inhibited—their negative mood, social isolation, and feelings of inadequacy in acquiring an age-appropriate sexual identity.

None of these studies included a control group of girls with other psychiatric disorders to determine whether the findings were specific to girls with anorexia or to psychopathology in general. These studies also relied on a standardized self-report scale to assess problematic areas of self development as proposed by classic psychodynamic theory, excluding important aspect of the self as defined by developmental and feminist theory.

Engel et al. (1988) utilized a different approach. Using Kohut's self-system model, they framed anorexia as a "narcissistic disorder" with fundamental problems of self regulation. They utilized a self system questionnaire modeled after Kohut's theory which differentiated four spheres of self-organization: the endangered self, classic narcissistic " self, the ideal self, and the hypochondriac self. Comparing 30 clinically diagnosed anorexic patients with 64 healthy controls, they found that the anorexics scored as more symptomatic in the "endangered self" and "hypochondriac self" categories. The authors suggest that there is a link between these categories and depressive emotions and social withdrawal. This study is of interest primarily because it applies a "self psychological" approach to an empirical examination of self-conceptions in anorexics. Although using this conceptual framework, the measure appears to be a static symptom inventory, skewed towards psychopathology and lacking healthy or

normative descriptions within the self spheres. Additionally, this study lacks a developmental framework, without a clear discussion of how the various self-spheres are appropriate for different developmental stages.

#### Studies from cognitive psychology

Another body of literature studies the self-concept among anorexics from the perspective of cognitive psychology. Cognitive theorists believe that anorexia and bulimia nervosa are represented in organized cognitive structures or schemas that unite views of the self with beliefs about weight: That is, eating disordered patients connect and associate weight with various psychological beliefs and attitudes, often equating their overall worth or value as a person with their physical appearance (Vitousek et al., 1990). Such schemas involve the "self" by affecting perceptions, thoughts, affect and behavior. Cognitive structures provide the subject with information about what it means to be thin or fat, rather than about the status of the self as thin or fat. For example, an associative network may exist between thinness and self-control and virtue, whereby fatness may be associated with negative traits. As a result, the meaning of weight will be more elaborated and emotionally charged for eating disordered patients.

Two studies utilized repertory grids, a cognitive psychological technique to explore the personal meanings of food, weight and self. Repertory grids provide relatively unstructured and idiographic techniques that explore both surface constructs and underlying structures and thinking styles within which these constructs operate (Butow et al., 1993). Using such a repertory grid, Ryle and Evans (1991) found that eating disordered subjects had a more negative self image than controls. Eating disordered subjects are characterized more by their identification of a negative self image

with the average and overweight body images than by their positive identification with the underweight body image.

Butow et al (1993) compared cognitions among 53 anorexics, 45 normal weight bulimics, 65 restrained eaters, and 68 normal controls. Eating disorder patients talked more about control of weight and impulses to eat more often than did controls and used more extreme language in doing so. Many patients also applied these constructs very broadly to eating situations for which most controls believed were not appropriate (in control, virtuous). Patients were prepared to go hungry, dislike the taste of food and eat abnormally if this meant being able to maintain control over eating, remain unconcerned about their weight, and feel virtuous. Both patient groups exhibited more extreme and constricted thinking in relation to eating situations than the non-eating disordered controls. Patients tended to see themselves as completely in control or completely out of control, very virtuous or extremely indulgent and either perfectly normal or very abnormal. Although bulimics appeared to associate low weight with positive self attributes, anorexics were much more ambivalent about weight and wanted to stay at their current weights. The authors also describe that the bulimics sense of difference—or distinctness from others—appeared grounded in their weight. When weight was equalized, bulimic patients saw themselves as fairly similar to others. Anorexics did not exhibit this pattern, thus pointing to a stronger connection between deficits in the self and social functioning among anorexics than bulimics.

Ryle and Evans (1991) also looked at self cognitions in the context of ideal and actual self constructs. Eating disordered patients differed in how they construe the relation of the body at different weights to their images of their feared and ideal self, the

importance of which is also emphasized by Higgins (1990). Patients construed an example of an average weight body as further from their image of the ideal self and nearer to their image their feared self. In other words, they construed both the example of an average weight body and an overweight body as significantly nearer to their feared self.

These cognitive approaches to studying the self in eating disorders allows us to see disturbed or distorted thoughts and their link to disordered eating and behaviors and suggest that deficits in the self are linked with such cognitions (Butow et al., 1993). However, identifying such cognitions does not allow us to understand how they develop from and relate to existing categories of self structures, or how girls see themselves in relation to their social environment.

#### Influence of sociocultural values on anorexia

There exists a large body of literature that argues that the sociocultural component of anorexia is the most important key or determinant of this illness (Bruch, 1985; Orbach, 1985; Selvini-Palazzoli, 1985). The emergence of anorexia has been traced back to as early as medieval times, where women starved themselves in the name of God, piety and female spirituality, often obtaining a saint-like status (Bynum, 1991). A second re-emergence or awakened interest in anorexia was noted in Victorian times (Brumberg, 1988), where women were described as presenting themselves as unusual, sickly and requiring great care and attention. The popular press of the time referred to these women as “fasting girls”, whose self-starvation and ensuing survival took on a miraculous and “circus side show” quality.

However, the current or contemporary epidemic of anorexia is far greater than any other historical period. Many studies and theorists argue that the increasing prevalence in contemporary times is a result of the strong sociocultural emphasis on dieting and a thin beauty ideal, in a culture ironically characterized by an abundance of food (Bruch, 1985; Garfinkel & Garner, 1982; Selvini-Palazzoli, 1985). Bruch (1978) has referred to the increased prevalence of eating disorders as a sociocultural epidemic and has also suggested that fashion's beauty ideal may indirectly affect vulnerable adolescents who may come to believe that weight control is equal to self-control and will lead to beauty and success. Interestingly enough, over the decades, there have been changes in the characteristics of the females presenting with this illness. According to Bruch (1985), the patients who were seen in the 1950s and 1960s were similar in that they each believed they were the "original inventor of this effort at self-assertion" (p.11). Bruch claims that certain changes seem to have occurred when anorexia became more common and publicly discussed. She proposed a "copycat" theory arguing that as anorexia became more publicized, there was an increase in individuals who deliberately "tried it out" after having watched a TV program, or discussed it in class.

Many feminist theorists proclaim that eating disorders are not just diseases of a certain individual but a growing social issue (Steinam, 1992; Orbach, 1985; Wolf, 1991). These writers make a poignant point about the prevalence of eating disorders and the great difficulty in "curing" those suffering from them. Dieting and the enormous emphasis on weight and beauty in our culture is socially acceptable and even socially encouraged for women. According to Wolf (1991), 60% of all American college women will struggle with some type of eating disorder and up to one-fifth of female students in

the US are struggling with different extremes of anorexia. She cites statistics showing that a generation ago, the average fashion model weighed 8% less than the average American woman, whereas today she weighs 23% less. A contemporary Glamour magazine survey found that 3/4 of women in the 18-35 age range believed they were too fat, even though most were of normal weight or even underweight (Muuss, 1985).

The few existing cross-cultural studies on eating disorders have found that the existence of such illnesses in non-western cultures is relatively rare and/or underreported (Pate et al., 1992). Furnham and Alibhai (1983) point out the differing cultural preferences for the ideal female body size and weight. Western culture highly values the thin and fit beauty ideal. Moreover, although there have been brief historical flirtations with a full, buxom female appearance in Western culture, more often than not the beauty ideal has been on the thin side of the figure scale. There have been extremes such as the acceptance of a fuller "Monroesque figure" in the 1950s and the emaciated look of the model Twiggy in the 1960s. The 1980's focused on a more healthy, fit body, accepting some curves as part of the beauty ideal, but with the 1990's we saw the return of the waif-like emaciated ideal epitomized by the supermodel Kate Moss. In the West, as Nasser (1988) states, thinness has come to symbolize certain cultural values such as self-discipline, control, sexual liberation in the form of sexual attractiveness, competitiveness, and aspirations towards higher socioeconomic status.

In opposition to Western beauty ideals, non-western cultures admire obesity and consider it an important aspect of female sexuality (Furnahm & Alabhai, 1983). In these cultures, obesity is often viewed as a marker of success and wealth, as well as health. There appears to be a relationship between the lack of eating disorders and the

preference for obese versus thin female figures (Nasser, 1988).

However widespread this notion of a sociocultural premise for eating disorders, there are few studies that try to examine how sociocultural values and pressures for women are tied to the onset of eating disorders. One study, examining how social values may influence eating disorder (Steiner-Adair, 1990), will be discussed in detail because it utilizes the relational model that is central to my proposed research study.

Steiner-Adair (1990) has conducted research on girls' identification with cultural ideals from a relational perspective in an attempt to identify non-symptomatic indicators of eating disorders. Girls who identify a female ideal that is in opposition to female developmental needs are often then able to reject such stereotypes and choose their own ideal. These girls are less prone to eating disorders. Those girls who do not see the impossibility in attaining these stereotypes (and actually aspire towards them) are at risk for eating disorders. It is not that you are concerned with your looks (indeed, most adolescent girls have such concerns) but the way in which you are concerned about your looks that is linked to unhealthy behaviors. However, Steiner-Adair's research does not address how adolescent girls understand their actual selves, and examines only one aspect of the impact of social values on the self.

In conclusion, Damon and Hart's self-understanding theory and methodology is useful for the study of anorexia for several reasons. First, it allows researchers to address cognitions related to the physical body as in the cognitive theorists work, enables one to examine the social aspects of the self as Steiner-Adair's study suggests research should, and allows for the identification of levels of psychological self conceptions in

relation to cognitive development, rather than focusing on psychopathology. Although this method does not explicitly assess the "ought" self as emphasized in self-discrepancy theory, it is simple to include. Damon and Hart's theory also does not overtly examine the impact of interpersonal relationships on self development, a notion that—according to relational theory—is considered to be central to girls self development (Miller, 1991; Surrey, 1991). It is possible to assess self-understanding in relation to various social relationships by expanding the interview.

### **SPECIFIC AIMS**

Relatively few studies have examined self-concept among girls and women with anorexia nervosa. These studies vary in how self-concept is defined and measured, with little or no application of developmental theories. Thus it is time to examine how self development differs among anorexic girls using a clearly defined and relevant conceptual model of the self.

The overall purpose of this study is twofold: (1) to confirm empirically what has been described anecdotally in the clinical literature as deficits and developmental delays in the self concept of young women with anorexia nervosa and (2) to use an integrated theoretical model that bridges developmental and feminist approaches to examine how such so-called deficits and delays in self development are related to interpersonal relationships. To accomplish the first goal, the structure and content of self understanding in adolescent girls with anorexia nervosa will be compared to asymptomatic girls. By comparing the two populations, I hope to identify which, if any, of the proposed "deficiencies" of self development are unique to AN and what psychological mechanisms help explain these differences. The second goal examines self

development in the context of interpersonal relations. There is strong support for the notion that self development for females does not revolve entirely around separation and individuation as those terms are traditionally used (Erikson, 1968). Often, disturbances in the self and the way individuals perceive their experiences and interactions with others are examined as separate issues. However, the integrated model proposed here emphasizes that self development is inseparable from understanding and interacting with others. This study will document how self development among anorexic and non-anorexic girls is connected to one's interactions with others.

This will be one of the first studies to integrate feminist and developmental theories on self development and then test the model empirically in a sample of adolescent girls with anorexia. It is hoped that doing so will force us to rethink traditional ways of viewing anorexia. Most theoretical models look at the anorexic's problems from the perspective of developmental deficits or deficiencies. Clearly an anorexic's behavior is maladaptive. This dissertation hypothesizes that there will be deficits in the self-concept of anorexic girls. However, I am not solely interested in framing the anorexic's development and behavior from a deficit orientation, but wish to note the many ways in which anorexics are speaking about their distress, though their worlds, behaviors and bodies—hopefully uncovering a plurality of voices. Thus this dissertation will attempt to understand both how the anorexic's self development is “different” and not just “deficient”. Through "bridging" Damon and Hart's model of self-understanding with relational modifying the resulting methodology, we may get a more realistic representation of how anorexic girls understand their "self" and how such conceptions may vary depending of the relational context in which they are expressed

and understood. By examining the connections that girls have about self and others, we may get a more authentic and clinically useful picture of where deficits in the self occur, and how such deficits develop.

## CHAPTER 2: METHOD

Forty-five girls diagnosed with anorexia nervosa and 25 girls without diagnosed eating disorders were recruited for this study. The study methods will be described in three phases: (1) sample recruitment and study procedures, (2) measures, and (3) coding and analyses.

### **Sample Recruitment and Study Procedures**

#### **Anorexia (AN) Sample**

Forty-five adolescent girls, ranging in age from 13-21 years, were recruited from the Eating Disorders Center at Schneider Children's Hospital, Long Island Jewish Medical Center. Participants either had been admitted for inpatient or outpatient treatment or were obtaining a diagnostic evaluation. Participants all met DSM-IV criteria for anorexia nervosa.

Outpatient Recruitment. The Principal Investigator (PI) made a presentation to the entire staff that described the research study and enlisted the staff's assistance in recruiting eligible participants. After approval by the medical staff and by the Graduate Center's and hospital's institutional review boards, the PI attended the outpatient eating disorder clinic twice weekly for six months to recruit participants. Physicians and residents identified appropriate research candidates. If the physicians or the unit social worker thought that it would be upsetting to the patient to be approached by the PI, recruitment was postponed to a later time.

The PI approached each patient and her parent(s), introduced herself, and described the research study (see Appendix A for text of introduction and study description.) Among other things, girls and their parents were informed that refusal to

participate in this study would not affect their medical or psychological treatment. If families were interested, informed consent was obtained from the participant and her parent(s). If the participant was over 18, parental consent was not required. However, if parents had accompanied older patients to the clinic, the PI would inform the parents of their child's participation. None of the parents of older participants expressed concerns.

As the medical evaluations lasted from 1 ½ -3 hours, the PI was able to conduct the research interview in an empty office while patients waited for their examinations. The PI worked closely with the physicians, nutritionists and social workers not to delay any scheduled treatment or evaluation.

Inpatient Recruitment. Recruitment procedures differed slightly for inpatients admitted to the adolescent medicine unit at Schneider Children's Hospital. Typically, inpatients' days are structured with a morning school session, group and individual therapy sessions, and supervised meals and snacks. Throughout the day, patients have scheduled free time, and most of their evenings are free. Before approaching the inpatient, the PI consulted with the patient's assigned nurse to see if participation in the research study would interfere with any scheduled treatment or behavioral modification plans. If permission was given, the PI introduced herself to the patient and described the research study using the same script as for outpatients. If the patient agreed to participate and was under age 18, she was asked to have both herself and her parents complete the informed consent form, with the study description attached. The PI arranged a later date to come back and retrieve the consent form and conduct the research interview. Often, parents would visit each night and consent was obtained at that time. If the patient was over age 18, parental consent was not required, so if the participant agreed, consent was

obtained and the interview was conducted at that time. Inpatients were interviewed in an empty conference room on the adolescent medicine unit.

In all, 54 anorexic girls (28 inpatients and 26 outpatients) were asked to participate; 23 inpatients (82%) and 24 outpatients (92%) agreed to participate, yielding an 87% overall response rate. Seven girls chose not to participate. One girl refused because she was extremely shy and did not want to speak to anyone but the staff, one girl did not want to be tape recorded, two girls refused to participate without explanation and three girls refused to complete the written questionnaires. For all girls that agreed to participate, no parents opposed their participation.

Interview Administration. The screening and assessment measures were administered to inpatients and outpatients in the same manner. At the beginning of each interview session, the PI described the study again and answered questions. Participants were administered the measures in the same sequential order. The interviews lasted from 30-90 minutes, with most interviews lasting approximately 60 minutes.

The interview was described as an attempt for the researcher to understand different ways in which girls understand and perceive themselves, and how such perceptions and actions may be different across different relationships—for example, how a girl perceives herself when she is with her mom, or her friends, or her teachers. The participant was assured again that the interview would be tape-recorded for research purposes only, and that the conversation would be strictly confidential unless the PI felt the participant was in danger. In two outpatient cases, the PI was obliged to breach confidentiality and report to the medical staff that the participant was actively considering suicide. Prior to informing the staff, the PI told the participant that she was legally

required to report this information and would break their confidentiality agreement out of concern for the participant's health and safety. In both cases, the participants understood this breach of confidentiality.

Upon completion of the semi-structured interview, participants were given a folder that contained self-report questionnaires that assessed eating behaviors, depressive symptoms, social desirability, self-evaluation, and demographic information. When the self-report questionnaires could not be completed at the same time as the interview, participants were asked to complete the questionnaires that same day and return them by mail or hand them back to the PI at the next office visit (for outpatients) or return them to the PI when she came to the inpatient unit the next day (for inpatients). Eighteen percent of outpatient respondents completed the questionnaires at the time of the interview, 55% returned the questionnaires by mail, and 27% brought them back at the next office visit. All of the inpatients' questionnaires were obtained the day after the interview.

After the participant completed her interview and had asked any questions, the PI asked if she could recommend two to three friends who did *not* have eating disorders (as far as she knew) who might be interested in participating in a research study on "adolescent girls and self-image." These friends would constitute the comparison group. In order to compensate for participants who did not refer friends, each participant was asked for two or three names. The participant was told that any girls she referred could decline participation if they wished, that her friends would not be told about her diagnosis or treatment, and that whether or not she provided any names would in no way influence her treatment. The PI was also sensitive to the fact that the participant might not have informed friends about her illness. If a participant was reluctant to give any names and

addresses, the request was dropped immediately. Given this sensitivity to participants' circumstances, only seven of the anorexic patients provided a friend's name.

### Non-Anorexic (NAN) Sample

Recruitment. Peer nomination and snowball techniques were used to recruit the comparison sample of girls without diagnosed eating disorders (NAN group). These methods were chosen in order to obtain a comparison sample broadly matched on sociocultural and socioeconomic factors.

As just described, seven of the participants with anorexia provided names of friends without a diagnosed eating disorder. Each friend was a mailed descriptive letter of the research study requesting her participation, and asking for both her and her parents' consent (see Appendix B). Five of the seven friends agreed to participate. These five NAN participants also were asked to recommend friends who might be interested in participating in a study of adolescent girls and self-image. Twenty additional comparison group participants were recruited through this snowball or "friend of a friend" procedure.

The recruitment letter described the research study and how the girl's name was obtained, and included an informed consent form and a self-addressed stamped postcard. If the girl was *not* interested in further contact from the researcher, she was asked to mail the postcard indicating this. If the postcard was not returned within two weeks, the PI phoned the potential participant. When the PI phoned, the study was described again and the girl was asked if she was interested in participating. If she agreed, the researcher scheduled an interview at a setting of the participant's choice (her home or a community setting such as a local diner or library). If the participant was

under age 18, she was told to bring the informed consent form signed by both herself and her parent(s). No interviews were conducted without signed consent forms.

### Procedures

The interview format was similar to that of the AN group. About half (48%) of the NAN interviews were conducted at the girl's home or dorm room, one-quarter (28%) at the girl's school or campus cafeteria, and one-quarter (24%) at the PI's home. All NAN participants were given self-addressed, stamped envelopes to mail their completed self-report questionnaires to the PI. All of the questionnaires were returned within 10 days of the interview.

### **Sample**

The demographic characteristics of the sample are presented in Table 1. All participants were female, ranging in age from 13-21 years. Socioeconomic status, as measured by the Hollingshead Index (1958), did not significantly differ between the groups. Most of the girls' families were within the upper two levels. All participants were Caucasian, with the exception of one Latina in each group. Parents' marital status also did not differ between the two groups. Approximately 85% of the girls came from two-parent families. In the AN sample, approximately half of the girls were inpatients (48.9%) and were outpatients (51.1%).

### **Measures**

Measures were administered to the AN and NAN groups in the same order: the eating disorder and major depressive module of the Diagnostic Interview Schedule for Children-Revised Version (DISC-revised); the Self-Understanding Interview (SUI); and the self-report questionnaires: the Eating Attitudes Test (EAT), Beck Depression

Inventory (BDI), Higgins' Selves Questionnaire and a demographic questionnaire. The measures will be described according to the construct(s) of interest and not in chronological order.

Presence of an eating disorder. Two measures were used to validate the presence of an eating disorder and to identify the presence and level of eating disorder symptoms among all participants. *The Eating Disorder Module of the Diagnostic Interview Schedule* (DISC-revised; Costello et al., 1984; Shaffer et al., 1993) is a structured diagnostic interview administered orally by a trained interviewer. Structured questions requiring a yes/no response assess for the presence of specific eating disorder symptoms. The revised version of the DISC corresponds to DSM-IV criteria and has been shown to have good overall reliability (Shaffer et al., 1993) as well as sensitivity to the diagnosis of specific disorders, including anorexia and bulimia nervosa (Fisher et al., 1993).

The 26-item-*Eating Attitudes Test* (EAT-26; Garner & Garfinkel, 1979, 1982) is a widely used measure that assesses attitudes towards foods, eating, and the body as well as related behaviors, such as exercising. The EAT-26 is a 26 item self-report questionnaire where each item is rated on a 6-point forced-choice Likert scale ("Always to "Never"). The extreme response in the "anorexic" direction (which is counterbalanced between "Always" and "Never") received a score of 3 points, whereas the adjacent alternatives were weighted as 2 points and 1 point, respectively, with the remaining three alternatives weighted as 0 points. The final score is the sum of these weighted responses. A cutoff score of 20 has been determined to reliably identify eating disordered patients in a female, adolescent population (Garner & Garfinkel, 1979, 1982).

Clinical observations have shown that girls experiencing anorexia sometimes deny the presence of symptoms on self-report inventories. Therefore, the diagnosis of anorexia nervosa obtained from strict DSM-IV criteria is more valid and was used as the primary inclusion criterion. Cross-tabulation of scores from the two measures indicated that 88% of the girls in the AN sample scored above the clinical cutoff on the EAT-26.

Depressive Symptoms. Measures were used to identify the presence of clinical depression as well as the level and presence of depressive symptoms. The *Depressive Disorder Module of the Diagnostic Interview Schedule* (Costello et al., 1984) is a structured diagnostic interview administered orally to the subject by a trained interviewer; questions require a yes/no response that determines the presence or absence of clinical symptoms for depression. Like the eating disorder module described above, it provides scores that are in accordance with the DSM-IV criteria for depression. The *Beck Depression Inventory* (BDI, Beck et al., 1961), a second measure of depression, has been used widely in clinical research and has been shown to differentiate depressed from non-depressed adolescents (Kashani et al., 1990). The scale contains items assessing emotional and vegetative symptoms of depression, with five response representing 4 levels of severity. Each item is scored from 0 – 3. Scores are summed, to produce a scale with a possible range of 0 - 63. A score of 13 or more has been shown to correspond to clinical depression in outpatient adolescents (Ambrosini et al., 1991).

Self attributes. The *Higgins' Selves Questionnaire* (Higgins et al., 1985) is a structured questionnaire that assesses different aspects of self: the “actual” self, the “ideal” self, and the “ought” self. This measure is based upon Higgins’ (1985) theory that discrepancies between individuals' actual (current) self-representations and their

ideal (desired) or socially prescribed ought self-representations lead to emotional and behavioral states such as depression, anxiety, and eating disorders (Avants et al., 1993). The questionnaire asks subjects to generate up to 10 attributes to describe: (a) the kind of person they currently perceive themselves to be ("actual self"); (b) the kind of person they would ideally like to be ("ideal self"); and (c) the kind of person they feel they ought to be like ("ought-self"). For each attribute listed, subjects rate themselves on a scale of 1 to 4 the extent to which they believe they currently possess the attribute (1=attribute *slightly* describes me to 4=attribute *extremely* describes me). Actual/ideal and actual/ought self-discrepancy scores were calculated with a formula based on Study 2 in Higgins (1990). Positive scores represent the magnitude of the discrepancy between the two self-descriptions. A negative score indicates that the two self-descriptions are congruent.

Self Understanding Interview (SUI). A modified version of Damon and Hart's (1988) Self-Understanding Interview (SUI) was used (see Appendix C). This semi-structured interview uses the clinical method (Piaget, 1969) to cover seven areas of self-understanding: physical, active, social, and psychological selves, as well as a sense of agency, continuity, and distinctness of self. Within each area, a question or set of questions is followed by standardized probes in accordance with the subject's line of thought. The researcher is careful not to lead or direct the subject's answer in any particular direction. Although central questions must be asked, the wording can be varied as needed so that the participant understands the questions; probes are added to expand upon the participant's reasoning. In the chain of questioning, the subject must be allowed and encouraged to express the meaning of the initial self-statement to the extent that the

subject is will and able to do so—in other words, follow up probe questions to the initial question must be asked.

The SUI addresses seven areas of “self”. The first four areas of the SUI explore the “self-as-object” in some of its most common manifestations: (1) self-definition, (2) self-evaluation, (3) self-projected in past and future, and (4) self-interest. Specific questions allow the researcher to assess the subject's use of objective self schemes (physical, active, social, and psychological self) and the developmental level of these self schemes. The last three areas of inquiry explore “self-as-subject” or subjective self components, including the sense of continuity, agency, and distinctness in the self.

The SUI was modified for this study by asking not only how the subject perceives the various components of her self, but also how specific significant others such as friends, mother, father, siblings, romantic interest, view that domain of her self, and what kind of person the participant thinks she *should or ought to be*. For example, in the domain of self definition, one of the central questions is "What are you like--what kind of person are you?" This was followed by the question, "What kind of person do your parents think you are? Your friends, teachers, romantic interest?" These additional questions reflect self-in relation theory and self-discrepancy theory, which underlie the study's hypotheses.

### **Coding the Self Understanding Interview**

Transcripts were coded in several stages. First, chunks of reasoning were identified. Then, in accordance with Damon and Hart's (1988) manual, self-schemas in each chunk were identified. Next, the relationality of each schema was coded, assigning it as either a self or relational schema. Then, the constructiveness of each schema was

coded, assigning it as a constructive or unconstructive statement. Finally, returning to Damon and Hart's manual (1988), developmental levels of each schema was coded (see below for more detail). For example, the following chunk was coded as social-*other, constructive* at *Level 2*: "I'm outgoing with my friends. I don't really let things bog me down. I'm a fun person."

Three case examples were coded a second time using Brown and Gilligan's Reader's Guide Method (1992). This coding scheme involves codes on three additional dimensions: the subject's voicing of her sense of self; her sense of self in different relationships; and the role of the body in speaking distress.

Demographic Data. The following information was obtained: date of birth; zip code; grade in school; number and ages of siblings; ethnicity; parents' marital status; education, and occupation. Socioeconomic status was calculated according to the Hollingshead Index (1958) using the information about parents' education and occupational status.

### **Coding Schemes for the SUI**

#### Damon and Hart's Original Coding Scheme

The original coding scheme developed by Damon and Hart (1988) divides responses into "chunks" of reasoning, which are then coded for developmental level. A chunk consists of one self-characteristic mentioned during the interview and *all* statements--whether spontaneous or in response to the interviewer's probes--that explicate the meaning or importance of that characteristic. Appendix D provides the decision rules for the original Damon and Hart coding scheme.

After chunking, the percentage of chunks that fall into each category of self schemas, within each domain, can be calculated. For example, for the objective self, statements regarding the physical body or material possessions are coded within the physical self-scheme ("I am fat and ugly", "I have a car that lets me go back and forth between school and the doctor's office"). Inter-rater reliability was calculated for the identification of the seven self-schemas within each chunk, yielding an 83% rate of agreement. Each chunk also was coded for developmental level, on a scale of 1 to 4, with 4 representing the most advanced developmental stage of self-understanding.

Damon and Hart's original coding scheme was expanded by refining the existing categories (see Appendix E). First, the original seven self-schemas included in the original coding guide (physical, active, social, psychological, agency, continuity, distinctness) were coded in two contexts—self and relational. For example, if a participant was talking about how she liked to jog for the health benefits it gave her—that was coded in the *physical-self category*. If she talked about how she like to jog with her track friends because she like the time to talk and gossip with friends—that would be coded in the *physical-other category*. The goal of this added coding scheme was to determine the extent to which girls' self-conceptions were self-based or relational-based. These changes reflect the goals of the feminist theory used in this dissertation and are congruent with Brown and Gilligan's Readers Guide methodology.

Second, each self-conception was coded on the dimension of constructivity, or positive versus negative valence. *Constructive self-conceptions* were defined as positive self references, that reflect actions, thoughts and feelings in accordance with one's true beliefs. *Unconstructive self-conceptions* were defined as harshly critical self-references

that signify ignoring, diminishing or silencing one's true beliefs and/or feelings. Therefore if a subject said she was pretty she would be given a code of *physical-self constructive*. If a girl said she was fat and ugly, she would be given a code of *physical-self unconstructive*. If she said she wanted to tell her friends how she really felt about them but couldn't because she was afraid, she would be given a code of *social-self unconstructive*.

Third, coding scores were collapsed across categories for the objective and subjective selves. Damon and Hart's self-understanding categories are based upon James' (1890) notion of a subjective and objective self. The physical, active, social and psychological self conceptions are considered to be *objective self components* and the agenic, continuity and distinctness self conceptions are considered to be *subjective self components*. Thus, by collapsing scores across each of these components, I obtained a quantitative comparison of subjective and objective self descriptions. (This is demonstrated in the scoring sheet in Appendix F.) This echoes one of the important themes in Brown and Gilligan's Reader's Guide (1988): whether the girl talks about herself in subjective or objective terms, whether she sees herself as an object or as a subjective agent, and whether this self view is dependent upon the relational context.

The modifications of Damon and Hart's original coding scheme capture the important relational context of self-understanding and self-development as discussed by Brown and Gilligan, as well as the constructiveness of the subjects' self-conceptions. These modifications expanded the number of variables coded in each transcript, to examine seven self schemas along two dimensions—self and other (creating 14 self

schemes)—as well as consider the constructive versus unconstructive nature of each of these 14 self schemas, creating 28 self schemes in all.

### Reader's Guide Coding Scheme

Three of the self-understanding interviews were coded a second time using Brown and Gilligan's (1992) Reader's Guide (See also, Brown et al., 1988; Debold, 1995; Tolman, 1992.) This allowed me to compare Brown and Gilligan's interpretation of self with the interpretation that the modified Damon and Hart Self-Understanding model provides. The Reader's Guide coding scheme focused on the participant's voicing of her sense of self, her sense of self in different relationships, and the embodiment of distress. It is an interpretive method that utilizes multiple close textual readings of an interview narrative. This allowed me to document the complexity of a girl's experience and the context of that experience, and to note the relationship between the girls' "speaking self" and their level of cognitive and emotional development.

The method of "reading for self and knowing" involves a process of interpretive readings done sequentially for each interview (Debold, 1995). The five readings conducted are as follows:

- 1) Reading for self. The reader looks for self-representations, with the goal of reading for the "self story" (Tolman, 1992) or "self poem" (Debold, 1995). Based upon Elizabeth Debold's (1995) method of reading for self, self poems were constructed from the girls narratives. Places where the active "I" emerged were extracted to create the self poem. It is through this reading that one notes examples of agency or the absence of agency. For example, a poem compiled from an anorexic participant's transcript:

*I guess  
I kind of act like everything is good  
I am very unsure of myself  
I'm more myself  
I don't know  
I want to make everyone happy  
I'm a people-pleaser*

After compiling this self poem, the reader would state what about the self is clear, what is confused and answer whether the self is positioned as a subject or agent. In the above example, one can argue that the narrator is agenic, although in a maladaptive way. She alters herself to the expectations of others. She is also a subject in that she sees herself as an object to satisfy others needs.

- 2) Reading for silences. The reader examines the text for silences in the actual narratives as well as where the girls note self-silencing in their own lives--what it is that girls cannot or do not wish to speak and in what context this happens. The reader underlines areas in text where the narrator says "I don't know", is unresponsive to questions, or where she describes situations and times that she did not feel free to do, say, speak or think what she thought, felt or wanted to do. For example: "I don't let people see my real feelings", "I don't really talk about my problems", "I don't express my emotions a lot". These statements were spoken in the context of when she is with friends and family.
- 3) *Reading for embodied knowledge*. Here the reader looks for the ownership of thoughts, feelings and actions and identifies areas where there is no dichotomy between how one feels and one thinks. This reading concerns an awareness and expression of the full range of human feelings and responses, both in oneself and in others. First, one identifies what the narrator knows about herself, her body, her

relationships, and her world. Then one notes whether the narrator is acting, thinking or feeling “false” or “true” to her self. For example, statements such as “I know myself, I know when I get tired I’ll be in a bad mood and I won’t be with people, or “When I feel good and happy I love to be with my friends and go out”, indicate that the narrator is acting “true” to her self.

- 4) Reading for disembodied knowledge. Here the reader notes and interprets incidents where a girl abandons what she knows or feels. This is heard from places in the text where girl’s erase, censor, negate, retract, or silence their feelings, their bodily responses and their knowledge. Disembodied knowledge can also be located in psychological defense processes such as intellectualization, minimizing, abstraction, distancing and dampening of emotional intensity. Both embodied and disembodied knowing are both mainly concerned with the relationship between the knower and the known, what has been discussed in this proposal as the subjective self and objective or definitional self. Similar to the reading above, one first identifies what is known by the narrator about herself, and then note whether she is acting, thinking, feeling “false” to her self. A statement such as, “I just kind of act like everything is good all the time, even when it’s not. I’m less likely than others to acknowledge my feelings myself provides evidence that the narrator is acting and feeling “false” to her self.
- 5) Reading for intellectual knowing. This reading looks for the presence of “oughts”, “shoulds”, and ideals. First the reader must identify the oughts, should and ideals in the girls language and then answer what her “moral code” is for herself—what she feels she ought or should be in comparison to how she is now. It is important to note the narrator’s ideals for herself in her body and her world. For example, “I should

always be the 'good girl'. I should be the person they want me to be," or "I'm a people-pleaser" or "If the doctors want me to be healthy, then I should be healthy, be the best patient ever", all indicate that the narrator believes she exists to please others, to make them happy, that she is an object.

The five interpretive readings were done sequentially. The text is interpreted as evidence of a particular phenomenon and was underlined in a different color on the interview transcript for each self feature. These pieces of text were transferred onto worksheets with a brief interpretation by the reader, and an overall summary of readings is written. Appendix G presents a sample worksheet. The Reader's Guide coding scheme is a more interpretive and less quantitative method than Damon and Hart's coding scheme, but the reader must provide a "trail of evidence" that supports the interpretation that she develops from the text. By listening closely to the girl's description of self and holding that in relation to different ways of knowing, the reader looks for patterns of self-understanding and self descriptions, self embodiment as well as disembodiment, "voicing" of self as well as "silencing" of self.

### CHAPTER 3: RESULTS

I will first present the findings of my quantitative analyses and then the findings of the qualitative analyses. The Discussion section will integrate these two types of analyses.

Although two groups were sampled in the original design (anorexic and non-anorexic girls), quantitative analyses were conducted with three groups. The group of 47 anorexic girls was subdivided into two groups based on the DSM-IV criteria for major depressive disorder: girls with anorexia nervosa *without* co-morbid depression (AN-ND group;  $n=21$ ) and girls with anorexia nervosa *and* co-morbid depression (AN-D group;  $n=26$ ). Girls in the NAN group ( $n = 25$ ) had no eating disorders or major depressive disorder.

Depression originally had been conceptualized as a potential covariate. However, in looking at the distribution of co-morbid major depression in the anorexic sample, it was apparent that there were two distinct groups of anorexic girls. Participants in the AN-D group had significantly greater Beck Depression Inventory (BDI) scores than the other two groups ( $F = 41.2, p = .000$ ). The mean BDI score for the AN-D group was 18.9, which was significantly greater than the AN-ND group ( $M = 10.5$ ) or the NAN group; ( $M = 3.6$ ; Tukey HSD test,  $p = .000$ ). However, BDI scores were still significantly greater in the AN-ND group compared to the NAN group (Tukey HSD test,  $p = .001$ ). Interestingly, group differences were also found between all three groups on the EAT ( $F = 44.3, p = .000$ ) with the AN-D group having significantly greater EAT scores ( $M = 47.1$ ) than either the AN-ND ( $M = 37.2$ ; Tukey HSD test,  $p = .065$ ) or NAN group ( $M = 9.5$ , Tukey HSD test,  $p = .000$ ). The AN-D group had slightly higher EAT

scores than the AN-ND group (Tukey HSD test,  $p = .065$ ). Thus, although the anorexic girls were higher on measures of eating disorder and depression than the non-anorexic group, there were significant differences in depression and eating behavior *within* the group of anorexic girls. These data, combined with recent writings (Ivarsson et al., 2000) suggest that anorexic girls with and without co-morbid depression be examined separately.

There were no significant differences in age, ethnicity, or socioeconomic status among the NAN, AN-ND and AN-D groups (Table 2). There was also no significant difference in inpatient versus outpatient status between the AN-ND and AN-D groups ( $\chi^2 = .026$ ,  $df = 1$ ,  $p = .871$ ). Girls in the NAN group had a significantly greater Body Mass Index (BMI) than both anorexic groups ( $F = 53.7$ ,  $p = .000$ ). The mean BMI score for the NAN group was 23.8, which was significantly greater than the AN-ND group ( $M = 16.6$ ) and the AN-D group ( $M = 16.6$ ; Tukey HSD test,  $p = .000$ ).

#### A Note on Significance Level

Because of the small sample sizes, statistical power is lower than originally calculated with two groups, so I will include trend findings (group differences at  $p = .06$  to  $p = .10$ ). At the same time, I will note the number of significant differences in any family of analyses and where trend analyses do and do not conform to the pattern of analyses at  $p = .05$  or better.

#### Group Differences in Self-Discrepancy

It was hypothesized that anorexic girls would have greater discrepancies between their perceptions of both their actual and ideal self as well as their actual and ought self. Significant differences on the Higgins' actual-ideal self discrepancy score

were found between the AN-D and NAN groups (Tukey HSD test,  $p = .000$ ) and between the AN-D and AN-ND groups (Tukey HSD test,  $p = .025$ ). In addition, significant differences were found on the Higgins' actual-ought self discrepancy scores between the NAN and AN-D groups (Tukey HSD test,  $p = .010$ ) and between the AN-ND and AN-D groups (Tukey HSD test,  $p = .072$ ). Means for each group are shown in Table 3. A higher positive score indicates a greater degree of discrepancy between the subject's self-states (or fewer "matches" in adjectives used to describe one's various self-states), whereas a negative score indicates that subject has minimal discrepancy between self-states (or more "matches" in their choice of self-descriptive adjectives).

Girls in the AN-D group showed the highest degree of discrepancy between their conceptions of their ideal self (or how they would ideally like to be) and their actual self (how they think they actually are), as well as between their conceptions of their ought self (or how they feel they ought to be) and their actual self. The AN-D group also showed the highest degree of discrepancy between their actual and ought self-conceptions ( $M = 2.63$ ), although this discrepancy was slightly lower than their actual-ideal self-discrepancy ( $M = 3.94$ ).

According to Higgins' theory, discrepancies between one's actual and ideal self representations arouse feelings of shame and are related to depression. To examine this relationship further, I explored the relationship between self-discrepancy scores and BDI scores for the total sample. Interestingly, both actual-ideal and actual-ought self discrepancy scores were significantly correlated with BDI scores. However, the actual-ideal self discrepancy score had a stronger association with depression than did the

actual-ought discrepancy score ( $r = .57, p = .000$  for actual-ideal vs.  $r = .39, p = .002$  for actual-ought discrepancy scores).

The actual-ideal discrepancy was significantly smaller in the AN-ND group than in the AN-D group (.82 vs. -.65,  $p = .025$ ). Although the AN-D group had a high amount of discrepancy between their actual-ought self perceptions, the AN-ND group had a significantly lower actual-ought discrepancy score than the AN-D group (-.25 in the AN-ND group vs. 2.63 in the AN-D group,  $p = .072$ ). However, actual-ought and actual-ideal self discrepancy scores did not significantly differ between the AN-ND and NAN groups.

In sum, significant differences in self-discrepancy scores were found among the three groups with the depressed anorexic girls having significantly higher actual-ideal and actual-ought self-discrepancy scores than both the non-anorexic girls and the anorexic girls without depression.

#### Unpeeling Layers of Self-Concept

I next examined differences between anorexic and non-anorexic girls in terms of Damon and Hart's (1988) conceptual schema of self-understanding. In accordance with Damon and Hart's original model, the self is conceptualized into seven different components: physical self, active self, social self, psychological self, agency, continuity and distinctiveness. These self components, or self schemas, were expanded for this study to incorporate the relational context as well as constructiveness of self-statements (i.e., positive vs. negative valence). Thus, a total of 28 variables denoting different self schemas or components of self were examined: Damon and Hart's original seven, those seven coded for relational context—i.e., others' views—and then, these 14 schemas

expanded again to consider positive or negative valence. In other analyses, the seven original self schemas were collapsed into two broad categories: the subjective and objective self (the “me” and the “I”). In addition to testing for group differences in frequency of usage of each of these self schemas, I discuss how the modifications to the original Damon and Hart measure add layers of context and provide a richer understanding of the self among anorexic girls. I also examined group differences in terms of developmental level. Specifically, group differences in self-understanding will be examined and discussed in the following manner, each adding a new layer of understanding to the previous analyses. To recap:

- 1) First I will examine self conceptions in accordance with Damon and Hart’s original seven self schemas: physical, active, social, psychological, agenic, continuity and distinctiveness.
- 2) Next, the relational context—self vs. other—will be added to the seven Damon and Hart self-schemas, producing 14 schemas (physical-self, physical-other, active-self, active-other, social-self, social-other, psychological-self, psychological-other, agency-self, agency-other, continuity-self, continuity-other, distinctiveness-self, and distinctiveness-other).
- 3) Next, constructiveness of self statements (i.e., negative or positive valence) will be added to the 14 categories just described, producing a total of 28 self schemas. For example, within the physical domain, I coded for physical-self constructive, physical-self unconstructive, physical-other constructive, and physical-other unconstructive.
- 4) The 28 self schemas were then collapsed into objective and subjective self categories, or the “Me” and the “I”. To do this, the physical, active, social and psychological self

schemas were combined to calculate the objective self, or “me”, and the agenic, continuity and distinctiveness self schemas will be combined to calculate the “T”.

5) Finally, modal developmental levels for each of the following schemas were compared among the groups. For example, in the physical self domain, modal levels were compared for the overall physical category and then for the physical-self and physical-other categories. This was pattern was repeated for the remaining six self schemas.

#### Damon and Hart’s Original Self-Schemas

There were few group differences in the frequency with which the seven original schemas, as described by Damon and Hart (1988), emerged in the girls’ statements (Table 4). Significant differences were found in only the social and distinctiveness schemas. The AN-ND group had significantly fewer social chunks than did the NAN group (Tukey HSD test,  $p = .012$ ). Both the AN-ND and AN-D groups have significantly fewer distinctiveness chunks than the NAN group (Tukey HSD test,  $p = .027$  and  $.061$ , respectively).

#### Adding Relational Context to the Simple Self-Schemas

When the original seven self-schemas were expanded to include relational context—talking about the self in the context of relationships with others vs. without consideration of relationships—a more precise picture of group differences was detected. Significant group differences were detected in 5 of the 14 self schemas (see Table 5): Social-other, psychological-self, agency-other, continuity-self, and distinctiveness-other. Tukey HSD comparisons indicated that the NAN group used significantly more social-other and agency-other descriptions than either the AN-ND or AN-D groups (social-other

$p = .002$  and  $.069$ , respectively; agency-other  $p = .000$  and  $.001$ , respectively).

Interestingly, the NAN group used significantly *less* psychological-self descriptions than either the AN-ND or AN-D groups (Tukey HSD test,  $p = .029$  and  $.001$ , respectively).

The AN-D group used significantly more continuity-self descriptions than the NAN group (Tukey HSD test,  $p = .029$ ), but not more than the AN-ND group. The NAN group also showed a trend for using significantly more distinctiveness-other descriptions than the AN-ND group (Tukey HSD test,  $p = .072$ ), but not more than the AN-D group.

More specific group differences were detected when considering the relational context of self-descriptions than the original Damon and Hart schemas. In general, when considering the relational context, there was a pattern of the non-anorexic girls using more self-descriptions than the anorexic girls in the social-other, agency-other and distinctiveness-other schemas, and fewer self-descriptions in the psychological-self and continuity-self schemas. It appears that the non-anorexic girls were more “relational” focused in several of the schemas, whereas the anorexic girls were more “self” focused in several of the schemas.

#### Adding the Notion of Constructiveness

The dimensions of constructiveness and unconstructiveness of self-statements were added next to the relational self schemas. A consistent and more complex pattern of group differences emerges when the self-schemas are differentiated by constructiveness as well as relational context. The nature of the differences, however, depends on whether a constructive or non-constructive statement is made. These analyses are presented in Table 6. Overall, significant differences were found in 24 of the 28 ANOVA's. Tukey HSD comparisons ( $p < .05$ ) indicated that the NAN group gave more self-statements

across most of the constructive schemas (nine out of 14) than either anorexic group. Tukey HSD comparisons ( $p < .05$ ) also indicated that the NAN group gave fewer self-statements in four of the 14 unconstructive schemas than either anorexic group. Significant differences were found between the NAN and AN-D group in the following schemas: active-other unconstructive, social-self unconstructive, social-other unconstructive, psychological-other unconstructive, agency-self constructive, agency-other unconstructive, continuity-other constructive, distinctiveness-self constructiveness and distinctiveness-self unconstructiveness. The pattern of differences followed those as described earlier: the NAN group had more constructive and less unconstructive self-statements than the AN-D group in all of the categories. Finally, in two schemas there was a trend for differences between all three of the groups: continuity-self unconstructive (Tukey HSD test,  $p = .003$ ) and distinctiveness-other unconstructive (Tukey HSD test,  $p = .082$ ). As was predicted, the AN-D group had more negative statements than either the AN-ND or NAN groups in both the continuity-self and distinctiveness-other unconstructive categories.

In sum, both groups of anorexic girls—those with and without co-morbid depression—had fewer constructive and more unconstructive self-statements in their self-descriptions—regardless of relational context—than the non-anorexic group. Both anorexic groups described themselves more negatively—regardless of relational context—than the non-anorexic group. Significant differences in accordance with this same pattern were found only between the NAN and AN-D group in 9 of these 14 analyses. In two of the self- schemas (continuity-self and distinctiveness-other), the AN-D group described themselves more unconstructively than even the AN-ND group. Although significant

differences were found in several of the schemas between only the AN-D and NAN group, the NAN group still appears distinct in patterns of self-understanding from *both* the anorexic groups. In other words, although non-depressed anorexics differ from depressed anorexics in several self-domains, healthy girls still see themselves much differently than anorexic girls—whether they are depressed or not.

### The Objective versus Subjective Self

Until now, I have been adding complexity to Damon and Hart's original self schemas. Next I collapsed the expanded schemas to comprise a different way of talking about group differences. Self-understanding theory is premised upon James' (1890) notion of the self, which in essence has two categories—the objective and subjective self. Damon and Hart (1988) based their theory on this notion, conceptualizing four specific self domains that comprise the objective self and three specific self domains that comprise the subjective self. Thus, group comparisons were made between the subjective and objective self, or the “me” and the “T”, starting with the two “simple” broad categories and then following the above process of adding layers of meaning to understanding the self in relational context and the constructiveness of the self-statements. For all of these analyses, the physical self, active self, social self and psychological self schemas were combined to calculate the objective self or the “me”, and the agency, continuity and distinctiveness schemas were combined to calculate the subjective self or the “T”. Mirroring the analyses presented earlier, the finer coding for relational context and constructiveness was analyzed next.

No significant group differences were found in the most basic “me” and “T” comparisons (i.e., those using Damon and Hart's original self-schemas). However,

group differences were found in all of the more refined “me” schemas, which included the relational and constructiveness dimensions (see Table 7), and in seven of the eight “T” schemas (see Table 8).

The Objective Self. When considering the relational context, the NAN group used more “me-self” schemas than the AN-D group (Tukey HSD test,  $p = .016$ ), and more “me-other” schemas than the AN-ND group (Tukey HSD test,  $p = .048$ ). When considering the context of constructiveness, the NAN group had more positive self statements than both anorexic groups (Tukey HSD test,  $p = .000$ ) and fewer negative self statements than both anorexic groups (Tukey HSD test,  $p = .000$ ). When considering relationality and constructiveness together, the NAN group had significantly more “me-self positive” and “me-other positive” variables than *both* anorexic groups (Tukey HSD test,  $p = .000$ ). Conversely, the NAN group had significantly less “me-self negative” schemas than both anorexic groups (Tukey HSD test,  $p = .000$ ), and less “me-other negative” schemas than the AN-D group (Tukey HSD test,  $p = .000$ ). In sum, both anorexic groups had less constructive, objective *self and other* statements than the non-anorexic group. Only the anorexic girls with depression had more unconstructive, objective *self and other* statements than the non-anorexic group.

The Subjective Self. When considering the context of relationality, the NAN group had significantly more I-other statements than both the AN-ND and AN-D groups (Tukey HSD test,  $p = .000$  and  $.006$  respectively). When considering the context of constructiveness, the NAN group used significantly more subjective positive and less negative statements than both anorexic groups (Tukey HSD test,  $p = .000$ ). Overall, the AN-D group used more subjective negative self statements (I-negative) than the AN-ND

group (Tukey HSD test,  $p = .000$ ). When considering constructiveness and relationality are considered together, the NAN group had more I-self positive statements than the AN-D group (Tukey HSD test,  $p = .000$ ) and more I-other positive statements than both anorexic groups (Tukey HSD test,  $p = .000$ ). Conversely, the NAN group had significantly less I-self negative than the AN-ND and AN-D groups (Tukey HSD test,  $p = .005$  and  $.000$ , respectively). Interestingly, the AN-ND had significantly fewer I-self negative statements than the AN-D group (Tukey HSD test,  $p = .002$ ) and fewer I-other negative statements than the AN-D group (Tukey HSD test,  $p = .023$ ). The NAN group also had significantly fewer I-other negative statements than the AN-D group (Tukey HSD test,  $p = .000$ ).

When looking at group differences in objective self conceptions or the “me”, both the notions of relational context and constructiveness add layers of meaning. Examining only the most basic objective sense of self (the “me”) yields no significant group differences among anorexic and non-anorexic girls. Once the relational context is added, however, group differences emerge. In the me-self schema, significant differences were found between the AN-D and NAN groups; depressed anorexic girls made more subjective self statements than the healthy girls. When this relational coding was expanded to include constructiveness, we can see that the non-anorexic girls make significantly more *self-positive* statements and fewer self-negative statements than both anorexic groups.

At first, it looks as if the depressed anorexic girls are making more self statements, but upon closer inspection, they are making many more *negative* self statements. And, when looking at the objective self in the context of relationships, it

appears non-anorexic girls are making more me-other statements than the AN-ND group (Tukey HSD test,  $p = .045$ ). But when the notion of constructiveness is added, it becomes clear that they are making more other-positive statements than either anorexic group (Tukey HSD test,  $p = .000$ ) and significantly less other-negative statements than the AN-D group (Tukey HSD test,  $p = .000$ ). In other words, the AN-D group is making the most other-negative statements.

The notions of relationality and constructiveness also add layers of meaning to subjective self conceptions. No significant differences were found in the most basic subjective sense of self, or the "I". However, once the relational context is added, group differences were detected in the I-other schema, with the NAN group making significantly more subjective-relational statements than both the AN-ND and AN-D groups. When constructiveness is added, the NAN group made significantly more I-other positive statements than both anorexic groups and fewer I-other negative statements than the AN-D group. Interestingly, in this I-other negative schema, the AN-ND group had significantly less negative statements than the AN-D group.

Although there were no group differences in the general I-self category, when further distinguished by constructiveness, the NAN group had significantly more I-self positive statements than the AN-D group only. Also, the NAN group had significantly less I-self negative statements than both the AN-ND and AN-D groups (Tukey HSD test,  $p = .005$  and  $.000$ , respectively). Again, in the I-self negative schema, the AN-D group made significantly more negative statements than the AN-ND group (Tukey HSD test,  $p = .002$ ). Overall, in the subjective self categories, it appears that the AN-D group made significantly more negative statements than both the AN-ND and NAN groups.

In sum, adding relational context to the subjective and objective notions of self helps to denote where group differences lie. Accordingly, also adding the context of constructiveness, we get a richer picture of the meaning of these group differences.

#### Modal developmental levels

Damon and Hart's model also suggests that researchers index the individual's developmental level of self-understanding. Thus, one can compute a developmental level score for each of the self schemas. The scale ranges from 1 to 4, with 1 representing the lowest developmental level and 4 representing the most advanced level. A Level 1 understanding of the self usually corresponds with early childhood self conceptions. Level 2 typically corresponds with middle and late childhood, Level 3 with early adolescence and Level 4 with late adolescence and early adulthood.

Because developmental levels were not hypothesized to relate to constructiveness of self statements, but may theoretically be linked with relational context, modal developmental levels were calculated and analyzed for the seven "basic" self schemas as well as for the 14 modified schemas that include relational context (if the constructiveness context were added, the number of subjects in each category would be very small, so these analyses were not done). That is, an overall modal level was calculated for each of the self schemas, without consideration of relationality, and then *with* inclusion of relationality. For example, developmental level scores were computed for "active", "active-self" and "active-other". Modal level was analyzed as a continuous rather than a categorical variable, given the small number of girls at any developmental level.

Group differences in modal levels were found in 10 out of 21 self schemas, as shown in Table 9. The NAN group had the highest developmental levels. In the overall physical and physical-self schemas, the NAN group had significantly higher modal levels than the AN-ND group (Tukey HSD test,  $p = .011$  and  $.001$ , respectively). The NAN group also showed a trend for higher physical-self modal levels than the AN-D group (Tukey HSD test,  $p = .080$ ). For the overall active and active-self schemas the NAN group had significantly higher modal levels than *both* anorexic groups (Tukey HSD test,  $p < .05$ ). In the social-self schema the NAN group had significantly higher modal levels than the AN-D group (Tukey HSD test,  $p = .046$ ), and showed a trend for higher modal levels than the AN-ND group (Tukey HSD test,  $p = .083$ ). In the overall psychological and psychological-self schemas, the NAN group once again had higher modal levels than both anorexic groups (Tukey HSD test,  $p < .05$ ). In the overall agency schema, the NAN group showed a trend for higher modal levels than the AN-ND group (Tukey HSD test,  $p = .058$ ). Similarly a trend was detected for group differences in the overall continuity schema ( $p = .086$ ), with the NAN group having higher modal levels than the AN-D group (Tukey HSD test,  $p = .077$ ). Finally in the only “other” schema where differences were found, the NAN group had higher modal levels than the AN-D group in the continuity-other schema (Tukey HSD test,  $p = .004$ ).

Considering the relational context helps us understand differences in developmental levels across the three groups. Significant differences were found in five of the seven “basic” categories (i.e., self-schemas without relational consideration). In all five, non-anorexic girls showed more advanced conceptions of self than either group of anorexic girls. Include relational context, and it becomes clear that the anorexic girls’

self-conceptions were less advanced developmentally than healthy girls'. For example, when talking about their psychological-self understanding, anorexic girls appear less developmentally advanced than the healthy comparison group. In other words, when talking about the independent self, anorexic girls' conceptions are less mature. The following chunk from a girl with anorexia would receive a code of psychological-self at Level 2: "I used to not worry as much about thing. I just went out and did things that made me happy. Now, I don't do anything that makes me happy." The following chunk from a girl without anorexia would receive a code of psychological-self at Level 4: "I've experienced a lot of emotionally painful experiences—I went through a lot of tough things. But I dealt with them and used them to develop a stronger self image—better self-esteem—of myself, and you know, and whatever I was told that was bad I never believed and strived for something better." However this difference disappeared when girls are talking about the self in a relational context. It should also be noted that there were no significant differences in developmental levels of self-understanding between anorexic girls with and without co-morbid depression.

#### Summary of Self-Understanding Findings

Differences were found between anorexic and non-anorexic girls in both the types of self schemas they hold, and the developmental level of self-understanding. Most of these differences were revealed when one moves past basic "content-focused" dimensions to the more complicated notions of self in relation to others and the positive and negative tone of those statements. Few group differences were detected in Damon and Hart's (1988) original self-schemas or in developmental level. Where differences were detected, it appears that both groups of anorexic girls were more "self" focused and

less “other” focused than the non-anorexic girls. Moreover, there were few distinctions in self-understanding between depressed and non-depressed anorexics.

The most compelling pattern of group differences occurs when the constructiveness of self statements is considered in addition to the relational context. In general, anorexic girls made more unconstructive and fewer constructive statements than non-anorexic girls—regardless of relational context. Interestingly, in two of these categories—continuity-self unconstructive and distinctiveness-other unconstructive, the depressed anorexic girls made more negative statements than the non-depressed anorexic girls did.

However an interesting picture of group differences emerges when the self schemas are collapsed into broad categories of objective and subjective self. Without consideration of relational and constructiveness context, no group differences were found. However, once expanded to include these notions, clear group differences emerged. In the objective self domain, group differences were found between the non-anorexic and anorexic girls, but no differences were found between the depressed and non-depressed anorexic girls. Again, in the subjective self domain, group differences were found between the non-anorexic and both anorexic groups. Interestingly in this domain, group differences did emerge between the two anorexic groups, with the depressed anorexics making more overall negative subjective statements than the non-depressed anorexics.

Finally, as was expected, the non-anorexic girls had higher developmental levels across several of the self schemas, with a clear pattern for higher modal levels than either anorexic group when discussing the self alone—*without* the context of

relationships. In other words, when talking about the independent self, the anorexic girl's self conceptions are less mature than their healthy counterparts. Overall, it seems that the anorexic girls are more self focused than relationally focused and make significantly more negative self statements than their healthy counterparts.

Interestingly, the social and psychological self schemas were the most frequently discussed by all of the girls in this study, with the frequent discussion of agenic self schemas not far behind. It is not surprising that the strongest group differences were detected within these three categories. Generally, the non-anorexic girls were making more social and agenic statements than either anorexic group, whereas the anorexic girls were making more self-focused psychological statements than their healthy counterparts. So in the areas that appear to be the focus of adolescent girls' self talk, the anorexic girls were the most "weak" or deficient.

The strongest difference detected between the two anorexic subsamples was in the discrepancy between the actual self and the self as it should be or was desired to be. Overall, the depressed anorexic group had more actual-ideal and actual-ought self discrepancies than the non-depressed anorexic group. Anorexic girls with depression saw their actual selves as very different from what they wanted to be like (ideal self) or feel they should be like (ought self). Depressed anorexic girls also have more negative subjective and less positive self conceptions (agency, continuity, distinctiveness) than the anorexic girls without depression.

#### Expression through poetry: Themes of study emerging from a struggling girl

I now turn to the qualitative data from three girls in the study, one from each group, that were coded using the Reader's Guide. These data support some of the points

made in the previous sections, but uncover a number of other issues that the interviews did not or could not.

The following is an excerpt from a poem than an anorexic patient wrote and shared with me: “The night is still and the silence is screaming. I walk down a black, windy road. I do not know where I am or how I got here. How did I get lost? Will anybody be able to find me? I need guidance—somebody to direct me home. I hear voices, some loud and some very, very soft. They are calling me, from all around, each one pleading for me to look its way. Why can’t I see anybody? My senses have left me...My mouth opens to scream for help, but no sound comes forth. I try again, but to no avail. Is my will not strong enough? Do I really believe that I will not escape this terrible, evil doom? Oh where is the light?”

This except reverberates the story that this dissertation is trying to tell. This girl has lost her voice (the silence is screaming); she looks for healthy, guiding relationships that she does not have (I need guidance—somebody to direct me home); she feels the pull of different relationships, giving in to the needs of others and denying the needs of her self, losing her own self-direction to follow that of others (I hear voices...they are calling me from all around, each one pleading for me to look its way); she feels a lack of agency and efficaciousness (Is my will not strong enough?) and is confused as to what path to follow, what voice to listen to, and from whom and where to seek guidance (Why can’t I see anybody...My mouth opens to scream for help but no sound comes forth).

The themes emerging from this poem brings the theoretical to the personal. How do girls with anorexia nervosa see themselves? Do they see themselves as separate

individuals with unique feelings, thoughts and desires? Do they see themselves as agenic beings, able to set goals and realize them? Do they see themselves as relational beings, struggling to define themselves in connection with the needs, expectations and desires of others? If all these self-views exist, how do they integrate these individual and relational notions of self? Does one way of seeing the self—or defining the self—overshadow or outweigh the other?

The findings discussed earlier suggest that the anorexic girl's self-view is unique and distinctive. I identified specific domains—structurally defined components of the self -- where anorexic girls were unique from girls without eating disorders. Furthermore, there were distinctions in self-understanding between anorexic girls with and without clinical depression. So yes, one can suggest that girls with anorexia, have more unconstructive, less subjective, less relationally-oriented self-conceptions than their non-eating disordered peers. Moreover, girls with anorexia *and* co-morbid depression have even more unconstructive and less subjective self-conceptions than even their non-depressed, anorexic peers. These differences speak to the phenomenology of girls' experiences. I believe that the words of these girls speak volumes. To supply the poignant sounds of self-expression and attempt to qualitatively answer the questions identified in the above poem, narratives from three study participants were analyzed using the Reader's Guide Coding Scheme (Brown et al., 1988). Each of these readings was chosen to bring voice to each of the three groups discussed in this dissertation: one narrative is from a girl with anorexia nervosa with co-morbid depression; one is from a girl with anorexia nervosa without co-morbid depression; and one is from a girl without an eating disorder or depression. These three girls were similar on many dimensions—

socioeconomic status, education, intelligence, beauty, and athletic achievement. Yet there is something different about each of them—different about how they perceive their achievements, gifts and role in the world—that hopefully points to why they are different along eating and mood disorder symptoms.

#### Reading a narrative from a girl with anorexia nervosa and depression

This narrative is from “Ann”<sup>2</sup>, a 20 year old, white girl who had been in treatment for her eating disorder for several years. She had been hospitalized twice and when I met her was an outpatient. Unfortunately, a few months after the interview, Ann was re-admitted to the inpatient unit. She was enrolled in a local college, but was forced to withdraw several times due to her illness.

Prior to the onset of her eating disorder, Ann was a popular, overachieving adolescent girl. At the time of the interview, she is still strikingly beautiful, although extremely emaciated, and was quite friendly with the other eating disorder patients at the clinic. Many of the girls at the clinic had been inpatients together and have gotten to know each other and their stories quite well. Ann was more than happy to speak with me about her illness especially if it meant “helping to keep someone from suffering like I am”. She had been in individual therapy for several years and had been on several antidepressant medications.

#### Knowing vs. Not Knowing the Self. Embodied vs. Disembodied Knowledge

Ann was quite forthcoming with sharing her self-doubts, insecurities and fears. It was noticeably difficult for her to make any positive self-statements in the

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<sup>2</sup> All names are fictional in order to protect the identities of the girls being discussed.

interview, and she would reluctantly do so when encouraged. However, whatever minimal positive self statements she made were either oriented towards how good she was in serving the needs of others, successful in silencing her own wants and desires, or were eradicated by another negative statement countering the positive one. For example, when asked to describe her self, one of her first descriptions was that “I think I’m smart”. Later in the interview she states, “I’m not smart...I’m like a failure at school”, and “I don’t always act smart with my boyfriend”.

Ann talked a lot about wanting to be exceptional in one area—to have a special gift or be different from others. Many adolescent girls experience this same desire to a certain degree—wanting to be special or distinctive. Perhaps they want to be the best student or soccer player or dancer—they aspire to dreams and goals. Identity formation, developing independence and distinctness are considered to be developmental tasks of the adolescent period. However, teens must often grapple with this appropriate desire of wanting to be unique with the opposing desire of wanting to fit in with peers as well as meeting the expectations that society and family have for them.

Many of the issues that Ann was struggling with—self-definition, satisfying the expectations her parents and society had for her—are common amongst most teens and young women. However it is the way in which Ann struggled with these conflicts, by focusing on her body and her inadequacies with no awareness or articulation of her own specific dreams or desires that distinguished her from the girls without eating disorders. For example, she states that “I always have that need to have my thing when I’m out with my friends...my one thing that I’m good at and what makes me different from anyone else. I don’t have that one good thing so I have my anorexia.” Ann was

quite appropriate in expressing her desire for distinctiveness, but unfortunately the only thing she felt she “knew” about herself that was unique was her eating disorder.

Ann was also quite articulate about “knowing” where and how she fit in socially. She felt most comfortable with her friends who also had eating disorder—whom she felt she understood and in whom she felt she saw herself. She states that that when she is at the Eating Disorders Center, “I don’t have that need to want to be different as much when I’m in the hospital. *I can just feel like I’m here* and we all talk about the eating disorder...I see the other eating disorder patients playing with their food, or look around feeling lost and I’m like wow, that’s like me”. This commentary about her only feeling comfortable with her self, in her own body, when she is in the hospital with other “lost patients” is quite tragic. Perhaps this speaks to her many relapses and frequent hospitalizations. It seems she feels at “home” with other girls sharing the same kind of pain, not having to put on a front or false face in her interactions with others. It is with these girls, at that place, that she can be her true self—as ill as her true self is. It may be the only place where she feels safe to share the internal pain she is experiencing. Perhaps in that setting she is able to use her voice to make her internal world external. In the hospital, with other suffering girls, her body is not her only mechanism of communicating her internal state—she is actually able to give voice to her pain, self-doubts, insecurities, and self hatred.

In other words, one can surmise that when she is with her “healthy” friends, she can’t express with words how she feels and thinks differently, so she does so with her body. With other anorexic girls, she doesn’t feel the pressure to assert her distinctiveness through her body—there is emotional understanding and feelings of similarity between

the girls. “I get scared and sometimes I deny that I have an eating disorder and that I shouldn’t be in the hospital. I see myself in these other people and then I realize I kind of have a problem.” Interestingly, after each of her hospitalizations she maintained a healthy weight for about a month or two. Then she would slowly descend into the anorexia. She explained to me how she starts out strong, able to articulate her wants, but after a short while, she loses hold of her own beliefs—is no longer able to assert her own self. “I thought I was better with my eating disorder, I thought I was doing good. I thought I found my self and what I wanted to do. I just lost it and became the person who I was before. I’m very afraid of being what I wanted to be. Maybe I’m afraid of being responsible or like an adult. I just want to be happy and enjoy life, but don’t think life is really like that”.

Hopelessness, pessimism and living to serve the needs of others are the overarching themes of her narrative. “I’m very afraid of being what I want to be. Like I want to achieve things, but not have to worry about being thin or being a certain way. I’m afraid of being productive—I hate that word. Like I want to be productive for myself. Like I want to do what I like to do and I do want to do it for anything or anyone else. And I don’t know if that can happen. Like I feel like you have to be thin to be a successful woman. Like I don’t want to be an adult it’s too scary.” Interestingly, her talk about wanting to do and be what she wants evolves into talk about how one must be thin to be a successful woman. The only clear desire she articulates is her want to be thin to be successful. I asked her why being an adult is scary to her. “Like being an adult for me, is just being who I am. If I’m thin, or I’m my normal weight or whatever, I just want to be happy and enjoy life. But I don’t think it’s really like that. Like I’ll look at my

parents and you know, I don't feel like they're doing that. It doesn't make sense. To live to pay taxes. And they're like living such a logical life and I want to live a rewarding life...I want to follow my own direction and not follow what society expects. Like society expects that you get a good job and make a lot of money and they always talk about the pay you get up to—that's all they talk about. So basically I don't want to be what others expect an adult to be like.” It seems as if Ann does have some idea of how she wants to live her life and what she wants to be in the future, but she also has some awareness of how her desires are different from what others expect for her. Instead of running towards defining and pleasing herself, she retreats into a world focused on weight, food, calories and exercise.

Unfortunately, there are many places in this narrative where we can see that Ann is not acting “true” to herself and often does not feel free to do say speak or think what she thought felt or wanted to do. Even more unfortunate, is that when Ann does assert some knowledge about her self or her world, this knowledge is peppered with hopelessness and negativity. For example, when I asked Ann how she was with her family she stated: “I pretty much like please them, like I do a lot to make them happy. I always like talk bout the good things and don't let them see the negative things...I project the person that I feel they want be to be.” When I asked her if she often projects a certain image of how she wants people to see her, she replies: “Yeah. Umm, I usually like, can tell what other people expect or like and I act like what they expect. It's like I have a lot of surface relationships and it's exhausting. I feel strained, you know, to be a certain way all the time, to be happy, to athletic or outgoing, but it just not how I was. I always had to act to be like happy or like superficial—like talk about clothes or guys or whatever—

and that's not what I felt or liked to talk about...I'm always trying to be what I feel someone else wants me to be." When asked about what she was proud of about herself, she was silent for quite a while. Then she finally responded that, "I don't really like that much about myself, but I don't know, I like that I know what's going on that I see what's really happening." So it seems as if her knowledge only involves knowing the needs of other, or seeing the sad reality of the world and her situation.

Interestingly, Ann's only sense of agency emerges when she talks about her ability to serve the needs of others—almost like it's a gift, or her calling. "I think I was born with a certain personality. I was always good to other people since I was little. I caught on really quick at what would make somebody happy and what they liked. I also learned what wouldn't be good enough. I wanted to make them happy all the time, so I pushed myself to be and do what they wanted". There is no sense of self-creating, of setting her own goals that pleased her, and reaching them. Even when she talks about her "gifts" of sensing other people's needs, it sounds as if it is something she was born with—not something she taught herself to do or chose to do because she wanted to. I specifically asked her how she got to be the person she is, or the way that she is. She responded: "Probably by doing what others expected all my life and just winding up with an eating disorder because of it." Again, Ann has an intellectual awareness about both the physical and personal price she has had to pay in order to fulfill the complex, contradictory expectations others have had for her. However, this awareness is not enough to help her let go of the anorexia—to let go of the comfort and safety it provides her—and jump into the real world around her.

Much of Ann's narrative is focused on what she feels she should be like or what she feels she ought to be like: "I should be like way ahead of where I am in school, and I should have like good grades, I should have a job, and should have a boyfriend, maybe get married." When I asked her how all these "shoulds" were different from what she really wants, she replied, "cause I don't want anything. I don't know. I just really want to wait and see what happens, but like right now I feel like I should be married, should be perfect."

Finally, when I asked her how she was different from other girls her age she said that, "as much as I'm selfless and I can't say what I want—I know a lot more than most people my age...also, the eating disorder makes me different, it gives me my identity. It always comes down to that's the one thing that I know I have."

#### Self Summary

Overall, it seems that Ann sees her self as existing to serve the needs of others—subjugating her own needs and desires to meet the expectations and needs of others. Her only sense of distinctness or individuality is experienced through her illness—she believes her anorexia is all that she has to make her different and that it defines her very existence. What she "knows" about herself as a physical, active, social, psychological being is characterized by unconstructive or self-deprecating statements. Also, with the exception of "being" with her eating disordered peers, one can argue that Ann does not even have a true social conception of her self. All of her social interactions, and the objective components of herself that she exposes to others, are simply reflections of their expectations. In other words she reflects what others want to see in her, her true self shielded with an all-encompassing mirror.

### Self Poem: Ann's Own Composition

Based upon Elizabeth Debold's (1995) method of reading for self, self poems were constructed by the PI from the girls' narratives. Places where the active "I" emerged were extracted to create the self poem. Following is the self poem extracted from Ann's narrative.

I think I'm pretty quiet  
I think I'm smart  
I'm not like very outgoing  
I'm not like gossipy  
I don't go to bars, I don't think that's fun  
I'd think I'd be shallow if I were gossipy  
I pretty much please my family  
I do a lot to make my family happy  
I don't like them to see negative things  
I always like talk about the good things that are happening at school and stuff  
I don't really like them to say negative things  
I feel like they want me to be successful so I won't have to rely on them  
I actually fell like the most relaxed when I'm in school  
I like to participate in class  
I'm like there for other people or like act happy or whatever  
I don't trust them  
I don't feel comfortable  
I like felt comfortable being assertive with him  
I'm like myself when I feel comfortable  
I'm just afraid of like sharing my feelings  
I usually like, can tell what other people expect or like and I act like what they expect  
I have a lot of surface relationships and it's exhausting  
I felt strained—you know to be a certain way all the time, to be happy, to be athletic, outgoing  
I always had to act happy  
I don't really like that much about myself  
I see what's really happening  
I don't like my physical appearance that much  
I don't like that I let people down  
I feel like a failure about certain things  
I'm like a failure at school  
I'm not smart  
I want to see myself as smart but I don't  
I like that I'm closer with my sister

I'm always there for my friends.  
I used to like being the person they turned to, now it's too much  
I never let anybody be there for me  
I hate the way I always listen to what my parents say  
I hate the way like I don't try to face my parents  
I like being there for my friends  
I don't like how my friends kind of use me when they just need me  
I didn't always act smart with my boyfriend  
I always acted like myself for the most part  
I wasn't ready to do a lot of things and I'm not ready for a relationship, I wish I  
could be  
I am different in different relationships  
I'm always trying to be what I feel someone else wants me to be  
I read into things too much  
I always feel like my parents want me to be a good student but they never actually  
said it  
I hope to be sure of myself, to know how I am  
I want to be like thin, smarter, and not worry about what others think  
I want to be successful—like doing what I want to do  
I want to work with eating disorders because I have my own beliefs about that  
I think behavior modification is stupid  
I see that they throw people out of the eating disorder program if they don't  
change their behavior  
I should be like way ahead of where I am in school  
I should have like good grades  
I should have a job  
I should have a boyfriend, maybe get married  
I want to just wait and see what happens, like in 10 years if I want to get married I  
will, but right now I feel like I should  
I realized that I haven't changed  
I thought I was better with my eating disorder  
I thought I was doing good  
I thought I found myself and what I wanted to do  
I just lost it and became the person who I was before  
I'm afraid of being responsible or like an adult  
I'm very afraid of being what I wanted to be  
I want to achieve things but not have to worry about being thin or being a certain  
way  
I'm afraid of being productive—I hate that word  
I want to be productive for myself  
I want to do what I like  
I don't know if that can happen  
I just want to be happy and enjoy life  
But I don't think it's really like that  
I don't feel like my parents are doing that—being happy

I feel like my parents are working for benefits, money and to pay taxes  
I want to live a rewarding life  
I was always like good to other people since I was little  
I caught on really quick at what would make somebody happy and what they liked  
I think I was born with a certain personality  
I also learned what wouldn't be good enough  
I wanted to make them happy all the time, so I pushed myself  
I hate the word productive—it's like a machine  
I don't know, I just want to be human  
I'm like selfless and I can't say what I want  
I know a lot more than most people my age  
I know I have my eating disorder, it makes me different, gives me an identity  
I don't have the need to be different when I'm with my eating disorder friends  
I always have that need to have my thing when I'm out with my friends—my one  
thing that I'm good at and what makes me different from anyone else  
I don't have that one good thing, so I have my anorexia  
I don't have that need as much when I'm in the hospital  
I can just feel like I'm here and we all talk about the eating disorder  
I just don't have that need to want to be different  
I see the other eating disorder patients playing with their food, or look around  
feeling lost, I'm like wow, that's like me  
I get scared  
I deny that I have an eating disorder sometimes and I shouldn't be in the hospital  
I see myself in these other people  
I kind of realize I have a problem  
I never answered questions like this before—it was good.

#### Reading a narrative from a girl with anorexia nervosa without depression

This narrative is from “Robin”, a 16 year old, white girl with anorexia nervosa. At the time of the interview she had been struggling with the illness for about a year. When I interviewed her she had just been transitioned from the inpatient unit to the day hospital unit. She had made steady weight gain and seemed to be improving. After reading this narrative, I found myself struggling to see how it was distinct from the Ann's interview. How did this narrative differ from the one above? Can we clearly see how depression manifests itself in the girls' discussions about the self? At first, it wasn't clear, but after several readings I was left with a different feeling about this girl. Although

there was much that she did not like about herself, there was not a pervasive sense of hopelessness. There were glimmers of happy encounters with other people, with working hard to try to achieve goals—even if the goals were based on unrelenting standards of perfectionism. Robin does indeed have more of a sense of agency than Ann and that she has some influence on who she is and who she can become. She even has a glimmer of hope in what the future holds for her.

#### Knowing vs. Not Knowing the Self: Embodied vs. Disembodied Knowledge

Like Ann, Robin finds it hard to identify any good or positive characteristic about herself. She talks about her perfectionism and drive to be the best in school as a negative quality, “like I want perfectionism so badly that I put everything that I have into it. Like I do it to the point of a breakdown. Like we got assigned to do a do a poster and I got all my friends together, I got the poster board, I typed up the stuff to go on the poster and decided to make a few different posters. I worked hours and hours on this. I got the best grade.” When I asked her why she felt badly about this, that this was something many students would be proud of she claims that she feels she has to put more effort into her work than most people do. She asserts that she feels “that I’m not good enough to be in advanced classes. I hate feeling that I could do better, that I’m not the best—even at sports”. Again although she identifies that she wants to be the “best” at academics and sports, and when she actually does achieve the high standards she sets, this is still not good enough. It seems that for Robin, being is doing. She talks about all the sports she plays, work she does and goals she has for herself. Although perfectionistic in her unrelenting standards, there is some sense that she is doing and accomplishing—though never enough. This sense of accomplishment or “doing” was something that was

completely absent in Ann's narrative. The only "doing" involved things specific to her eating disorder.

There are several incidences in this narrative where Robin talks about positive relationships—ones that she feels engaged in. Although at times she claims she is shy and quiet around friends she doesn't know that well, she can be herself and joke around with good friends and her dad. However, like with Ann's narrative, there are many times where she refers to the importance of caring for others needs above and beyond her own. To Robin, being a good person is being "helpful to everyone, caring, giving all of your self...I guess I like to help people, I care about people. I care about people but I'm not so sure other people care about me. That's OK. I guess my parents always say they'll be there for me but I never really asked them for help. I don't know if my friends really care about me."

Interestingly, Robin articulates quite clearly why the needs of others surpass her own. She recognizes the fear that if she stands up for herself and claims her true thoughts and desires, that she might lose relationships she considers important. "I just can't stand up to anyone for what I want. I guess I can be a little more assertive at times with my parents because ultimately I know they won't reject me. Where I worry is that if I assert myself with my friends they might reject me—or not like me. But I still won't make my parents mad, I'm still afraid of conflict. I like run from conflict or fighting." When I pointed out to her that I'm sure there were times her friends were assertive with her and she didn't reject them she replied, "I just can't imagine it being even."

Much of Robin's self-descriptions are about things she doesn't like about herself or fears she has of letting other people down. "I have really low confidence, I don't really talk in school and I don't really express myself to people and I'm afraid of letting down other people. I can't think of one thing that's good about me." Like Ann, there are many instances where Robin describes actions or thoughts that are "false" to her self, with minimal reference to any actions or thoughts that are "true" to her self. "My parents are proud of me, I think, because I'm a good person. I kind of hope they see me as a good person...I really don't really believe I am, but I try to act like that." Also, Robin acknowledges that it is hard for her to say what she wants or say no to doing things with friends. "Like I'll just go along with whatever my friends decide. And I have problems saying no to things. Sometimes I won't want to do something but I won't say it. Like I'm afraid to do certain things. My friends wanted me to go with them to this club, but I didn't want to go but didn't tell them. I got out of it by saying I had to do something with my family, but I just didn't feel comfortable going to a place like that, but I couldn't tell them that."

She also is weighed by the pressure of many things she should or ought to be. "I always feel like I should be a really strong person who doesn't really need anything and be able to deal with any problems on my own and always be happy. I used to think that my parents always wanted me to be strong and independent, but in family therapy I learned that my mom still wants to help me, she'll still be there for me even though she just wants me to be strong and healthy". Here, Robin confronted a belief that she may have misinterpreted or exaggerated from her parents. She confronts the misconception and makes room for the notion that her parents wanting her to be strong and independent,

does not mean that they will abandon her and will support and help her whenever they can. It seems like she is trying to understand that a woman can be strong and independent *within* relationships—independence of thought and action does not mean one is alone. Instead one can seek strength and support from those around her.

Although there were several instances where Robin referred to her primary wish or goal to be “thin”, unlike Ann she was able to express some other, specific goals she had for her future. When I asked her what she wanted to be when she grows up, she claimed, “A lot of things. I want to be either a journalist/writer or I want to go into sports, like writing/coaching.

Robin also talked about how she feels she is growing up, becoming more serious in a way that was less fearful than Ann. Ann quite clearly asserted that she did not want to be an adult, that it was too scary. In contrast, Robin acknowledges a clear awareness that after age 14, anorexia took hold of her. She used to care, of course about her appearance, but could look at herself in the mirror. After the anorexia “took charge of my life, I like couldn’t look at myself.” Despite this sad awareness about an increase in body concern and self-hatred, she shared positive beliefs about her maturation. “Like now I think about things, well not like an adult, but much more mature. I’ll like analyze life a lot more where I didn’t’ really think about those things before. I feel like I’m growing up and can’t take things for granted and have to be more serious. You know, what you do now influences your future, and I realize that now.” However, with the anorexic there is always a disclaimer. Though this could be a positive, self-realization, Robin takes it to the extreme. She notes that she used to care about school and stuff, but now “I take it to the extreme. I get scared that my work isn’t good enough I worry about

things being good enough, that not doing enough now will affect me in a bad way in the future.” She also acknowledges that she wants to change and become more mature but like Ann, she acknowledges that it does scare her. “In a way I want to mature, but in a way I also don’t—I wish I didn’t have to think about all this, about the future, about being so serious.”

Similar to Ann, when Robin was asked how she was different from other girls her age she claimed, “well my eating disorder, I guess, makes me different from people at home and I just don’t feel like I’m good enough. My friends don’t worry about these kinds of things. Like they have pretty good self-esteem. Like when we go shopping they can try on clothes and be like, you know, this looks good on me. I could never be like that.”

Much of Robin’s self descriptions were active—though one can argue her actions are in pursuit of unrelenting and unrealistic standards. For Robin, “being” is “doing”. When I asked her how she got to be the person she is—a hard-working, great student, caring but unconfident girl, she simply replied that “I guess it’s just how I was brought up.” When I asked her about how she thinks she can become different, how she can become a person who likes herself, she struggles to answer. “Like when I think about myself I don’t like anything—there’s nothing really good in me. I guess once I find something that I *do* really well, that I’m good at, I might start liking myself.”

### Self Summary

Quite clearly, Robin’s self-awareness is characterized by action and doing. It seems that much of her self-knowledge—whether talking about her physical, psychological or even social self—is derived from action. However, even though she

seems to reach the goals she sets for herself, her actions are never “good enough”, or even just “good”. In addition, the goals she supposedly sets for herself seem to be in response to the goals she perceives others want her to achieve. “My parents are proud of how well I do in gymnastics and school.” She also talks about hoping that her parents see her as a good person, “because I try to act like that... helpful giving, sharing what you have... but I don’t really believe I am.”

Though it is quite apparent that Robin’s “actions” are in the service of what she perceives others expect from her, she has less self-awareness than Ann in realizing how much she silences her own thoughts and desires for the service of others. Like Ann, Robin feels that the one thing that makes her different is her “eating disorder. I guess it makes me different from people at home. And I also don’t feel like I’m good enough. My friends don’t worry about these things.” So although Robin claims that her eating disorder is something that distinguishes her from others, she does not appear to use her illness as her sole identity to the same degree that Ann does. Her illness is part of her, but it does not seem to *be* her. Perhaps this is because Ann has suffered with her illness longer, or perhaps it is that Ann hold on to that part of her self more strongly—that it is this omnipresent illness identity is somehow linked to her depression or what I see as extreme self despair and self abandonment

Though much of Robin’s narrative is indeed characterized by self-hatred, fear of self-expression resulting in lost relationships or abandonment, there was still a glimmer of hope for what may lie ahead for her. “Like when I think about myself, I don’t like anything—there’s nothing really good in me. But I hope that one day I can look at myself and be like finally, wow, look at what I’ve done or what a good person I am.”

### Self Poem: Robin's Own Composition

I'm very shy and quiet  
I get uncomfortable in new situations  
I know that I have really low self-esteem  
I have really low confidence  
I don't really talk in school  
I don't really express myself to people  
I'm afraid of letting down other people  
I want perfection so badly  
I put everything I have into having perfection  
I do it to the point of a breakdown  
I got all my friends together  
I got poster board  
I like worked hours and hours  
I always do extra  
I don't know  
I'd feel really bad  
I'd feel lazy  
I'm not good enough to be in advanced classes  
I'm not the best—even in sports  
I stopped eating  
I was depressed I wasn't running as fast  
I thought I would lose weight to make myself go faster  
I don't know  
I'd feel like more horrible  
I'd be different if I was confident—I'd probably get more of what I want  
I see girls in school that are confident and get what they want  
If I was more confident I wouldn't starve myself  
I'm really friendly  
I like to joke around a lot  
I'll be open with people that I'm comfortable with  
But I'll be shy around friends I'm not sure of  
I don't know  
I like to joke around with my dad  
I feel the same  
I'm really shy when I'm around the guy I like  
I don't really talk to him too much  
I'll feel good only if I work hard  
I'm proud of my brother  
I guess I'm not proud of myself  
I don't really see that I'm smart  
I don't feel that  
I don't know  
I kind of hope my parents are proud of me

I kind of hope they see me as a good person  
I try to act like a good person, but I don't really believe I am  
I guess I like to help people  
I care about people  
I care about people but I'm not so sure other people care about me  
I never asked them for help  
I don't know if my friends really care as much about me  
I don't think I am different in different relationships  
I hope I'll be more open with people  
I want to be able to like be more comfortable around people  
I want to always be able to give everything my best shot  
I want happiness for my family  
I don't know. I guess I want to be think forever  
I want to be either a journalist/writer  
I want to go into sports—writing or coaching  
I always feel like I should be a really strong person  
I used to think that my parents wanted me to be strong and independent  
I learned in therapy that my mom still wants to help me  
I think friends think I should be the strong one  
I don't think my friends see me any other way  
I don't care  
I won't want to do something but I won't say it  
I'm afraid to do certain things  
I didn't want to go but I didn't tell them  
I got out of it  
I didn't feel comfortable  
I couldn't tell them that  
I think I've definitely changed  
I didn't care about what I ate when I was 14  
I ate pretty much whatever and didn't work  
I like had to be careful but it wasn't a big deal  
I could walk up to the mirror in my leotard and not care  
I like couldn't like look at myself after the anorexia took charge of my life  
I guess I've always had bad self-confidence  
I like feel the same but my ideals about stuff are different  
I used to care about school and life  
I used to not be worried about writing a major paper  
I look at it now, analyze it differently and work hard  
I have to get into a good college in the future  
I get scared that my work isn't good enough  
I think about things, not like an adult, but more mature  
I'll like analyze life a lot more  
I didn't really think about things before  
I feel like I'm growing up  
I realize that what you do influences your future

I wish I didn't have to think about all these things  
I guess it was how I was brought up  
I think about myself and don't like anything  
I hope I can look at myself and be like wow, look what I've done or what a good person I am  
I'm like so down on myself  
I guess I can be different once I find something I'm really good at  
I had to give up gymnastics  
I don't really have anything else now.  
I guess I feel that it's not good enough  
I do well in school but it doesn't make me feel special  
I didn't have to try that hard at gymnastics  
I guess my eating disorder makes me different from people at home  
I just don't feel like I'm good enough and my friends don't worry about these things  
I could never be like that—try on clothes and be like this looks good on me  
I just see people who are confident  
I wonder why I can't be like that  
I'm sure they have doubts but they like push through it  
I don't know why I can't push through it  
I just can't stand up to anyone for what I want  
I guess I can be a little more assertive to my parents  
I know my parents won't reject me  
I worry that if I assert myself with friends they might reject me or not like me  
I still won't make my parents mad  
I'm still afraid of conflict  
I run from conflict or fighting  
I just can't imagine it being even

Reading a narrative from a girl without anorexia nervosa or depression

In contrast to the self-deprecating narratives described above, “Karen’s narrative was filled with enthusiasm, hope, and a tremendous sense of efficacy. Although one can argue that Karen was not a good choice to represent the “non-eating disordered girl”, I feel she is quite comparable. Both of the anorexic girls described above were beautiful, bright girls, excellent students and athletes—stereotypical overachievers in a sense—but they couldn’t recognize or “own” their talents or abilities. Karen, instead, is able to “own” the active role she played in achieving her goals and allows herself to

enjoy the fruits of her labor, feel the fun and laughter in life, in addition to the hard work and struggling that goes hand-in-hand with the joy.

Knowing vs. Not Knowing the Self: Embodied vs. Disembodied Knowledge

Karen, an 18 year old, white girl, talks about not always acting true to herself, as did Ann and Robin, but it is in very specific, appropriate contexts. Karen has strict parents and acts in a way to please them. However with her friends, she allows her effervescent personality to be expressed. “Well, I act really prim and proper with my parents. And polite, just because they’re really strict, so I’m very nice with them. With my friends, I’m off the wall, I’m totally wild and loud.” Here I sense that it is not so much that Karen is not acting true to herself, but just deciding when to show the different facets of her self. This is something I noticed in many of the non-eating disordered girls’ narratives. They knew they should show a certain side of their personality to some people and not others. But they never completely “opposed” their core beliefs. They just let different facets of their self show to different people. “With my friends my real self comes out. With my parents, they just couldn’t handle everything. With my friends I don’t have to hold back anything. They’ve known me for so long they know all sides of me. They know how I get when I’m mad they know how I get when I’ve had too much sugar. They just like me all around. They respect when I can play and when I have to be very focused on something.”

Karen also has an extraordinary sense of efficacy. When asked what she was especially proud of about herself, she replied, “I like that I can achieve goals and reach them. It’s all like the little steps you take that get you to the bigger goals. It’s amazing when you achieve a goal. Cause then you know you can keep reaching for higher things.

Like I want to go to the Olympics. I know it's a big stretch, but if I work towards the little goals on the way, I might just get there... Sometimes I do reach for think that are a little too high and I have to accept that I can't reach them. Like getting 100 GPA. It just can't happen—it's almost impossible. I'm not that hard working or that smart."

Although Karen had lofty ambitions and works towards big goals, she also has a realistic perspective about what can and cannot be achieved. Yet this "reality awareness" did not keep her from striving to get as close as possible to the impossible goals or standards.

Karen also acknowledged that this strength, self-confidence, and identification of personal wants and goals, was not always something she had. "I'm a lot more outgoing that when I was younger. I express my feelings more and tell people if I don't like something. Like when I was little I just used to go along with everybody else. I didn't make my own decisions. Now if a group of people are doing something that I don't like, I just won't do it. It's no big deal."

At the time of the interview, Karen was preparing to start college in the fall. She was excited because it was a chance for her to recreate herself to start over. Her talk of "recreation" had developmentally appropriate context—getting cooler clothes, being able to be more expressive and to break away from preconceived notions of herself that existed amongst peers she has known since kindergarten. I noticed that when girls with anorexia talk about similar notions of "recreation" it is more fixated on losing weight and physical appearance. With Karen one can see an enormous sense of efficacy and control over her life and what she wants to be. She says that she's excited to "be different but not extremely different. But I won't have the preconceived notion that I had in high school with everyone knowing me from elementary school. Not everyone is going to know me

as the ‘goody-goody’. It’s appealing that it’s a new start, that if you want to, you can start differently—be who you want to be and who you are.”

When I asked her how she was different from her friends or other girls her age she claimed, “Other girls fall to peer pressure a lot. And they do what people expect of them but it’s like superficial. And I just do my own thing. No one tells me what to do except my parents, or how to act or how to be. I get frustrated because like if some people would change like one little thing they would be so much happier. My friends, like, complain to me every day but they don’t know how to change that one little thing. But it’s their life, not mine. It really bothers me when I see them try to change for other people though. I would never be that way. Sometimes I don’t always show every part of myself to every person, but at least what I do share is real. It’s me.”

#### Self Summary

The most resonant difference in Karen’s narrative is her sense of agency and acknowledgement of the active role she has taken in defining her self and setting independent goals. It seems that for the most part, she acts, thinks and feels in a way that is “true” to her self. Interestingly, she expresses no concern that acting true to her self will sever important relationships. Instead, she quite clearly acknowledges that sometimes she doesn’t act how people expect her to. For example, her boyfriend “wishes I would party more, or be more mellow. That’s just not me.” Of course, Karen does worry about how others perceive her, particularly her parents. So though she defines her own goals, she clearly does not disobey the morals of her parents. If she does rebel, she hides her rebellion, knowing it’s not something her parents really need to know. She also doesn’t like being perceived as a “goody-goody” and looks forward to having the chance

to erase that perception once she begins college. So, of course, Karen does have some normal adolescent insecurity about fitting in and doing the right thing. However, unlike her anorexic peers, she feels she has some control over what she becomes, what relationships she chooses, and faith that proclaiming her unique goals, desires and ambitions will not sever the relationships she so clearly values. She does not feel she has to “win” anyone’s love or approval. Although there are some things Karen does not know about herself and many questions unanswered, she seems to, for the most part, “know” herself, leave room for discovering the answers to her questions, and has no problems with other’s knowing that very same self.

Self Poem: Karen’s Own Composition

I’m athletic  
I’m always happy  
I’m always off the wall  
I’m majorly hyper  
I’m well rounded  
I have priorities  
I achieve to be good at something  
I’m not cranky and grouchy all the time  
I’m not superficial  
I’m not a goody-goody like everyone says I am  
I do get straight A’s  
I don’t party until like three o’clock in the morning  
It makes me feel uncomfortable  
I act like really prim and proper with my parents  
I’m very nice with my parents  
I’m off the wall with my friends—totally wild and loud  
I’ll only talk about school and work and stuff my parents want to hear  
I would be very loud and friendly and all around have a good time with friends  
I’m usually loud with my boyfriend  
I’m very relaxed  
I’m just like relaxed and quiet and mellow  
I’m usually loud to a point, until they kill me  
I don’t have to hold anything back with my friends  
I have to be serious and I have to focus  
I think I should be pretty good at making new friends at college

I get along with people really well  
I think I should get along well  
I've already talked to my roommate  
I'm like the teacher's pet  
I'm kind of like very serious  
I take school very seriously  
I don't talk back to teachers  
I'm not late to class  
I don't cut classes and stuff  
I don't start food fights  
I went to do a back flip and my teacher picks me up  
I was so excited  
I loved it  
I like teachers to see what I like to do, so they get to see what I like to do instead  
of just schoolwork  
I like that I can achieve goals and reach them  
I was ranked 13<sup>th</sup> in the nation last year for diving  
I wanted to move up  
I want to go to the olympics  
If I work towards the little goals that will get me to the bigger goal  
I don't know  
I reach for things that are a little too high  
I'm not that smart  
I'm not that hard working  
I don't work that hard  
I feel like going back and laughing in my teachers face  
I feel nice now  
I kind of like if I got the highest score it's not that big of a deal  
I wasn't gonna be upset if I didn't get it  
I really knew  
I proved something to myself  
I want a 4.0 my first semester  
I don't know  
I've always strove to get the highest I could  
I took college courses in high school  
I work so hard towards things  
I can't do two sports in college  
I could do lacrosse  
I'm not really that good at it  
I like contact sports  
I'm very hard on myself  
I wish I could get a C and be good with it  
I'd be like the girl in class that cries when she gets a C  
I'd probably have a lot less pressure on my  
I guess being hard on myself is what makes me do better

I'll sit in practice and cry if I can't get something  
I know I can do it  
I wouldn't achieve as much as I do  
I told my boyfriend  
I'm on a full scholarship  
I always want to do best  
I know I can  
If I work hard enough  
I can  
I give the best advice, so they say  
I know that if I'm that way to some people then they'll be that way to me  
I have some friends that would be there  
I'm always there for my brother  
I'll have college  
I want to make the Olympic team  
I won't put so much pressure on myself in 5 years  
I won't have to put pressure on myself once I'm in med school  
I've already achieved it  
I'm gonna be in medical school  
I'm a lot more outgoing  
I express my feelings  
I tell people if I don't like something  
When I was little I just used to go along with everybody else  
I didn't make my own decisions  
I just won't do it now  
I want happiness  
I want to like get married and be successful  
I just wish I had more time to spend with my grandfather  
I just wish he was around a little bit longer  
I could get to know everything about him  
I dove on his birthday  
I think it would have been good to grow up with him  
I've always worked so hard at it  
I might find that I just can't handle it  
I might find it might not be what I want to do  
I might want to do something else  
I've worked so hard  
I haven't worked hard as a doctor yet  
I have room to change my mind  
My parents think I should be prim and proper  
I'm scared  
I relate because you want to rebel  
I lie to my parents sometimes  
I don't see the difference  
I'm scared of my parents if they ever find out

I don't drink or smoke  
I don't need all that stuff to have a good time  
I've never  
I guess he wants me to  
I guess he wants me to go out and get drunk or something like that  
I'm still not gonna do it  
I decided to stay home  
I just wanted to relax  
I can't go out every night  
I was like just because you go out every night doesn't make me  
I don't think that's fun  
I was like skipping around and was loud  
I was like, no leave me alone  
I can be the biggest flirt  
Sometimes I wish I wasn't with Stephan so I could be my true self-flirtatious  
I'm always like the same person  
I got a little lazy and didn't do very much work  
I met my boyfriend  
I changed a little bit there  
I wasn't hanging out with people my own age  
I was hanging out  
I didn't really change that much  
It opened me up  
I won't have that preconceived notion I had in high school  
I want to start kind of a fresh  
I like that trendy look  
I didn't have any money  
I don't know, it's a whole new start  
No one will have preconceived notions of how I have to act or have to be  
I'll be able to do what I want  
I won't have to be home at nine o'clock  
I won't have to worry that my parents might catch me  
I don't have to worry about that  
I think I'll handle freedom pretty well  
I've always handled freedom well  
I think  
I might be able to manage my time  
I set for myself  
I have to credit my parents  
I still wish I could have more of a life  
I'm looking forward to that in college  
I did a lot of that myself (who you became the person you are)  
I'm looking forward to moving into a dorm  
I think I'll have a lot better time  
I don't have to make my bed

I wanted to go out this morning  
I'm kind of scared I might go overboard  
I don't know how I'm going to handle it  
I've never handled it before  
I think I might be able to manage my time and achieve the goals I set for myself  
I don't follow everyone else and stiff  
If I did, I'd be in a lot of trouble  
I think the environment has a lot to do with it  
I'm my own person and set my own ways and do my own thing  
I just do my own thing  
I can hold a relationship  
It really bothers me when I seek them try to change for other people  
I would never bet that way  
I can't tell someone how to be  
I've tried to tell my boyfriend how to be  
I was getting frustrated  
I tell my mom every day  
I don't know  
I guess I'm more outgoing  
I can go up and say hi to someone  
I think it's more my personality  
The way I react to different situations  
I'm only like that sometimes  
I'm not like that at all  
I can just go in and not have a game plan  
I get stuff done  
I told her to get out  
I was organized  
I got like, so frustrated when people don't do things organized

## CHAPTER 4: DISCUSSION

The overall purpose of this study was to examine how girls with anorexia nervosa conceptualize their self and to see if their self-concept is distinctive, both developmentally and structurally, from girls without anorexia nervosa. Moreover, I sought to examine how these distinctive conceptions of self are related to interpersonal relationships among girls with anorexia nervosa. Briefly, I found that both relational context and constructiveness (or positive valence) of the girls' self-descriptions were different between girls with and without anorexia. Overall, girls with anorexia had a more unconstructive, less "developmentally advanced", view of themselves than their non-anorexic counterparts did. I also found that the subgroup of girls with dual diagnoses of anorexia and comorbid major depressive disorder had more severe eating disorder symptomatology and more unconstructive—or negative—self conceptions than their anorexic counterparts who did not have major depressive disorder.

### Limitations of the Study

The limitations of the study may affect the interpretation of the data, so I present them up front. The major limitations were in the realm of sampling. First was the small sample size. This study was originally conceptualized as a comparison of two groups, and estimated statistical power indicated that the sample size would have been sufficient to detect differences. By using a three group model, statistical power to detect even a medium-sized effect was extremely low (.45), though it would be more than adequate (.86) for large effects.

Another limitation was that the anorexic girls were being treated (medically, psychologically or both) for their eating disorder. Untreated anorexic girls might present

a different picture of self-understanding. Given the fact that some of the anorexic girls were interviewed at their first office visit or early in their treatment, the effects of treatment may have been minimal. Also I recruited both inpatients and outpatients, thus having a sample of subjects with different degrees of illness severity. Balancing the self-referred nature of the anorexic sample, however, was the fact that the participation rate was very high, as almost all of the girls approached agreed to be in this study.

Third, because the anorexic girls were asked to suggest friends without eating disorders (to their knowledge) that might be willing to participate in the research study, this sampling strategy might have resulted in a comparison group that was similar psychologically to the target population. However, only seven anorexic girls provided names of friends, and most of the comparison sample was friends of these friends. Moreover, the anorexic and non-anorexic groups differed substantially on the two eating disorder measures. So in the end, the "friend-of-a-friend" referral strategy may have compensated for sampling bias.

A fourth limitation lay in the ethnic and socioeconomic homogeneity of the sample. Recruitment of girls with anorexia was conducted at an eating disorders clinic in a middle to upper-middle class suburb on Long Island. Reflecting the ethnic and socioeconomic composition of this area, most of the participants were middle class, privileged, Caucasian girls. Early literature (Selvini-Palazzoli, 1985) suggested that this was the population with the highest prevalence of anorexia. More recent research, however, suggests that eating disorders are pervasive among many ethnic groups and social strata (Thompson, 1994). Thus, this dissertation speaks only to differences in self-understanding among anorexic, privileged, Caucasian, middle-class girls.

A second set of limitations involves the coding scheme and its many variations. Although based on a validated measure of self-understanding and reliable in this study, the expanded coding schemes needs further reliability testing. And given the interpretive coding required by the Reader's Guide, it is possible that other readers would have interpreted Ann, Karen, and Robin's narratives in a different way. Similarly, by knowing the eating disorder status of these three women, I may have interpreted their narratives with that knowledge in mind. Interpretative qualitative analysis is always reflexive however, as the coder's perspective interacts with the interpretation

There were also strengths of this study. First, eating disorder and depressive symptoms were measured both by self-report and by a structured, clinical interview. Using two measurement methods strengthens the classification of the clinical diagnoses. Second, the research design included both qualitative and quantitative assessments of the self. Although the qualitative data were not examined as fully in this dissertation as I had hoped, more narratives will be analyzed in the future.

#### Building bridges: Bringing existing theory into uncharted territory

I began this dissertation with the goal of trying to distinguish differences in self-conceptions in girls with and without anorexia nervosa. I looked to existing developmental and feminist theories on the self to help me conceptualize this construct, and found that there was not *one* theory alone that captured the essence or meaning I wanted. Damon and Hart's (1988) multidimensional, developmental model of self-understanding identifies multiple levels of functioning of specific objective and subjective self schemas. Although this model has been applied to children and adolescents, even girls with anorexia, I felt this model was missing an essential "piece"

that would capture subtle differences in adolescent girls' self-concept. Specifically, it does not overtly address the important role that interpersonal relationships play in adolescents' developing sense of self.

Thus, I also drew on a more feminist approach, self-in-relation theory (Gilligan et al., 1990; Jordan et al., 1991; Miller, 1991), which has as its central tenet that girls'/womens' self-concept is developed and defined within the realm of their interpersonal relationships. Within self-in-relation theory, traditional male-oriented definitions of the self as an individualistic and self-centered construct do not apply to women's self-understanding self-construction. Thus, I felt that integrating these two theories would best address not only the structural and developmental components of the self, but also would address the important relational context in which the self develops.

Bridging these two models posed a bit of a methodological challenge. Both use detailed open-ended coding schemes applied to interview data, but the interpretation of the data is very different. Damon and Hart's method is based on a quantitative analysis of different categories and levels of self-understanding that are arranged hierarchically, reflecting more mature or more adaptive levels of self-understanding. In contrast, the self-in-relation method, as exemplified by the Reader's Guide, utilizes a more interpretive analysis of self narratives. What I wanted to draw from the more interpretive coding of the Reader's Guide was not simply the emphasis on the relational context of the girls' self-conceptions, but also the fact that it locates the places in their narratives where they *did* and *did not* speak, act, or acknowledge their true thoughts, feelings and desires.

Early on in the data analysis phase, I felt that I could capture these notions by expanding Damon and Hart's existing coding scheme to capture the self versus other distinction. Thus, I modified the original categorical coding scheme to differentiate selves in the context of different relationships--to what extent the self-statements included explicit references to relationships or were independent of relational references. I also expanded this schema to include the property of constructiveness--i.e., whether self-descriptions were constructive, positive self references as well as acting, thinking and feeling in accordance with one's true beliefs, or unconstructive, harshly critical self-references or statements that ignored, diminished or silenced the girl's true beliefs or feelings.

Few differences in self-understanding emerged between the anorexic and non-anorexic girls when I did not consider the relational context or the constructiveness of their statements. This contradicts much of the clinical as well as empirical literature that argues that the anorexic girl's *overall* self-concept is quite distinct from non-anorexic girls (Bruch, 1988; Crisp, 1984; Engel et al., 1988). Considering the relational context of the girls' self-descriptions did uncover specific group differences that the simple scheme missed. Differences between anorexic and non-anorexic girls were dependent upon whether the girl was speaking about herself in self or what could be called "independent of other" terms. Anorexic girls' had more statements that reflected a sense of distinctness in less relational or other-oriented contexts to a greater degree than non-anorexic girls' statements. At first glance, these results reflect in the clinical literature (Bruch, 1984; Casper et al., 1981; Crisp, 1984; Garner & Garfinkel, 1980) that describe anorexic girls as socially focused, more withdrawn, and less than non-anorexic girls. However, I

believe that this interpretation misses the critical aspect of agency that appears in anorexic girls' voices when one looks beneath the surface.

### Different Ways of Expressing A Sense of Agency

The anorexic girls in my study spoke about their sense of agency less than non-anorexic girls *only* in the context of interpersonal relationships. Thus, it is not a "more or less" interpretation, but a contextual one: it wasn't that anorexic girls have a less developed sense of agency, but a clearly different one. Their agency was quite actively fixated on how they appeared to others--not only controlling the appearance of their physical bodies through diet and exercise, but also controlling their personality, for example, projecting a "false self" to accommodate what they felt were the expectations of others. The findings from the more interpretative reading of the narratives, combined with the more quantitative data, suggest that anorexic girls are indeed exerting a sense of agency, but it is a *different* type of agency, a more maladaptive agency in terms of health, more body-focused than relationship-focused, and more inward than outwardly- focused. This is not equivalent to saying that anorexic girls are solely focused on the self (*vs.* the other); indeed most anorexic girls pride themselves on their selflessness.

With their self-understanding framework, Damon and Hart (1988) define agency as the sense of control an individual has over her world and herself as well as awareness of control over your own destiny. This awareness determines the extent to which one feels that events are subject to "one's volitional intent as opposed to uncontrollable forces beyond of within the self...it therefore underlies one's sense of personal freedom and self-determination...or in some cases, the lack of such a sense" (p.124). Anorexic girls feel little control over their relationships, often feeling that they

have to portray what they feel others expect of them in order to maintain valued relationships. A strikingly similar notion is asserted by relational theory: adolescent girls feel it is important, or even necessary, to suppress their “voice”, thoughts, wants and desires in order to maintain valued relationships and embrace traditional notions of feminine identity (Brown & Gilligan, 1992; Gilligan et al., 1990).

My data suggest that anorexic girls perceive little control over their social lives, when compared to girls without anorexia. They feel they have little to do with their own self-formation in the social world. Damon and Hart’s conceptualization of agency assumes that with more advanced development comes ways to exert control over life choices, control over relationships, and control over the places and roles in society they can explore and embrace. Yet this supposedly developmentally-appropriate conception of agency is in direct opposition to relational theories’ assertion that girls *do not* feel they can and should exert that type of control. In order to conform to societal expectations of femininity, adolescent girls feel they must suppress or deny agenic experiences.

It is in this contradiction *between* the two theories that the important message from anorexic girls is heard. My data lead to the conclusion that anorexic girls are extremely agenic, controlling their cognition, actions, and emotions, in the form of eating behaviors. They control the appearance of their body as well as what parts of their inner selves they want others to see — in essence creating masks of their own design for others to see. Though this expression of agency is clearly unhealthy and even life-threatening, anorexic girls are clearly being agenic and making choices. They are arguably rejecting traditional paths of female development and replacing them with what seems, on the surface, to be a somewhat “age-appropriate” path of embracing the feminine beauty ideal,

but is a much more extreme, destructive assumption of this ideal—the feminine beauty ideal *gone awry*.

One girl with anorexia stated matter-of-factly, “I’d rather be dead than fat”—a comment that most anorexic girls would nod in agreement with. From this qualitative interpretation of the data, we must question what it means that these girls are more willing to embrace a life-threatening illness rather than be “fat”. One needs to interpret what “being fat” means to the girl with anorexia. Fat often still means relatively thin or average weight. When asked to examine silhouettes of female figures, girls with anorexia rate the average or “healthy” weighted person with appropriate curves as “fat” or “overweight” (Thompson, 1990; Touyz & Beumont, 1987).

One could argue that in rejecting the typical” female body, these girls are rejecting typical or traditional roles and expectations for women. This rejection or resistance of traditional societal expectations is strong, but unfortunately, is played out with the body rather than words. Perhaps anorexic girls believe they cannot or should not comment on what they see and feel to be the injustices and conflicting messages of their social world, but they cannot remain silent. Their body becomes their voice, planting itself firmly in the ground of their beliefs or rejection of what others expect them to believe—screaming to be heard<sup>3</sup>.

My research findings can be interpreted that anorexic girls’ experience of agency is much stronger—albeit severely unhealthy—than non-anorexic girls. Their

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<sup>3</sup> I am indebted to Michelle Fine and Suzanne Ouellette for this insight.

rebellion needs to be recognized, their rejections affirmed, and redirected into another voice—a speaking voice, or a voice found in a more healthy form of rebellion.

After listening to anorexic girls' narratives, I believe the "speech" and active, agenic assertion of the anorexic girl's body is not captured by either developmental theory or self-in-relational theory. These girls have an astute sense of awareness of the world, their role in it, and the impossibilities and possibilities they face, what could be construed as an advanced notion of agency. Although they are focused on their bodily self—the body separate from the world—is it fair to say that they totally self focused, selfish instead of selfless? Again I would argue that though it appears on the surface that they are only fixated on their "self", separate from relationships, this fixation is indeed in reaction to the very complex relationships around them. It's as if they can go either way—partake in the age-appropriate social world (i.e., don their "mask") or withdraw from that same world. Indeed, in the narratives, we hear how anorexic girls often describe putting on a "false face", being in relationships in accordance with how they feel others want them to be. As one girl said to me, "I usually like, can tell what other people expect or like and I act like what they expect...I project the person I feel they want to be." So although anorexic girls may appear "self"- focused, this service and manipulation of the appearance of the self is really in the service of others. It's not that they don't experience their social selves, or have the capacity to understand themselves in social terms, it's that they *choose* not to. The question to ponder - should be *why* - they make this choice.

## Revisiting the Self versus Other Dichotomy

This observation of “self” focused as really being self-focused *in the service of others* brings into question the dichotomy that has been set up in this dissertation. Does this self-other dichotomy really exist, especially for women? The results of this study indicate that anorexic girls are more “selfish” perhaps than their non-anorexic counterparts, but this contradicts existing clinical literature as well as the internal experiences that anorexic girls described. Most current modalities of psychotherapy for anorexics is directed towards getting the patient to be less selfless and more selfish—to assert her own wants and desires and to be less other-oriented (Bruch, 1985; Crisp, 1984; Engel et al., 1988). The non-anorexic girls’ narratives sounded more “social”, or other-focused than the anorexic girls’ narratives, voicing more specific goals, wants, needs and hopes. Perhaps the critical difference is not in self vs. other, but *how* the other is addressed, understood, and interacted with. I question whether there really was such a thing as an “independent self” for the anorexic girls in this study. Instead it seems that “self” conceptions—*independent of relational content* -- are not independent of social expectations but are in reaction to them. Others’ expectations become internalized and less overtly addressed, with fewer boundaries between self and other. Perhaps this could be considered a withdrawal from relationships, but it is certainly not a separateness from relationships.

Indeed, what I was identifying as “self”, may be more other in nature than what I was calling “other”. When there is a clear identification of others and our specific reactions to and relationships with them, there usually co-exists a clear sense of self. It is when we don’t recognize and emphasize the relational context of our life that we may

have less of a distinction of where we end and others begin. Flipping around the meaning of “self” and “other” seems to be more fitting of the voices that emerged in the girls’ narratives.

### Continuity and possible selves

Another interesting finding that challenges the relevance of existing theories was that anorexic girls talked more about their sense of self continuity, in more unconstructive terms, than non-anorexic girls. For Damon and Hart (1988), the most advanced conception of self-continuity—developmentally appropriate for late adolescents—is established with reference to the relation between one’s earlier and present characteristics of the self. At this advanced level, “the self is no longer viewed as having characteristics that remain unchanged over the lifespan. Instead, the self’s characteristics are believed to evolve from earlier ones. Thus later properties of self are seen to be directly related to, although not identical with, the self’s earlier ones. The relation between the self’s past and present is often expressed in terms of one’s personal feelings and special knowledge of oneself” (p. 73-74). Like the notion of agency, there is an inherent contradiction in what is considered to be age appropriate conceptualizations of continuity between developmental and self-in-relation theory. Brown and Gilligan (1992) discuss the rift in self-knowledge that begins in early adolescence. Pre-teens who used to describe their beliefs, skills, and characteristics quite clearly lose this ability in adolescence. Suddenly the young girl who thought she was a strong, agile soccer player, gifted in science and playing games, loses touch with or denies these characteristics, struggling to define herself in new, more socially appropriate terms. Her voice of “strength” becomes replaced with a voice of “self-doubt and unknowing”. So therefore,

how can a strong sense of self-continuity, as defined by Damon and Hart (1988) co-exist with the lack of continuity and disconnection that Brown and Gilligan (1992) have identified?

Indeed, the disconnection that Brown and Gilligan document asks us to question how girls' orientation towards the world can be stable at late adolescence -- How can they know they are the same person as they were when they were children (despite emotional and physical maturation) given the sociocultural messages they receive to abandon the very strengths they valued as children in order to become women? To flip Damon and Hart's definition around, one might argue that *it is more real*, or more mature, to see the self in flux, in complete disconnection with their girlhood ideals and values. Perhaps anorexic girls see their lack of self-continuity and contradictory social expectations much more clearly than others. Perhaps they see that in order to achieve "superwoman ideal" (Steiner-Adair, 1990), they need to be both *selfless and selfish*—a near impossibility. For example, Karen, the girl discussed earlier who did not have anorexia, had very clear goals, based on her childhood aspirations to be an Olympic swimmer, to become a medical doctor, and to have a great husband and family. She would tone her loudness down when with her boyfriend so as to not agitate him, but she didn't really struggle with doing that. For the most part she felt she remained true to her own wishes, desires and self. She believed that she would never change herself to satisfy another person, that you had to "take her or leave her." At the time I interview her -- her high school graduation—she did not see that it might be difficult to achieve her goals in coordination with each other. She asserted that she just knew from past experience than

when she set goals for herself, she worked hard to achieve them, and in the end usually did.

In contrast, Ann, the girl with anorexia, observed that she didn't want to live like her parents, giving up what they really wanted for themselves to simply live and work "to pay taxes". The question this data leaves me with is how each of these girls see their future selves and is this future self a self clearly related to their past self—in other worlds a continuous self? Which is a more right or realistic view? How might Karen see and define her goals at the end of college? Will she still think she can reach for her dreams and have it all, medicine, family, athletic success? What price will she, the healthy girl pay in the future—will she too find that she has to abandon the parts of herself she once so valued in order to obtain relational security, her feminine place in the world? Maybe it won't be a price, but something she will just accept.

Anorexic girls see the price they are paying and will have to pay and are not accepting that fate. Their rebellion is unhealthy, but adolescent rebellion just the same. The conundrum is whether this rebellion to fight for self continuity is less developmentally advanced, as Damon and Hart's model and my data suggest, or the opposite. In identifying the "crossroads of adolescence" do anorexics feel they must choose a road completely different from the one they have traveled, and that in *refusing* to take it—they are showing a more advanced self that is not captured adequately by either existing theory.

Damon and Hart (1988) note that late adolescents' conception of continuity is characterized by "relations between past, present, and future selves" (p. 56). However, they do not discuss in detail the role of the future self, and how this fits into their notion

of continuity. As Damon and Hart theorize that continuity is an essential component of the adolescents' identity formation, it would seem that the role of the future self, or how one dreams it, would be central to the notion of identity. In the all of the girls' narratives, frequent references were made to what they want to be like in the future, or most interestingly for the anorexic girls, what they didn't want or what they feared for themselves in the future. When listening to the girls' conceptualizations of their "future selves", I heard differences between the three groups of girls. Karen, the non-anorexic girl, clearly had high hopes and specific ambitions for the future and felt that she had a sense of agency over what she would become and how she would become it. Ann, the anorexic girl with depression seemed to know what she wanted for herself in the future, but in more abstract, reactive, philosophical terms: "My parents...are living such a logical life and I want to live a rewarding life...I want to follow my own direction and not follow what society expects. I don't want to be what others expect an adult to be like." She knew she did not want to embrace traditional definitions of adulthood, but had not truly created a replacement role. She was left with a fear of what the future held for her, instead of hope for what she could create for herself.

These observations reflect Markus and Nurius' (1986) work on "possible selves". They found that positive judgments about the future were related to mood—the more positive characteristics people used to describe their past and future selves, the more positive a lifetime history of moods was reported. Absence of positive, future characteristics was related to more negative moods and depression. In the case of Robin, the anorexic girl without depression, I heard a hesitant voice talking about her future self,

but one that was more goal-directed than Ann's; Robin was less fearful of what the future held for her.

#### Depressed versus non-depressed anorexic girls

In discussing how anorexic girls with comorbid depression had more hopeless future self conceptions than non-depressed anorexic girls, I was left wondering how else these two "subgroups" differ. Higgins' measure of self-discrepancy showed clear differences between the two subgroups. Depressed anorexic girls had more actual-ideal and actual-ought self discrepancies than their non-depressed counterparts. According to Higgins, both ideal and ought self conceptions are influenced by our social environment, with "ought" self conceptions being more reflective of internalized expectations of significant others (such as parents) and ideal self conceptions being more reflective of an internalization of general societal expectations. These data, along with the data that were analyzed using the Reader's Guide, suggest that depressed anorexic girls have internalized more discrepant societal expectations, based upon unrelenting and unrealistic expectations than the non-depressed, anorexic girls (or the non-anorexic girls). Again, one can argue that the "other" is omnipresent in the anorexic girls' self-conceptions. Again, one is forced to question whether what was being called the "self" focus of anorexics is an extreme version of being completely other oriented.

#### Different, not deficient

Taken together, the quantitative and qualitative data suggests that notions of agency, continuity and one's future or possible self are interconnected notions that need to be reconceptualized to reflect the experiences of both anorexic and non-anorexic adolescent girls. In trying to bridge developmental theory and self-in-relation theory, I

more realistically captured where and how anorexic girls had different self conceptions than either theory was able to do alone. Together the data illustrate how anorexic girls speak of themselves in relation to others in a very different way than non-anorexic girls do, although, in retrospect, the dichotomous labels of “self” and “other” that were used to conceptualize these differences now seem lacking. This bridge model does not truly resolve the limitations of each theory as well as the inherent contradictions between the theories. Instead, the bridge I created leads us to uncharted territory, requiring new language about what is self and what is other and what defines true developmental advancement for adolescent girls. What has been seen as deficits and immature self-conceptions in the clinical literature on anorexia should be reconceptualized as perhaps astute observations about life’s possibilities, albeit seen through sad and hopeless eyes rather than through optimistic, hopeful eyes. It is this degree of hopelessness that seems to distinguish anorexic girls with and without depression from each other. Those that seem to have lost all hope, and all sight of how they can stay true to themselves and achieve their youthful ambitions, have retreated more severely, *or run into wholeheartedly*, into a narrow world of weight, calories, and exercise, actively choosing to abandon the relational world filled with hopes, dreams, and possibility.

### Clinical Implications

By examining the self as a multidimensional construct, with each dimension considered in a relational and constructive context, I was able to identify specific areas of the self that are less developed in girls with anorexia. These findings speak strongly to the appropriateness of current approaches to psychotherapy with anorexic girls, although some of my findings are relevant to medical interventions as well. As noted earlier, the

anorexic girls were less focused on relational aspects of their self than their adolescent counterparts without a diagnosed eating disorder; anorexic girls are clinically described as socially withdrawn and isolated. Many researchers claim that the major developmental tasks of adolescence involve identity formation as well as the strengthening and reliance on peer relationships.

The findings from this study support the importance of reintegrating the anorexic into her social world. This is often an area that therapists address, but it is not always in the forefront of treatment. Not only will this address one of the associated “symptoms” of the illness, but will further advance anorexic girls’ sense of self by developing a more positive, age-appropriate personal identity and minimizing the unhealthy “anorexic identity”.

The findings from this study also point to the importance of strengthening constructive or positive self-conceptions in anorexic girls, perhaps using cognitive-behavioral therapy. Cognitive-behavioral therapy identifies negative cognitions that the individual has and attempts to substitute positive cognitions. This has been shown to be effective treatment in adult anorexia, but has not been widely used or adapted for adolescents.

The study data also suggested that anorexic girls with co-morbid depression had more severe eating disorder symptoms and less developed self-understanding than anorexic girls without depression. This points to the utility of using new psychopharmacological treatments to diminish the severity of the depressive symptoms as part of treatment. Many adolescents with anorexia—regardless of the presence or absence of depression—are treated with selective serotonin reuptake inhibitors (SSRI’s).

However, this class of anti-depressants has not been shown to be effective in the treatment of anorexia. Despite the lack of data supporting the efficacy of SSRI's in this population, physicians often prescribe these medications regardless of the severity of the depressive symptoms, hoping they will decrease eating disorder symptoms. Moreover, SSRI's have a common side-effect of appetite suppression, an unwelcome side effect for girls that are purposely starving themselves. Newer psychotropic drugs that affect neurotransmitters, decrease cognitive distortions, and have "welcome" side effects of increase in appetite and weight gain may be better suited to treat depression among anorexic girls.

#### Directions for Future Research

This study applied a strong methodology combining quantitative and qualitative data to explore self-understanding in girls with and without anorexia nervosa. The unanticipated finding of two distinct subtypes of anorexics requires further investigation. Also, we may better understand how depression mediates or moderates impaired self-understanding in anorexic girls. The finding of impaired social self-conceptions suggests that further research is needed that examines the social environment of anorexic girls, including specific familial relations and peer relationships. A family systems approach (Minuchin et al., 1978) may be useful in assessing how members of the social environment may buffer or exacerbate problematic self-conceptions. It would be important to not only examine how girls conceive of themselves in the context of relationships in general, but in the context of specific relationships—friends, parents, siblings, teachers, and romantic interests.

### Conclusion: Replacing Illness with Individuality

From these data I conclude that girls with anorexia have replaced the lack of a clearly defined self with a self that is defined by their anorexia. One of the questions I asked in my interview was “If you could have three wishes, what would they be?” The non-anorexic girls’ only difficulty was in naming only three—and I was able to get them to suggest not only humanistic wishes, but “selfish” wishes as well. However, the anorexic girls struggled to answer this question. They quite easily could wish for world peace, or health and happiness for their family, but when I pushed them to tell me what they wanted *for themselves*, giving them permission to acknowledge the material, the silly as well as the idealistic wants, the only clear self-focused answer was the wish to be thin or thin forever.

In answer to the questions I raised in the beginning of this chapter, it seems that anorexic girls do not seem themselves as agentic, or able to define themselves in accordance with their own feelings, thoughts, and desires. Anorexic girls believe that others’ needs far surpass their own and that to be a truly caring person who primarily values relationships, they must forgo anything that is in the least bit self-serving. Indeed as discussed earlier in this dissertation, the feminist literature suggests that girls and women do highly value relations and arguably develop their sense of self in the context of important relationships. However, there is an obvious balance to negotiating the needs of the self with the needs of the others, and it is apparent that anorexic girls have not discovered this balance. One that can argue that finding this balance is something most women struggle to find. But in the case of anorexia, the scales seem extraordinarily imbalanced. What is a hard road for most women to negotiate becomes nearly impossible

for individuals struggling with anorexia. Adding depression to anorexia, the load appears to be even more impossible to carry.

The general therapeutic goal for patients with anorexia is to help them identify their own wants and desires-- to become self-focused instead of other-focused. In other words, the goal is to help them recognize how they have defined themselves—their feelings, thoughts, and actions—in response to the desires, thoughts, and feelings of others. The importance of this therapeutic goal is apparent from the narratives discussed above. The narratives clearly speak to the clinical importance of developing the anorexic girls' subjective sense of self—specifically encouraging agency and distinctiveness based on health instead of illness. Also, anorexic girls need to refocus, from seeing themselves as an object to serve the needs of others first, to seeing themselves as an object to serve the needs of her self first and others second. With this shift towards becoming more self-focused will come the understanding that doing so will not sacrifice relationships that are valued, but instead strengthen and invigorate them.

In the beginning of this chapter I cited a poem that an anorexic girl shared with me. For me this poem exemplified the lost, confused and desperate condition of the anorexic girl. This poem spoke about a girl's desperate struggle to find her own self—her own voice—and to distinguish it from the cacophony of other voices surrounding her. What I did not share was the end of the poem, the faith that this desperate struggle may indeed pay off—and the payoff will be brilliant.

“I WILL find my way! I will keep on crawling inch by inch until I might see the light...I must focus on the goal, or else I will stumble and fall. And yet that will only make me stronger, because I will get up again. Oh, where is that light? Ah! I feel it! I

feel the warmth, deep down in my soul. How bright and shiny it is! Alas, I can see—  
because I've finally learned—that there's a diamond in me.”

Table 1

Demographic Characteristics of AN and NAN group

<u>Demographics</u>	<u>Total Sample</u>	<u>AN</u>	<u>NAN</u>	<u>Group Differences</u>
Mean Age	17.24	17.09	17.52	$t = -.718, df = 70, p = .477$
Mean family socioeconomic status	54.49	55.9	51.77	$t = 1.77, df = 61, p = .082$
Ethnicity				Fisher's Exact test = 1.00
Caucasian	97% (70)	98% (46)	96% (24)	
Latina	3% (2)	2% (1)	4% (1)	
Parents marital status				$\chi^2 = 2.25, df = 14, p = .134$
Single	15% (11)	11% (5)	24% (6)	
Married	85% (61)	89% (42)	76% (19)	
Inpatient vs. Outpatient Status				
Inpatient		31.9% (23)		
Outpatient		33.3% (24)		

Table 2

## Demographic Characteristics of AN-ND, AN-D and NAN groups

<u>Demographics</u>	<u>AN-ND</u>	<u>AN-D</u>	<u>NAN</u>	<u>Group Differences</u>
Mean Age	17.05	17.12	17.52	$F = .310, df = 2, p = .735$
Mean family Socioeconomic status	58.28	54.13	51.77	$F = 2.7, df = 2, p = .075$
Ethnicity				
Caucasian	100% (21)	96% (25)	96% (24)	
Latina	0%	4% (1)	4% (1)	
Parents marital status				$\chi^2 = 3.26, df = 2, p = .196$
Single	5% (1)	15% (4)	24% (6)	
Married	95% (20)	85% (22)	76% (19)	
Inpatient vs. Outpatient status				$\chi^2 = .026, df = 1, p = .871$
Inpatient	48% (10)	50% (13)		
Outpatient	52% (11)	50% (13)		

Table 3

## Group Differences in Higgins' Self-discrepancy Measure

	<u>F</u>	<u>df</u>	<u>p</u>	<u>Means</u>			<u>Post-hoc comparisons (Tukey HSD)</u>	<u>p</u>
				<u>NAN</u>	<u>AN-ND</u>	<u>AN-D</u>		
Actual/Ideal	9.24	2	.000	-0.65	0.82	3.95	AN-D > NAN AN-D > AN-ND	.000 .025
Actual/Ought	4.95	2	.011	-0.91	-0.25	2.63	AN-D > NAN AN-D > AN-ND	.010 .072

Note. NAN = non-anorexic group; AN-ND = anorexic group without depression; AN-D = anorexic group with depression

Table 4

## Group Differences in Damon &amp; Hart's (1988) Simple Self Schemas

	F	df	p	Means			Post-hoc comparisons (Tukey HSD)	p
				NAN	AN-ND	AN-D		
Physical	.924	2	.402	1.88	2.57	2.23		
Active	.249	2	.780	6.76	6.00	6.77		
Social	4.330	2	.017*	10.00	6.43	8.54	AN-ND < NAN	.012
Psychological	1.770	2	.178	10.12	11.38	13.08		
Agency	1.538	2	.222	5.36	3.90	4.73		
Continuity	2.611	2	.081 <sup>†</sup>	2.08	2.14	2.73	AN-D > NAN	.100
Distinctiveness	4.202	2	.019*	4.52	3.24	3.46	AN-D < NAN AN-ND < NAN	.061 .027

Note. NAN = non-anorexic group; AN-ND = anorexic group without depression; AN-D = anorexic group with depression; \* = significant at  $p < .05$ ; <sup>†</sup> = significant at  $p < .10$ .

Table 5

## Group Differences in Relational Self Schemes

	<u>F</u>	<u>df</u>	<u>p</u>	<u>Means</u>			<u>Post-hoc comparison (Tukey HSD)</u>	<u>p</u>
				<u>NAN</u>	<u>AN-ND</u>	<u>AN-D</u>		
Physical-self	.956	2	.390	1.44	2.05	1.77		
Physical-other	.070	2	.933	.44	.52	.46		
Active-self	1.008	2	.370	3.04	3.67	4.00		
Active-other	2.189	2	.120	3.72	2.33	2.77		
Social-self	1.596	2	.211	1.20	.90	1.73		
Social-other	6.355	2	.003*	8.80	5.52	6.81	AN-D < NAN AN-ND < NAN	.069 .002
Psychological-self	7.149	2	.002*	4.08	6.38	7.12	AN-D > NAN AN-ND > NAN	.001 .029
Psychological-other	.532	2	.590	6.04	5.00	5.96		
Agency-self	.865	2	.426	2.24	2.62	3.08		
Agency-other	12.84	2	.000*	3.12	1.29	1.65	AN-D < NAN AN-ND < NAN	.001 .000
Continuity-self	3.488	2	.036*	1.20	1.52	2.04	AN-D > NAN	.029
Continuity-other	.684	2	.508	.88	.62	.69		
Distinctiveness-self	.899	2	.412	2.08	1.76	1.58		
Distinctiveness-oth	2.57	2	.086 <sup>†</sup>	2.40	1.48	1.88	AN-ND < NAN	.072

Note. NAN = non-anorexic group; AN-ND = anorexic group without depression; AN-D = anorexic group with depression; \* = significant at  $p < .05$ ; <sup>†</sup> = significant at  $p < .10$ .

Table 6

## Group Differences in Constructiveness and Relational Self Schemas

	F	df	p	Means			Post-hoc comparison (Tukey HSD)	p
				NAN	AN-ND	AN-D		
Physical-self constructive	12.27	2	.000*	.80	.47	.12	AN-D < NAN AN-ND < NAN	.000 .000
Physical-self unconstructive	5.93	2	.004*	.64	2.00	1.65	AN-D > NAN AN-ND > NAN	.033 .005
Physical-other constructive	2.01	2	.142	.24	.95	.38		
Physical-other unconstructive	1.04	2	.358	.20	.43	.42		
Active-self constructive	6.23	2	.003*	2.52	1.19	1.12	AN-D < NAN AN-ND < NAN	.006 .015
Active-self unconstructive	16.54	2	.000*	.52	2.48	2.88	AN-D > NAN AN-ND > NAN	.000 .000
Active-other constructive	18.27	2	.000*	2.76	.76	.69	AN-D < NAN AN-ND < NAN	.000 .000
Active-other unconstructive	3.23	2	.045*	.96	1.57	2.08	AN-D > NAN	.035
Social-self constructive	6.56	2	.002*	1.04	.24	.31	AN-D < NAN AN-ND < NAN	.009 .006
Social-self unconstructive	6.22	2	.003*	.16	.67	1.42	AN-D > NAN	.002
Social-other constructive	29.50	2	.000*	6.36	1.86	1.96	AN-D < NAN AN-ND < NAN	.000 .000
Social-other unconstructive	5.86	2	.004*	2.44	3.67	4.85	AN-D > NAN	.003
Psychological-self constructive	6.82	2	.002*	2.92	1.67	1.38	AN-D < NAN AN-ND < NAN	.002 .023

Table 6 (continued)

Psychological-self unconstructive	26.56	2	.000*	1.16	4.71	5.73	AN-D > NAN AN-ND > NAN	.000 .000
Psychological-other constructive	8.85	2	.000*	4.20	1.90	1.65	AN-D < NAN AN-ND < NAN	.001 .004
Psychological-other unconstructive	6.13	2	.004*	1.84	3.10	4.31	AN-D > NAN	.002
Agency-self constructive	3.35	2	.041*	2.00	1.29	.81	AN-D < NAN	.032
Agency-self unconstructive	13.10	2	.000*	.24	1.33	2.27	AN-D > NAN AN-ND > NAN	.000 .030
Agency-other constructive	29.17	2	.000*	2.88	.90	.85	AN-D < NAN AN-ND < NAN	.000 .000
Agency-other unconstructive	3.51	2	.035*	.24	.38	.81	AN-D > NAN	.034
Continuity-self constructive	1.45	2	.241	1.08	.90	.65		
Continuity-self unconstructive	17.96	2	.000*	.12	.62	1.38	AN-D > AN-ND AN-D > NAN AN-ND > NAN	.003 .000 .075
Continuity-other constructive	3.74	2	.029*	.76	.38	.27	AN-D < NAN	.028
Continuity-other unconstructive	2.19	2	.120	.12	.24	.42		
Distinctiveness-self constructive	5.75	2	.005*	1.84	1.19	.62	AN-D < NAN	.003
Distinctiveness-self unconstructive	5.38	2	.007*	.24	.57	.96	AN-D > NAN	.005
Distinctiveness-other constructive	16.69	2	.000*	2.16	.62	.42	AN-D < NAN AN-ND < NAN	.000 .000
Distinctiveness-other unconstructive	10.65	2	.000*	.24	.86	1.46	AN-D > AN-ND AN-D > NAN AN-D > NAN	.082 .000 .077

Note. NAN = non-anorexic group; AN-ND = anorexic group without depression; AN-D = anorexic group with depression; \* = significant at  $p < .05$ ; † = significant at  $p < .10$ .

Table 7

## Group Differences in Objective Self Schemas: the "Me"

	$F$	$d$	$p$	Means			Post-hoc comparisons (Tukey HSD)	$p$
				<u>NAN</u>	<u>AN-ND</u>	<u>AN-D</u>		
Me Overall	.685	2	.508	28.76	26.38	30.62		
Me Constructive	31.08	2	.000*	20.84	7.76	7.27	AN-D < NAN AN-ND < NAN	.000 .000
Me Unconstructive	21.10	2	.000*	7.92	18.62	23.35	AN-D > NAN AN-ND > NAN	.000 .000
Me-self	4.17	2	.019*	9.76	13.00	14.62	AN-D > NAN	.016
Me-other	2.94	2	.059 <sup>†</sup>	19.00	13.38	16.00	AN-ND < NAN	.048
Me-self constructive	15.80	2	.000*	7.28	3.14	2.92	AN-D < NAN AN-ND < NAN	.000 .000
Me-self unconstructive	29.71	2	.000*	2.48	9.86	11.69	AN-D > NAN AN-ND > NAN	.000 .000
Me-other constructive	27.09	2	.000*	13.56	4.62	4.35	AN-D < NAN AN-ND < NAN	.000 .000
Me-other unconstructive	8.00	2	.001*	5.44	8.76	11.65	AN-D > NAN	.000

Note. NAN = non-anorexic group; AN-ND = anorexic group without depression;  
AN-D = anorexic group with depression; \* = significant at  $p < .05$ ; <sup>†</sup> = significant at  $p < .10$ .

Table 8

## Group Differences in Subjective Self Schemas: the "T"

	F	df	p	Means			Post-hoc comparisons (Tukey HSD)	p
				NAN	AN-ND	AN-D		
I Overall	2.75	2	.071	11.96	9.29	10.92		
I Constructive	28.79	2	.000*	10.72	5.29	3.62	AN-D < NAN AN-ND < NAN	.000 .000
I Unconstructive	40.37	2	.000*	1.20	4.00	7.31	AN-D > AN-ND AN-D > NAN AN-ND > NAN	.000 .000 .001
I-self	0.93	2	.400	5.52	5.90	6.69		
I-other	9.64	2	.000*	6.40	3.38	4.23	AN-D < NAN AN-ND < NAN	.006 .000
I-self constructive	8.75	2	.000*	4.92	3.38	2.08	AN-D < NAN	.000
I-self unconstructive	25.59	2	.000*	.60	2.52	4.62	AN-D > AN-ND AN-D > NAN AN-ND > NAN	.002 .000 .005
I-other constructive	31.88	2	.000*	5.80	1.90	1.54	AN-D < NAN AN-ND < NAN	.000 .000
I-other unconstructive	11.94	2	.000*	.60	1.48	2.69	AN-D > AN-ND AN-D > NAN	.023 .000

Note. NAN = non-anorexic group; AN-ND = anorexic group without depression; AN-D = anorexic group with depression; \* = significant at  $p < .05$ ; † = significant at  $p < .10$ .

Table 9

## Group Differences in Modal Developmental Level

	F	df	p	Means			Post-hoc comparison (Tukey HSD)	p
				NAN	AN-ND	AN-D		
Physical overall	4.51	2	.015*	3.11	2.28	2.68	AN-ND < NAN	.011
Physical-self	7.13	2	.002*	3.31	2.17	2.67	AN-D < NAN AN-ND < NAN	.080 .001
Physical-other	0.44	2	.648	3.00	2.86	2.78		
Active overall	11.72	2	.000*	2.96	2.19	2.38	AN-D < NAN AN-ND < NAN	.002 .000
Active-self	7.16	2	.002*	3.04	2.22	2.31	AN-D < NAN AN-ND < NAN	.006 .005
Active-other	2.18	2	.122	3.10	2.79	2.75		
Social overall	0.67	2	.514	2.92	2.86	2.77		
Social-self	3.56	2	.037*	3.08	2.43	2.39	AN-D < NAN	.046
Social-other	3.49	2	.818	2.92	2.86	2.85		
Psychological overall	8.99	2	.000*	2.96	2.48	2.35	AN-D < NAN AN-ND < NAN	.000 .010
Psychological- self	9.59	2	.000*	2.80	2.19	2.08	AN-D < NAN AN-ND < NAN	.000 .004
Psychological- other	2.30	2	.108	3.04	2.90	2.88		
Agency overall	2.83	2	.066 <sup>†</sup>	2.64	2.19	2.36		
Agency-self	2.06	2	.137	2.32	1.94	2.08		
Agency-other	1.07	2	.349	2.75	2.50	2.81		
Continuity-ove	2.55	2	.086 <sup>†</sup>	3.91	3.75	3.44	AN-D < NAN	.077

Table 9 (continued)

Continuity-self	1.29	2	.285	3.89	3.69	3.52		
Continuity-other	6.22	2	.005*	4.00	3.78	3.18	AN-D < NAN	.004
Distinctiveness Overall	.66	2	.520	2.42	2.57	2.65		
Distinctiveness-self	.25	2	.779	2.82	2.93	3.00		
Distinctiveness-other	1.88	2	.162	2.68	2.25	2.61		

Note. NAN = non-anorexic group; AN-ND = anorexic group without depression; AN-D = anorexic group with depression; \* = significant at  $p < .05$ ; † = significant at  $p < .10$ .

## Appendix A

### Script for introducing Research and Study to subjects

Hi, I'm Kim Gallelli, a graduate student in developmental psychology. I am conducting a research project to better understand how self-concept in adolescent girls. We know that many girls have problems with low self-esteem and negative feelings about themselves and their bodies, and we are trying to understand better such concerns.

The study consists of asking you several brief questions about your mood, self-concept, concerns about weight and appearance, and your family history. A longer interview, to be tape recorded for research purposes only, will ask how you perceive yourself in general, for example, asking you how you would describe yourself, what you would like to be like, and future goals. The questionnaires and interview should take about 1.5 hours to complete, and we could stop at any time. All answers would remain confidential and you would also be free to refuse to answer any questions that you do not like. We will also ask if you can recommend any friends that may be interested in participating in this study as well.

*For the anorexic patients, they will be asked for names of friends that they do not think have eating disorders, and that any friends names will not be given any information about their illness and treatment. Also, they will be informed that if they are not interested in participating this will in no way affect their treatment at the EDC.*

I have a brief description of the study, and a consent form for you and your parent(s) to look at and sign. There are 4 questionnaires that you would be requested to fill out yourself (taking about half an hour) and one long interview with me.

Do you have any questions?

Are you interested?

Would you like to read the description of the study?

May I leave some material for you to look at, and a consent form to sign?

(If consent obtained) May I schedule an appointment to interview you?

**Appendix B**  
**Recruitment Letter for NAN participants**

Dear \_\_\_\_\_ :

I am a doctoral student in psychology conducting research on self concept in adolescent girls. We know that many girls have problems with low self-esteem and we are trying to understand how self-esteem and self-concept are related to overall mental health in teenage girls. Your name and address was given to me your friend, [merge AN name], who I recruited from her pediatrician's office. [merge AN name] has already participated in this research study and suggested that you may also be interested in helping us with this research study.

The study consists of asking you several brief questions about about your mood, self-concept, weight and appearance concerns, and family history. A longer interview, to be tape recorded for research purposes only, will ask how you perceive yourself in general, for example, asking you how you would describe yourself, what you would like to be like, and future goals. The questionnaires and interview should take about 1.5 hours to complete, and we could stop at any time. All answers would remain confidential and you would also be free to refuse to answer any questions that you do not like.

If you are not interested in volunteering for this study, please mail the enclosed self-addressed stamped postcard which informs me that you do not wish to participate. If I do not receive this postcard in two weeks, I will contact you by telephone, once again describing the study and inviting you to participate. If you agree, an appointment will be scheduled at your convenience, either at your home, a community setting (such as a local library) or at the Adolescent Medicine Clinic at Schneider Children's Hospital--from where I am conducting this research.

I have enclosed a consent form for you and your parent(s) to look at and sign. There are 4 questionnaires that you would be requested to fill out yourself (taking about half an hour) and one long interview with me. This research is being completed in conjunction with the approval and supervision of child and adolescent psychologists at Schneider Children's Hospital. You may call me, Kim Gallelli at (718)263-6503 with any questions that either your or your parents may have regarding this study. You may also contact Dr. Stanley Hertz at Schneider Children's Hospitat at (718) 470-4704 with any questions or concerns you may have.

We hope that the information obtained from this research will help us to better understand the role that self-concept plays in both positive and negative feelings girls may have about themselves and their bodies. The goal is to use the knowledge we obtain from this research to develop interventions which promote positive self-esteem in adolescent girls. I thank you for your time and consideration.

Sincerely,  
Kim A. Gallelli, M.A.  
The Graduate School and University Center of CUNY

## Appendix C

**The Self-Understanding Interview—Modified Version: The following description is taken from Damon and Hart (1988).**

The first four items are intended to explore the self as object in some of its most common manifestations: self-definition, self-evaluation, self projected in past and future, and self-interest. Damon and Hart argue that these different questions yield similar results with respect to subject's understanding of self, both in terms of the subject's use of self scheme (physical, active, social, psychological) and in terms of the subject's developmental level. These first four items are thus considered alternate but conceptually parallel means of understanding the subjects knowledge of the objective self.

The last three items are intended to explore subjective self components, continuity, agency and distinctness, respectively. The text in italics are the modifications made to the original Damon and Hart interview format.

The questions are intended to structure the clinical interview--weaving the subject's responses about the self to focus on these areas. The questions can be asked in the order in which they appear, or may follow the subject's lead and may be asked in the order that seems most appropriate.

**Item 1: Self-Definition:** What are you like? What kind of person are you? What are you not like? **Probes:** What does that say about you? Why is that important? What difference does that (characteristic) make? What would be the difference if you were (were not) like that?

*What are you like when you are with your family (mother, father, siblings)? What kind of person are you with them? What are you not like with them?*

*What are you like when you are at school/job, with teachers or co-workers? What kind of person are you with them? What are you not like with them?*

*What are you like when you are with your friends? What kind of person are you with them? What are you not like with them?*

*What are you like when you are with someone you like romantically? What kind of person are you? What are you not like?*

**Item 2: Self-Evaluation:** What are you especially proud of about yourself? What do you like most about yourself? What are you not proud of? What do you like least about yourself? **Probes:** What does that say about you? Why is that important? What difference does that make?

*What are you especially proud of about yourself in how you are in different relationships (with mother, father, siblings, friends, romantic relations, school/job)? What do you like most about yourself in how you are in these relationships? What are you not proud of? What do you like least about yourself?*

*How do you think you are different in different relationships?*

**Item 3: Self in Past and Future:** Do you think you'll be the same of different five years from now? How about when you're an adult? How about five years ago? How about when you were a baby? **Probes:** What will be the same? What will be different? Why is that important?

**Item 4: Self-interest:** What do you want to be like? What kind of person do you want to be? What do you hope for in life? If you could have three wishes, what would they be? What do you think is good for you? **Probes:** Why do you want to (be that way, have those things you hope for, have those wishes?) What else do you (hope for, wish for, believe is good for you)? Why is that good for you?

*What do you think you ought/should be like? What kind of person should/ought you to be?*

*What do your parents think you should be like? What kind of person do they want you to be?*

*What does your boyfriend (romantic attachment if present) think you should be like? What kind of person does he want you to be?*

*What do your friends think you should be like? What kind of person do they want you to be?*

**Item 5: Continuity:** Do you change at all from year to year? How (how not)? If you do change from year to year, how do you know it's still always you? **Probes:** On what ways do you stay the same? Is that an important thing to say about you? Why?

**Item 6: Agency:** How did you get to be the way you are? How did that make you the kind of person you are? How could you become different? **Probes:** What difference

did that make? Is that the only reason you turned out like you did? Is that the only reason? What else could make you different? How would that work?

**Item 7: Distinctness:** Do you think there is anyone who is exactly like you? What makes you different from anyone you know? (*different from mother, father, siblings, friends, other girls your age*) **Probes:** Why is that important? What difference does that make? In what other ways are you different? Are you completely different or just partly different? How do you know? Are you different from everybody or just from some people? How can you be sure that you're different from everybody else even when there are many people in the world that you don't know?

**Appendix D**  
**DAMON & HART CODE BOOK**  
**FOR SELF UNDERSTANDING INTERVIEWS**

This code book is organized first by **SCHEMA** (physical, active, social, psychological, agency, continuity and distinctness). Within each schema you will find the description of the different **LEVELS** (1-4) as well as descriptions of **SUBTYPES** (a-l).

**PHYSICAL SELF SCHEME:**  
**Statements concerned with Physical Body or Material Possessions**  
**“I AM FAT” OR “I HAVE A TREADMILL”**

**Level 1: Physical and material attributes of self have significance in and of themselves.**

Identification of

- a. size
- b. gender
- c. race
- d. distinct bodily features
- e. age
- f. dress/clothing
- g. physical environment
- h. possessions
- i. voice
- j. aesthetic quality of appearance (pretty)
- k. body's health and functioning
- l. name

**Level 2: Physical and material attributes of self influence or reflect the nature of the self's activities or capabilities.**

Reference to abilities or activities:

- a. in relation to one's size (e.g. being tall to play basketball well).
- b. in relation to one's gender (boys like sports—girls play with dolls).
- c. in relation to race (scandinavians can't sit in the sun because of fair skin).
- d. distinctive bodily features (strong legs make me run fast).
- e. in relation to age (when you're 21 you get a good job).
- f. in relation to dress/clothes (I wear glasses so I can see).
- g. in relation to one's physical environment (a new house so we have more room to play).
- h. in relation to one's possessions ( a good job to have a nice house, things...).
- i. in relation to voice (high voice that lets me sing well).
- j. aesthetic quality of one's appearance (pretty so I can model and travel around the world).
- k. in relation to body's health/functioning (lost weight so I can be more active).
- l. in relation to name (my name means artist so I'm good at art).

**Level 3: Physical and material attributes of self influence or reflect the self's social appeal, interactions, relations or group memberships.**

- a. size (I'm big and people are afraid so I have to look nice to have friends).
- b. gender (girls who have lots of boyfriends might not be popular with other girls).
- c. race (If I was Indian, I might not be so popular).
- d. distinct bodily features (I have blond hair so I have boyfriends because boys like blondes).
- e. age (I'm 17, I can drive and hang out with friends at movies).
- f. dress/clothing accessories (I dress cool to have more cool friends).
- g. physical environment (I live in Islip and all my friends live far—no social life).
- h. possessions (we have a lot of money so we belong to the country club).
- i. voice (my good singing voice has made me popular).
- j. aesthetic appearance (being thin will make me have more boyfriends/be more popular).
- k. body health/functioning (healthy is good because if you're sick others will not play with you).
- l. name ( I have the same last name as my parents—we belong to the same family).

**Level 4: Physical and material attributes of self influence or reflect the self's personal philosophy, moral standards or lifestyle.**

- a. size (if I'm fat people will think I'm gluttonous—with all those starving people out there, it's selfish).
- b. gender (girls should work before being married, then have kids. Girls should be independent).
- c. race (I'm black and prejudice might hold me back—prejudice is wrong).
- d. dress/clothing (I'm orthodox and have to dress differently because girls must cover up in my religion).
- e. physical environment (I'm proud that I live in the US because we are free to live as we wish).
- f. possessions (I have a gun because it is important to protect my family and we should have a right to bear arms).
- g. voice (I'm loud and I believe it is important for people to voice their beliefs).
- h. aesthetic appearance (I'm pretty w/out having to wear makeup—you should be seen as beautiful for what's inside not out).
- i. body health/functioning (I'm a vegetarian because it's wrong to kill animals and it's healthier-I have more energy).
- j. name (my name is important because I was named after my grandma who was a great person with good values).

## ACTIVE SELF SCHEME

### Statements concerned with Activities or Abilities "I DANCE EVERY DAY" OR "I RUN VERY FAST"

#### Level 1:

Active attributes of self reflect the activities that the self performs, or the activities that are allowed, forbidden or demanded of the self.

Description of:

- a. one's *typical activities* (I read and write and play music).
- b. one's *activities in a particular time, place or social context* (I sang in a choir competition for the first time).
- c. *activities forbidden or allowed* to one (I wish I could eat cake because it would taste good/ I wish I could date because I want to).
- d. *activities one must or must not do* (I wish I didn't have to babysit but I have to until mom comes home from work).
- e. *identification of one's occupation* (I want to be an actor).

#### Level 2:

Active attributes of self are abilities considered RELATIVE to either other abilities of the self or to the abilities of other people.

- a. *Comparisons between one's abilities or inabilities* in different activities (I'm good at dance, but I'm good at soccer too. I'm better at dance, though).
- b. *Explicit comparisons between one's abilities* or inabilities and those of other people (I can't run track as well as my teammates).
- c. *Implicit comparisons between one's abilities* or inabilities and those of other people (I sing well because it's a talent I got from my parents).
- d. *Explicit comparisons between one's style of activities and that of other people* (I'm more motivated than most people, I try harder at whatever I do).
- e. *Implicit comparisons between one's style of activities and that of other people* (I'm athletic and play aggressively. I take changes with kids bigger than me).
- f. *Assessment of one's general activity level* (I'm not very active—I do a lot of quiet things).

#### Level 3:

Active attributes of self INFLUENCE THE SELF'S SOCIAL APPEAL, social interactions, social relations, or group membership.

Identification of:

- a. one's specific *activities that influence one's social appeal*, social interactions, social relations, or group membership (not occupation). (I'm not mean, I'm nice and like to help people because then people like you and you have lots of friends).
- b. one's specific *abilities or general action potential in relation to one's social appeal*, social interactions, social relations, or group membership (not famous) (When you're like good at soccer it's easier to make friends and they'll respect you).

**Level 4:**

**ACTIVE ATTRIBUTES** reflect or influence the **SELF'S PERSONAL PHILOSOPHY**, moral standards or lifestyle.

Reference to:

- a. *one's motivation for learning or improving one's abilities on the basis of personal philosophy*, moral standards, or lifestyle (I want to do well in school to get good grades and go to a good college. It's important to me to get a good education and have a good career).
- b. *one's choice of activities, occupation, or status on the basis of personal philosophy*, moral standards or lifestyle (I want to be a doctor to help children with problems—it's important to do things for other people).

## **SOCIAL SELF SCHEME**

Statements concerned with social-personality characteristics, social interactions, social relations  
IDENTIFICATION OF MEMBERSHIP IN FAMILY, FRIENDS, CLUBS, TEAMS  
"I'M SHY" OR "I FIGHT A LOT" OR "I'M GEEKY" OR "I'M FRIENDLY TO BE POPULAR"

### **Level 1.**

Social attributes of self reflect the fact of self's **MEMBERSHIP IN SOCIAL GROUPS (THE "I HAVE" LEVEL)**.

Identification of one's:

- a. family relations and memberships (I have a sister, mother, father).
- b. friendship relations (I have lots of close friends/ I want to have a boyfriend).
- c. other particular social relations, group membership, or status (I'm a cheerleader, member of the junior league).
- d. social environment (I have a close family/ My friends are important to my life).

### **Level 2.**

Self's **ACTIVITIES OR ABILITIES** are considered with reference to the **REACTIONS OF** other people (**APPROVAL & DISAPPROVAL OF ACTIVITIES & ABILITIES**).

- a. *Explicit consideration of one's activities in terms of another's or society's (e.g. jail) reaction* (I act quiet around boys so I don't seem pushy).
- b. Identification of *one's activities in terms of approval or disapproval of particular others* (I like to be good and help my mom—it makes her happy).
- c. Identification of *one's abilities* in terms of approval or disapproval of particular others (I like to be smart because it makes my parents proud).

### **Level 3.**

Social attributes of self reflect self's personality characteristics or group membership that influence the nature of self's social interactions (**SOCIAL CHARACTERISTICS OR GROUP MEMBERSHIP THAT MAKES ONE LIKEABLE**).

Reference to one's:

- a. *social characteristics or style of interacting* that influence one's social interactions or social appeal (I don't argue with people because they can get mad and I'd rather my friends like me than leave me/I'm not selfish when my friends need help).
- b. **group membership** that influences one's social interactions or social appeal (When I was hanging out with the geeks my jock friends started ignoring me).

**Level 4.**

**Social attributes of self reflect or influence the self's personal philosophy, moral standards, or lifestyle(HOW ONE'S INTERACTION WITH FRIENDS, FAMILY, GROUP REFLECTS ONE'S PERSONAL PHILOSOPHY).**

Reference to one's:

- a. *family relations and membership in relation to one's personal philosophy*, moral standards or lifestyle (I want to be a good family person because I believe our society is based on good families).
- b. *friends in relation to one's personal philosophy*, moral standards or lifestyle (I choose my friends carefully because I think it's important to have friends who have the same beliefs and values).
- c. *other particular social relations, group memberships, or status in relation to one's personal philosophy*, moral standards or lifestyle (I'm a candystriper because I think it's important to help people).
- d. *mode of interacting with others in relation to one's personal philosophy*, moral standards, or lifestyle (It's important to act strong with friends because kids need role models and the more good kids there are the better place the world will be).

## **PSYCHOLOGICAL SELF SCHEME**

**Statements concerned with emotions, thoughts or cognitive processes**  
**TO LIKE, LOVE, THINK, FEEL, KNOW (SCHOOL), LEARN (GRADES), REMEMBER,**  
**COMMUNICATE, UNDERSTAND, ATTENTIVENESS, INTELLIGENCE, PERSONAL PHILOSOPHIES,**  
**BELIEFS, VALUES, MOODS, EMOTIONS, FEELINGS**  
**“I’M CRANKY” OR “I THINK CLEARLY”**

### **Level 1.**

**Psychological attributes of self are moods and feelings that have significance in and of themselves (I LIKE, FEEL, KNOW—SIMPLY).**

- a. *Identification of one’s mood of feeling* (I’ve been really irritable because I’m tired)
- b. *Statements of one’s preferences* (I don’t like to go out/ I’ll always like reading)

### **Level 2.**

**Psychological attributes of self reflect one’s cognitive capabilities, acquired knowledge or activity-related emotional states (I KNOW, TO LEARN, TO REMEMBER, TO GET GOOD GRADES, I FEEL BECAUSE I’M DOING).**

- a. Reference to *one’s learning or knowledge* (I know in my mind what is right. I don’t want to be a doctor anymore because I know how hard med school is).
- b. Reference to one’s *cognitive capabilities for learning* (e.g. memory, intelligence, attentiveness). (I have a really good memory so school comes easy. I know I’m smart).
- c. *Comparison between one’s knowledge in one area versus another* (I get good grades in math and science but I’m not as smart at English).
- d. *Explicit comparisons between one’s knowledge and that of others* (I’m not as bright as the really smart kids in my school)>
- e. Identification of one’s *emotions or feeling arising from one’s activities* (e.g. fun). ((When I’m dancing I feel really free and happy).

### **Level 3.**

**Psychological attributes of self reflect or influence social skills or social interactions**  
**(INTERPERSONAL UNDERSTANDING, COMMUNICATIVE ABILITY, KNOWING OTHERS).**

- a. Reference to one’s *interpersonal understanding* (I’m really good with people because I’m good at helping them with their problems)>
- b. Reference to one’s *communicative competence* (When I get upset I talk about it with people).
- c. Reference to one’s *special knowledge of particular others* (We know each other really well. Nobody knows him as well as I do).
- d. Identification of one’s *emotions or feelings arising from one’s social relations* (When I’m hanging out with my friends I feel really happy and can be myself around them).
- e. Identification of one’s psychological *attributes that influence one’s social interactions* (Note: “knowing a lot” is not a psychological attribute). (I know that my intelligence makes me popular with my friends because I help them with their homework).

**Level 4.**

**Psychological attributes of the self are personal philosophy, moral standards, or lifestyle (STABLE BELIEFS, VALUES, UNDERSTANDING OF LIFE AND WORLD).**

- a. *Explanation of one's stable beliefs, values, or life philosophy* (It's important for me to live my life as a caring person).
- b. Reference to one's *stable orientation towards the world in general* (I wish there was world peace....when you think of all the useless fighting and death, there must be something we can do to end it).
- c. Reference to one's *understanding of the world*, or to the process of understanding the world (Life can be hard, there is so much to learn and not all of it is fun or easy).

## **AGENCY**

**Statements that refer to the formation of, existence of or control of self**

**“I GOT TO BE LIKE THIS BECAUSE MY PARENTS TAUGHT ME”**

**“I TRIED HARD TO BE LIKE THIS”**

### **Level 1.**

**Supernatural, biological, or social forces influence the existence or formation of the self. E.g. My body changed as I got older because that's just what happens.**

### **Level 2.**

**Talents, abilities, wishes, motivation, or efforts of the self influence the existence or formation of the self. E.g I got to be this way because I tried really hard to be like this.**

### **Level 3.**

**Communication with others influences the existence or formation of the self. E.g. I got to be the way I am by spending time/talking with my parents.**

### **Level 4.**

**Personal or moral evaluations of life's possibilities influence the existence or formation of the self. E.g. I decided to be a really kind person because when I was younger I saw lots of kids hurt by teasing and rejection.**

## CONTINUITY

### Statements that defend or explain the sense of self-continuity over time

“Even if I change from year to year, I’ll still have my same friends”

#### Level 1.

**Reference to one’s continuity in relation to stable physical properties, possessions, and behaviors. The self’s continuity over time is defended in reference to externally observable physical or behavioral characteristics of self.**

Identification of one’s:

- a. name as the basis for continuity (I know it’s still me because my name is the same).
- b. body as the basis for continuity (I know I’m me because my hair is always the same color).
- c. possessions as the basis for continuity (I always have toys and they’ll always be mine).
- d. stable behavior as the basis for continuity (I always play with my toys and always will).
- e. stable preferences as the basis for continuity (I still like science and swimming and I’ll always be doing science).
- f. social group membership as the basis for continuity (I’ll always have my friends and family even though I change).

#### Level 2.

**References to one’s continuity in relation to one’s cognitive and active capabilities. At level 2, the child moves away from a simple physicalistic assertion of self-sameness to an explanation that includes psychological characteristics. These psychological qualities are considered as immutable and permanent.**

Reference to one’s:

- a. *stable knowledge* as the basis for continuity (I know it’s me because I still know the things I knew five years ago).
- b. *One’s memory* as the basis for continuity (I know I’m the same person even though I look differently because I have a good memory and I remember who I was).
- c. *One’s abilities* in relation to one’s continuity (I’ve always be good at sports and I always will be).

#### Level 3.

**Reference to one’s continuity in relation to recognition from others. Self-continuity is no longer defended by reference to static physical or psychological characteristics. At level 3, self-continuity is related to the social context that extends beyond the self. One’s sense of self-continuity is in part dependent upon others’ continuing recognition of the self over time.**

- a. Reference to *physical properties that lead to recognition from others* (My eyes will always stay the same and that’s important because if my mom saw be she wouldn’t recognize me if my eyes were different).
- b. Identification of *continuity by recognition from family members* (I always know it’s me because I still have my family and they are the ones who raised and taught me. They’ll always know I’m me and not someone else).
- c. Identification of *continuity by recognition from friends* (Even though you change from year to year, people still like you, you change but not all that much. People will still say, “that’s Melissa”).

**Level 4.**

**Reference to one's continuity in terms of the relationship between one's earlier and present characteristics of self.**

At this level, the individual no longer views the self as having characteristics or properties that remain unchanged over the lifespan. Instead the self's properties or characteristics are believed to change from one earlier period or up to a later period of life. At the present moment, however, the properties or characteristics of the self are believed to be directly related to, although not identical with, the self's characteristics of earlier periods in life. This relationship between characteristics of the self past and present tends to be difficult to verbalize, and thus children tend to express it in terms of their personal feelings and special knowledge of themselves.

Identification of one's:

- a. *personal feelings and one's self-knowledge in relation to one's continuity across time* (I always know it's me by the way I feel inside. You just know that you're the same person—you know yourself).
- b. *orientation towards the world in relation to one's continuity across time* (I always know I'm me because I've always believed that everyone should be equal. I've always thought it to be terrible that just because someone has a different skin color that they're not treated the same. I think everyone should be treated equally).

## DISTINCTNESS

Statements that defend or explain the sense of distinctness from others

### Level 1.

**Reference to one's distinctness as based upon one's physicalistic features. The self's distinctness is asserted on the basis of observable physical properties and social group memberships, which may include the self's appearance, name, typical activities or social groups.**

Identification of one's:

- a. *name* in relation to a sense of distinctness from others (I'm different from everyone else because I'm the only one with my name).
- b. *physical properties* in relation to a sense of distinctness from others (I'm different from Kay because I have blue eyes and she has brown).
- c. *Possessions* in relation to a sense of distinctness from others (I'm different from Kay because she has cool shoes and I don't).
- d. *social group membership* in relation to a sense of distinctness from others (I'm different from the other kids in my class because I have different parents).

### Level 2.

**Reference to one's distinctness as stemming from differences between self and other along one's character, personality or cognitive dimension.**

Sense of distinctness in relation to one's:

- a. *abilities as compared to the abilities of others* (I'm special from all the other girls because I'm the fastest runner).
- b. *cognitive capabilities as compared to the cognitive capabilities of others* (I'm different because no one could know what I know—they might be a little smarter or a little dumber).
- c. *activities as compared to the activities of others* (I'm special because of the things I like to do).
- d. *personality characteristics as compared to the personality characteristics of others* (I'm different because I'm friendlier and more giving than most of the people I know).

### Level 3.

**Reference to one's distinctness as deriving from a unique combination of psychological and physical characteristics.**

- a. A sense of distinctness in relation to one's identification of a *unique combination of psychological and physical qualities* (I'm different from people in some ways and like them in others. A lot of my parts might be the same as some other people but nobody else has the exact same things).

### Level 4.

**Reference to one's distinctness as a consequence of the self's own unique subjective experiences and subjective interpretations of the world.**

Identification of one's distinctness in:

- a. *relation to one's personal feelings* (I'm unique because I don't feel like other kids—some things won't make me feel happy. I have feelings that are unique to me).
- b. *terms of one's orientation towards the world* (I'm different from other girls my age because I'm a lot more understanding. I know what will hurt other people's feelings and I'm careful not to do so. I could never be mean to others like some kids are).

## STEPS FOR CODING

- STEP 1:** IDENTIFY CHUNKS THAT ARE SCORABLE WITH BRACKETS
- STEP 2:** IDENTIFY ALL SCHEMAS IN EACH CHUNK--*PH, AC, SO, PSY, AG, CON, DI.*
- STEP 3:** ASSIGN EACH SCHEME A LEVEL.
- STEP 4:** ASSIGN A SUBTYPE FOR EACH LEVEL DECISION.
- STEP 5:** HIGHLIGHT WITH READ INK CHUNKS THAT HAVE MULTIPLE LEVELS FOR DIFFERENT SCHEMAS WITHIN THAT CHUNK (ie the same chunk can be coded a physical 2, active 4).
- STEP 6:** TRANSFER CODING TO FORM.

**Appendix E**  
**Layering Self-Understanding: Expanded Damon & Hart Self Schemas**

*Damon and Hart's original seven self schemas*

Physical  
Active  
Social  
Psychological  
Agency  
Continuity  
Distinctiveness

*Relational Context added to original schemas*

Physical-self, physical-other  
Active-self, active-other  
Social-self, social-other  
Psychological-self, psychological-other  
Agency-self, agency-other  
Continuity-self, continuity-other  
Distinctiveness-self, distinctiveness-other

*Constructiveness Context added to original schemas*

Physical-self constructive, physical-self unconstructive, physical-other constructive, physical-other unconstructive

Active-self constructive, active-self unconstructive, active-other constructive, active-other unconstructive

Social-self constructive, social-self unconstructive, social-other constructive, social-other unconstructive

Psychological-self constructive, psychological-self unconstructive, psychological-other constructive, psychological-other unconstructive

Agency-self constructive, agency-self unconstructive, agency-other constructive, agency-other unconstructive

Continuity-self constructive, continuity-self unconstructive, continuity-other constructive, continuity-other unconstructive

Distinctiveness-self constructive, distinctiveness-self unconstructive, distinctiveness-other constructive, distinctiveness-other unconstructive

## Appendix F Self-Understanding Scoring Sheet

Subject #:

Total Word Count for Interview: \_\_\_\_\_

Total # Chunks identified: \_\_\_\_\_

Total # self-independent chunks \_\_\_\_\_

Total # self-with-other chunks \_\_\_\_\_

Schema	# Chunks/Valence								Total +	Total-
	1+	1-	2+	2-	3+	3-	4+	4-		
PHysical-self										
PHysical-other										
ACtive-self										
ACtive-other										
SOcial-self										
SOcial-other										
PSYchological-self										
PSYchological-other										
AGency-self										
AGency-other										
COntinuity-self										
COntinuity-other										
DIstinctness-self										
DIstinctness-other										

## Appendix G

### WORKSHEET FOR READING SELF NARRATIVES

[Based upon the worksheet utilized by Tolman (1992)]

1. **READING FOR THE STORY**--As executed by Debold (1995) Events should be summed in temporal sequence and identify the relationships that are given importance across the entire interview. Note repeated words and phrases, metaphors and images. The "reader" should respond to the narrator with her own feelings and thoughts about the narrator, commonalities and differences between the narrator and the reader--acknowledging the readers own assumptions and biases about trying to understand a different person's story. It is important to note that the goal "is to get a sense of what is happening, to follow the unfolding of events, to listen to the drama (the who, what, when where, and why of the narrative).

2. **READING FOR SELF**--As Tolman (1992) states, "the purpose of this reading is to identify the "self story" in the narrative, in what ways the person speaks about and knows herself in and through the narrative". All statements that refer to self, "I", "my", or "me" are underlined and highlighted, creating what Debold (1995) calls a "self poem". I am most interested in noting how girls are defining themselves as objects in the context of different relations, as well as how they see their "self" as developing, their sense of agency--in other words, how they got to be the way they are, what they know about themselves as well as what they don't know.

- A. Self Story
- B. About what is the self clear? About what is the self confused?
- C. Is self positioned as a subject/agent? (agency in the service of what or whom)

#### SUMMARY OF SELF

**3. READING FOR SILENCE:** Highlight the places in the interview where girls silence themselves within the context of the interview and in which girls report silencing themselves--as Debold asserts, examining "these silences to see what it is that girls cannot or do not wish to speak and in what context this happens". Underline areas in text where the narrator says "I don't know", is unresponsive to questions or where she describes situations and times that she did not feel free to do, say, speak or think what she thought, felt or wanted to do.

**4. READING FOR EMBODIED KNOWLEDGE:** As Debold states, "this reading identifies places in the interview narrative where knowing and action arise from the knowing, perceiving sentient body, not just from mental categories or analysis. This knowledge concerns an awareness and expression of the full range of human feelings and responses, both in oneself and in others, as well as a "face value" reaction to the complexities and dangers of life". Areas in the narrative where feeling seems to determine and guide thought should be underlined, these are areas where feelings and thinking are integrated processes. In other words there is no dichotomy between what how one feels and how one thinks (or acts).

- A. What is known by the narrator about her self, her body, her relationships and her world?
- B. Are girls acting, thinking, feeling "true" to their self?

**5. READING FOR DISEMBODED KNOWLEDGE:** This reading "catalogues and interprets incidents where a girl abandons what she knows or feels". Sections of the text should be underlined where girls erase, censor, negate, retract or silence their feelings, their bodily responses and their knowledge. Debold also argues that disembodied knowledge is located in psychological defense processes such as intellectualization, minimizing, abstraction, distancing and dampening of emotional intensity. Areas where such psychological defense mechanism in the text are present should also be underlined.

- A. What is not known by the narrator about her self, her body, her relationships and her world?
- B. Are girls acting, thinking, feeling "false" to their self?

6. **READING FOR INTELLECTUAL KNOWLEDGE:** This reading notes the process of analysis that girls use and the appearance of normative standards, moral language, such as "shoulds" or "oughts", and ideals in the girls language. Such areas of the girls narrative should be underlined.

- A. What is the narrators "moral code"--what does she feel she ought or should be in comparison to how she is now? Note the narrators ideals for her self, her body, her relationships and her world.

**PARALLEL PROCESS:** Note how the reader responds to the narrator and to the above analysis.

Figure 1

Damon and Hart's (1988) model of self-understanding

Developmental Level	Systematic Beliefs and Plans	Physical Attributes Reflecting Volitional Choices, or Personal and Moral Standards	Active Attributes That Reflect Choices, Personal or Moral Standards	Moral or Personal Views Concerning Social Relations or Social-Personality Characteristics	Belief Systems, Personal Philosophy, Self's Own Thought Processes	Relations Between and Within Self	Other Subjective Experiences and Interpretations of Events	Personal and Volitional Influence of Self
4. Late Adolescence	Systematic Beliefs and Plans	Physical Attributes Reflecting Volitional Choices, or Personal and Moral Standards	Active Attributes That Reflect Choices, Personal or Moral Standards	Moral or Personal Views Concerning Social Relations or Social-Personality Characteristics	Belief Systems, Personal Philosophy, Self's Own Thought Processes	Relations Between and Within Self	Other Subjective Experiences and Interpretations of Events	Personal and Volitional Influence of Self
3. Early Adolescence	Inter-personal Implications	Physical Attributes That Influence Social Appeal and Social Interactions	Active Attributes That Influence Social Appeal & Social Interactions	Social-Personality Characteristics	Social Sensitivity, Communicative Competence, & Other Psychologically Related Social Skills	Comparing or Coping with Others	Physical Attributes and Psychological Identification of	Influence of Self, Others, and Environment
2. Middle & Late Childhood	Comparative Assessments	Capability - Related Physical Attributes	Abilities Relative to Others, Self or Normative Standards	Abilities or Acts Considered in Light of Others' Reactions	Knowledge, Cognitive Abilities, or Ability-Related Emotions	Self-illuminating	Comparative and Self-illuminating	Factors of Social and Environmental Influence
1. Early Childhood	Categorical Identifications	Body Properties or Material Possessions	Typical Behavior	Fact of Membership in Particular Social Relations or Groups	Momentary Moods, Feelings, Preferences & Aversions	Identifications	Identifications	Agency
	General Organizing Principle	Physical Self	Active Self	Social Self	Psychological Self	Continuity	Distinctions	

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