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EXPLORING THE RELATIONSHIP AMONG ETIOLOGICAL FACTORS RELATED
TO EATING DISORDERS

By
Erin K. Duffy

A Thesis

Submitted in partial fulfillment of the requirements of the
Master of Arts Degree
of
The Graduate School
at
Rowan University
May 10, 2004

Approved by
Jim A. Haugh, Ph.D

Date Approved 6/16/04

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ABSTRACT

Erin K. Duffy

EXPLORING THE RELATIONSHIP AMONG ETIOLOGICAL FACTORS RELATED TO EATING DISORDERS

2003/04

Dr. James A. Haugh

Master of Arts in Applied Psychology and Mental Health Counseling

The purpose of this study was to use a cross-sectional and longitudinal research design to explore the casual relationship between personality, coping, social support and eating disorder pathology. After initial data collection, participants were contacted at either an 8-month or 2-month follow-up period. Of the original 270 participants, 134 subjects completed a follow-up portion of the study (112 at 2-months and 22 at 8-months). Participants completed all measures at time 1, and completed measures of eating disorder pathology at time 2. Results from cross-sectional analyses indicated that neuroticism self-distraction and positive reframing were predictive of eating disorder pathology. Results from longitudinal analyses at 2-month follow up indicated self-distraction and positive reframing were predictive of eating disorder pathology. However, when controlling for time one symptomatology, results indicated that personality, coping, and social support factors were not shown to be statistically significant predictors of eating disorder pathology. Due to limited subject participation at the 8-month follow up, regression analyses could not be completed for this group of participants. Implications for treating and preventing eating disorders are discussed.

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Chapter 1

Introduction

Eating disorders are among the most common psychiatric problems faced by females, and they are marked by psychosocial impairment and comorbid psychopathology (Stice, 2002). Public awareness of eating disorders and the demand for clinical services and preventative interventions have increased significantly over the past few decades (Brookings & Wilson, 1994). In addition, there has been increased attention directed at exploring etiological factors contributing to the onset and maintenance of eating disorders. The importance of determining what causes such conditions is immense, because individuals with eating disorders are faced with various psychological and medical tribulations. To date, various factors related to the etiology of eating disorders have been examined and it appears as though they are multi-determined (Grisset & Norvell, 1992; Mallinckrodt et al., 1995; Bennett & Cooper, 1999). Specific factors that have been linked to the etiology of disordered eating that have been examined include personality, social supports, and coping skills. The literature related to each of these areas will be briefly reviewed in the following sections.

The Relationship Between Personality and Eating Disorders

One of the etiological factors that has been explored in relation to eating disorders is personality. Although such research is somewhat limited, it appears as though the onset of eating disorders may be partially predicted by, and related to, personality differences. While the specific role that personality may play in the etiology of eating

disorders has not yet been determined, research to date suggests that individuals with eating disorders possess certain personality traits that may predispose them to experiencing eating disorders. Moreover, this research suggests that specific personality differences may exist between those at risk for experiencing anorexia nervosa as compared to those at risk for experiencing bulimia nervosa.

Results of research conducted in an effort to differentiate eating disordered populations from non-symptomatic populations has continuously suggested that there are a number of personality traits that may distinguish between these two groups. One such personality trait is neuroticism. In general, neuroticism has been consistently linked to eating disorders, with results suggesting that higher levels of neuroticism may be related to the development of eating disorders (Gual et al., 2001; Podar et al., 1999; Brookings & Wilson, 1994; Diaz-Marsa et al., 2000). For example, Podar, Hannus, and Allik (1999), compared personality characteristics of women with clinically diagnosed eating disorders, women preoccupied with weight, and women without body weight problems or eating disorders. Personality was assessed using the NEO-PI. Results indicated that women with eating disorders scored significantly higher on the neuroticism factor than the weight reduction and control groups. Moreover, the eating disorder group scored significantly higher on most facet scales of neuroticism in comparison to the other groups, in particular anxiety, hostility, depression, and vulnerability.

Additional support for the role of neuroticism in eating disorders comes from a study by Gual et al. (2001) who examined differences in personality traits between women with eating disorders and a control group of non-eating disordered women. In this study, personality was assessed using the Eysenck Personality Scale, and a measure

of self-esteem was also included to explore how self-esteem and neuroticism may interact with one another. Results were consistent with previous literature and indicated that women diagnosed with an eating disorder experienced significantly greater levels of neuroticism than women without an eating disorder. Moreover, results indicated that females who scored the highest in levels of neuroticism and lowest in levels of self-esteem had a prevalence of eating disorders fourteen times higher than those females who scored in the lowest levels of neuroticism and the highest in self-esteem. The results of this study support the hypothesis that neuroticism is a personality trait that is commonly related to eating disorders and extends this research to suggest that the interaction between neuroticism and other psychological variables might be of additional importance to explore.

Interestingly, neuroticism is a personality characteristic that seems to be common for all individuals suffering from an eating disorder, regardless of which particular disorder (e.g., anorexia or bulimia). For example, Diaz-Marsa et al. (2000) examined the personality and temperament of patients with anorexia and bulimia in an attempt to see which factors might effectively differentiate between the two. Results indicated that while there were certain distinguishable characteristics between groups, neuroticism was a personality trait that was apparent and seemingly similar to both groups of patients.

Although neuroticism does not appear to differentially predict different types of eating disorders, some personality research does indicate that there are personality differences between individuals with bulimia and anorexia. More specifically, studies have indicated that individuals with bulimia nervosa tend to be more impulsive in comparison to individuals with anorexia nervosa, whereas individuals with anorexia tend

to be more perfectionistic compared to individuals with bulimia nervosa (Diaz-Marsa et al., 2000; Podar et al., 1999; Stein et al., 2002). For example, Diaz-Marsa et al. (2000) examined the personalities and temperaments of 72 female outpatients with diagnoses of restrictive anorexia nervosa, binge eating-purging anorexia nervosa, and bulimia nervosa. Results indicated that women with bulimia nervosa were found to be significantly more impulsive than either of the two anorexia groups. Additionally, the females in the anorexia groups showed significantly higher levels of perfectionism than did females with bulimia.

A similar study conducted by Podar et al. (1999) indicated that women with bulimia nervosa scored significantly higher than women with anorexia nervosa on the impulsiveness scale of the NEO-PI. It is important to note, however, that both eating disorder groups presented higher levels in impulsiveness and perfectionism in comparison to women without eating disorders. Such findings are also supported in studies comparing women who have or have not had bulimia nervosa at some point in their lives. Specifically, results of a study completed by Stein et al. (2002) indicated that women who have recovered from bulimia nervosa show significant differences in the area of perfectionism than did healthy matched females who had never been diagnosed.

In summary, the literature suggests that women with eating disorders present with different levels of personality traits when compared to individuals who have never had an eating disorder. More specifically, individuals with eating disorders tend to have higher levels of neuroticism than do individuals that do not suffer from eating disorders. Additionally, individuals with eating disorders seem to be more impulsive and perfectionistic in comparison to healthy controls. Finally, there appears to be distinct

personality differences between individuals with anorexia nervosa and bulimia nervosa, specifically in the areas of impulsiveness and perfectionism. In particular, individuals with bulimia nervosa have been shown to be more impulsive.

Despite these provocative findings, the actual role that personality plays in the onset of eating disorders has still yet to be determined. Although the above mentioned research does offer information that is vital in determining factors contributing to the onset, maintenance, and possible intervention options for eating disorders, there are other aspects of personality that may be associated with eating disorders. For example, personality traits such as extraversion and openness to experience have been implicated in playing such a role. As a result of our limited understanding, more research must be done to further explore the extent to which these characteristics affect the onset or maintenance of eating disorders.

Another problem with the current literature is that most of the studies exploring the relationship between personality and eating disorders has been done using cross-sectional designs. Although such research supports the notion that personality does influence some aspects of eating disorders, the exact role that it plays has yet to be determined. The question as to whether or not personality factors play a causal role or if they are an affect of disordered eating has not yet been explored in depth. Further research in this area will be important in developing prevention and treatment programs for individuals with eating disorders.

The Role of Social Support in Eating Disorders

A second etiological factor that has been explored in relation to eating disorders is social support. It has been suggested that social support can be viewed as an individual's

degree of social integration, the subjectively experienced quality of the individual's relationships, the perceived supportiveness and helpfulness of others, and the actual enactment of supportive behaviors (Bennett & Cooper, 1999). Attempts have been made to examine the various aspects of social support and the relation that social support factors may have with eating disorders.

Although social support has also been studied in relation to both anorexia and bulimia, the majority of this literature has explored its relationship with bulimia. For example, a number of studies have compared differences in social support between individuals diagnosed with bulimia nervosa and those who were not diagnosed with any eating disorder (Tiller et al., 1995; Rorty et al., 1999; Holt & Espelage, 2002). Results from this research indicate that women diagnosed with bulimia tended to perceive themselves as having lower levels of both emotional and practical support than those without an eating disorder (Tiller et al., 1995). Moreover, bulimic subjects tend to be significantly dissatisfied with the overall quality of support received in comparison to non-eating disordered women (Ghaderi & Scott, 1999; Tiller et al., 1995; Rorty et al., 1999).

Additional research has explored the question of whether these social support deficits are evident both during the active phase of the bulimia and during recovery from bulimia (Rorty et al., 1999). Participants in this study were women who were either currently diagnosed with bulimia, currently in recovery from the disorder (e.g., no active symptoms), or had never been diagnosed with the disorder. Interestingly, results indicated that women in recovery reported having more supportive friendships and emotional support in comparison to women with active bulimia. However, women with

active bulimia and women in recovery were significantly less satisfied with the level of emotional support from family when compared to women who had never had an eating disorder. However, the three groups did not significantly differ in the actual number of kin available to provide practical support.

Some research has also been conducted to explore differences between individuals diagnosed with bulimia versus those diagnosed with anorexia. For example, Tiller et al. (1995) investigated the social support networks of individuals with anorexia, bulimia, or no eating disorder and attempted to determine the levels and perceived adequacy of such support. Results indicated that patients with eating disorders reported significantly less social support than patients without eating disorders. Furthermore, women with bulimia nervosa appeared to be more dissatisfied with support received from parents than women with anorexia. Finally, women with bulimia tended to perceive less support from partners, parents, and siblings than did women with anorexia. Interestingly, both eating disordered groups appeared to have set significantly lower ideals for emotional and practical support than do women without an eating disorder.

In summary, it has been consistently found that women with eating disorders do in fact have significantly impaired social support in comparison to non-eating disordered women. Additionally, it appears as though perceived and actual levels of social support may differ in some aspects between individuals diagnosed with anorexia nervosa and those diagnosed with bulimia nervosa. However, the exact role that social support may play in the etiological development of eating disorders has yet to be determined.

The Relationship Between Coping and Eating Disorders

A final etiological factor that has been explored in relation to eating disorders is coping. Several studies have been conducted in an attempt to examine the different coping styles of individuals with eating disorders in order to determine if particular coping styles are unique to people who are diagnosed with an eating disorder. While the exact role that coping styles play in relation to eating disorders has yet to be determined, it appears as though there are particular styles of coping that may be specifically related to eating disorders.

Several studies have been designed to investigate the styles of coping used by individuals with an eating disorder. Ball and Lee (2000) reviewed eleven such studies that used cross-sectional or retrospective methodologies to explore differences in coping between individuals who were diagnosed with an eating disorder and those who were not diagnosed with an eating disorder. The results of this analysis indicated that individuals with bulimia, anorexia, or symptoms of disordered eating tend to use more emotion-focused and avoidance-focused coping strategies than individuals that do not have an eating disorder. Moreover, individuals with eating disorders demonstrated less behavioral-focused coping, a tendency to avoid confronting problems, and a perception of themselves as less able to cope, tolerate stress, or solve problems.

In another study, Koff and Sangani (1997) explored the relationship between coping styles, negative body image, and eating disturbances in undergraduate women. Results of the study indicated that emotion-oriented coping and distraction/avoidance-oriented coping were positively correlated with eating disorder symptoms as assessed by the Eating Attitudes Test. These results are consistent with results from other studies and

support an association between a greater use of these two particular coping strategies and eating disturbances, suggesting that emotion-oriented coping should be considered a risk factor for eating disturbances.

In addition to studying the relationship between coping and eating disorders using cross-sectional designs, these relationships have also been studied in “at risk” populations. For example, Garcia-Grau et al. (2002) analyzed the relationship between coping styles and predispositions to eating disorders in a sample of adolescent girls. Specifically, the authors examined four categories of coping strategies used by adolescents to cope with problems. These styles included problem-focused, intro-punitive avoidance, hedonistic avoidance, and avoidance of social support. Problem-focused strategies were defined as the use of appropriate problem-solving strategies when attempting to solve various problems. Intro-punitive avoidance strategies were defined as avoiding the problem and coping non-adaptively with the emotions that the problems generated. Hedonistic avoidance strategies were by problem avoidance and adaptive control of the emotions that the problem generates. Finally, avoidance of social support strategies were defined by avoiding social support to solve a problem.

Results of this study indicated that the use of intro-punitive avoidance was the factor most predictive of eating disorder pathology. Moreover, adolescents in the at-risk group used intro-punitive avoidance significantly more than the rest of the sample. Such results suggest that individuals who avoid problems and cope non-adaptively with the emotions that the problems create show a stronger predisposition toward developing an eating disorder.

Finally, the relationship between coping and eating disorders has also been studied using longitudinal designs. For example, Ball and Lee (2002) examined stress, coping, and symptoms of disordered eating in a sample of women aged 19-24. When examining the coping styles of individuals with eating disorders, it was determined that women who were currently engaging in disordered eating behaviors reported a significantly greater reliance on particular coping strategies, especially keep-to-self coping and self-blame. Again, these findings are consistent with past research and support the notion that emotion-focused and avoidance-focused coping strategies are generally used by individuals with an eating disorder. However, the results of this study indicated that the longitudinal relationships among perceived stress, coping, and disordered eating was weaker than suggested by previous cross-sectional design studies, indicating that stress and coping may not be as strong of a predictor of eating disorder pathology as once thought.

In summary, certain styles of coping have been consistently associated with eating disorders. Specifically, individuals with eating disorders tend to use more emotion-focused and avoidance-focused coping styles in comparison to individuals without eating disorders. Despite these encouraging initial findings, few studies have examined the relationship between coping and eating disorder pathology using longitudinal studies. Additionally, when such designs have been used, the results suggest that the relationship between these factors may be weaker than initially thought. As a result, further investigation seems to be necessary in order to better understand the role that coping plays in the onset and maintenance of such disorders.

Rationale and Goals for the Current Study

To date, research has suggested that personality, social support, and coping are all related to eating disorder pathology. However, there are a number of limitations to this literature base. One limitation is that very few, if any, researchers have examined predictive models that include more than one of the variables mentioned above. Thus, although we know that these factors are related to eating disorder pathology, it remains unclear which of the variables are of greater predictive utility when directly compared to one another. In addition, it remains unclear how the variables may be related to one another independent of their relation with eating disorder pathology.

A second limitation of the current literature within this area is that the majority of it has been conducted using cross-sectional research designs. As a result, we lack information regarding the longitudinal relationship between these variables and eating disorder pathology. The current study will attempt to correct for this by collecting follow-up data on eating disorder pathology in an effort to more clearly understand the casual relationship between personality, coping, social support and eating disorder pathology.

Chapter 2

Method

Participants

Participants were 270 college undergraduate students (210 females, 60 males). Participants were chosen from undergraduate psychology courses and were given the option of receiving course credit or extra-credit for participating in part one of the study. The participants ranged in age from 18 to 46, with a mean of 21.1 years. Participants were predominately Caucasian (84% Caucasian, 6% African-American, 5% Hispanic, 1% American Indian, 2% Asian American, and 2% other). Additionally, participants were predominately single (70% single, 21.5% married, 2.6% separated, 2.2% divorced, and 2.2% other). Most were in their sophomore or junior year level of college (37% and 31%, respectively), whereas 12% of the participants identified themselves as freshmen and 20% identified themselves as seniors.

Measures

Eating Disorder Inventory-2 (EDI-2; Garner, 1991): This instrument is a self-report measure intended to assess the behavioral and psychological traits that are common in anorexia nervosa and bulimia nervosa. The EDI-2 consists of 11 scales which include: drive for thinness, bulimia, body dissatisfaction, ineffectiveness, perfectionism, interpersonal distrust, interoceptive awareness, maturity fears, asceticism, impulse regulation, and social insecurity. The items on the inventory are rated on a 6-point Likert scale and responses for each item are assigned a score from zero ("never

true”) to three (“always true”), with higher scores indicating greater symptomatic distress.

The internal consistency for the EDI-2 has been analyzed within the eating disorder and non-patient samples. Internal consistency coefficients for the EDI-2 subscales range from .83 to .93 (Garner, 1991). The test-retest reliabilities for the first 8 EDI-2 subscales range from .41 to .75 (Garner, 1991). Content validity coefficients for items on the subscales ranged from .23 to .81. The average validity of the subscales appears to be good to excellent based on average coefficient scores (Garner, 1991).

For the current study, the drive for thinness and bulimia subscales were used as the two primary indicators of eating disorder pathology. These scales have consistently been found to be the two factors most clearly and strongly predictive of eating disorder pathology in previous studies (see Garner, 1991 for a review).

The NEO Five-Factor Inventory, Form S, College Age (NEO-FFI; Costa and McCrae, 1989): This instrument is a short version of the NEO-Personality Inventory-Revised (NEO-PI-R) (Costa & McCrae, 1985). It is used to obtain scores for the five domains of personality, consisting of neuroticism, extraversion, openness to experience, agreeableness, and conscientiousness. There are 12 questions for each domain of personality, resulting in the 60-item scale. The NEO-FFI subscales correlate highly with the domain scales of the NEO-PI-R, ranging from .86 to .95 (Costa & McCrae, 1985). Thus, the NEO-FFI provides a shorter, comprehensive, valid, and reliable measure of the five aforementioned factors of personality (Costa & McCrae, 1992; Tylka & Subick, 1999). Additionally, Tylka & Sublich (1999) found the five factors to have good internal consistency reliability, with four of the five factors with alphas at or above .85.

Brief COPE-Brief Version (Carver et al., 1997): This instrument is a shortened version of the COPE (Carver et al., 1989). The COPE is a 60-item self-report questionnaire designed to assess the various ways in which people respond to stressful events in their lives. The original COPE consisted of 13 distinct scales measuring aspects of problem-focused, emotion-focused, and behavior-focused scales. Specifically, the scales address active coping, planning, suppression of competing activities, restraint coping, seeking social support (instrumental), seeking social support (emotional), positive reinterpretation and growth, acceptance, turning to religion, focus on and venting of emotions, denial, behavioral disengagement, mental disengagement, and alcohol-drug disengagement. The items for each scale are scored on a 4-point Likert scale with responses varying from “I haven’t been doing this at all,” to “I’ve been doing this a lot.” The COPE has shown to be reliable, with internal consistency reliability coefficients ranging from .45 to .92 and test-retest reliability coefficients ranging from .20 to .24 (Carver et al., 1989). Moreover, evidence for the discriminant and construct validity of the instrument has been provided by Carver et al. (1997). The Brief COPE is a shortened version of the COPE consisting of 28 self-report items. The Brief COPE omits two scales of the full COPE, reduces others to two items per scale, and adds one scale (Carver, 1997). The reliabilities of the scales range from .50 to .90. Specifically, all exceeded .60 except for three of the fourteen scales, thus all meet the value of .50 value that is regarded as the minimally acceptable value of reliability (Carver, 1997).

Perceived Social Support-Friends and Family (PSS-fr and PSS-fa; Procidano and Heller, 1983): Each individual instrument is a 20-item self-report questionnaire designed to measure the extent to which an individual perceives that his or her need for support,

feedback and interactions are fulfilled by family (PSS-fa) and friends (PSS-fr) (Ghaderi & Scott, 1999). Each 20-item scale consists of declarative statements to which the individual answers “Yes,” “No,” or “Don’t know.” The PSS-fr and PSS-fa have been shown to have high internal consistency (Cronbach’s α of .88 and .90 respectively) as well as high construct validity. Additionally, the scales have the ability to distinguish between the perception of social support from friends and the perception of such support from families (Procidano & Heller, 1983, Ghaderi & Scott, 1999).

Procedure

During the initial data collection, participants completed five questionnaires, including the EDI-2, PSS-fr and PSS-fa, NEO-FFI, and brief version of the COPE. Participants were also required to complete a demographic questionnaire that consisted of questions pertaining to gender, age, race, academic rank, and marital status. Participants were chosen from undergraduate psychology courses and were given the option of receiving course credit or extra-credit for participating in part one of the study. Before completing the initial data packets, informed consent was obtained from each participant. Additionally, permission to contact each participant was obtained from those individuals who agreed to take part in the follow-up study.

Participants in the initial sample were contacted again at either 8-months or 2-months following the initial data collection. Participants received course credit, extra-credit, or were placed in a lottery to receive incentives for completing the follow-up portion of the study. At follow-up, the EDI-2 was either distributed during class and completed at home or sent via e-mail to participants to be downloaded, completed, and returned within a specified time. One hundred and twenty three participants were

contacted 8-months after the initial data collection. Of those contacted, 22 completed the follow-up questionnaires. One hundred and forty seven participants were contacted 2-months after the initial data collection. Of those contacted, 112 completed the follow-up portion of the study. In total, 134 of the 270 participants completed both parts of the study (49.6%), while 136 subjects (50.4%) did not complete the follow-up portion.

Chapter 3

Results

Correlation Analyses

Correlation analyses were conducted to explore how the personality, social supports and coping factors were related to the drive for thinness and bulimia scales. Three separate analyses were conducted, with the first using all study subjects, the second using only subjects who completed the follow-up at 2 months, and the third using only subjects who completed the follow-up at 8 months.

The results of the first correlation analysis exploring the relationship between the NEO-FFI, brief version of the COPE, PSS-fr, and PSS-fa factors and the drive for thinness and bulimia subscales were examined using all subjects in the current study. Analyses were conducted for both time 1 (initial time of completion) and time 2 (2 or 8-month follow-up). Results of the first analysis are presented in Table 1. In terms of personality, results indicated that neuroticism was significantly and positively related to both drive for thinness and bulimia ($r = .45$ and $.39$, respectively) at time 1. However, neuroticism was significantly and positively related to only the drive for thinness subscale at time 2 ($r = .44$). Interestingly, extraversion, agreeableness, and conscientiousness were all significantly and negatively related to the bulimia subscale at time 1, with coefficients ranging from $-.14$ to $-.18$. However none of the NEO-FFI factors were significantly related to the bulimia subscale at time 2.

In terms of coping skills, self-distraction and substance use were both significantly and positively related to both drive for thinness and bulimia subscales at time 1 and time 2, with coefficients ranging from .18 to .35. Additionally, denial and self-blame were also significantly and positively related to both EDI-2 subscales at time 1, with coefficients ranging from .22 to .40. However, both denial and self-blame were only significantly related to the drive for thinness subscale at time 2 ($r = .27$, and $.40$, respectively). Behavioral disengagement was found to be significantly and positively related to both EDI-2 subscales at time 1 ($r = .20$ and $.30$, respectively), however, it was only significantly and positively related to the bulimia subscale at time 2 ($r = .20$). Use of emotional support was found to be statistically significant and positively related to the drive for thinness subscale at time 2 only ($r = .19$), whereas use of instrumental support was found to be significantly and positively related to the drive for thinness subscale at time 1 only ($r = .14$). Venting was found to be significantly and positively related to the drive for thinness subscale at time 1 and 2 ($r = .15$ and $.19$, respectively), however was found to be significantly and positively related to the bulimia subscale only at time 2 ($r = .22$). Moreover, positive reframing was found to be significantly and negatively related to the bulimia subscale at time 1 ($r = -.22$) and the drive for thinness subscale at time 2 ($r = -.19$).

With regard to the social support variables, perceived social support from family was significantly and negatively related to the bulimia subscale at both time 1 ($r = -.14$) and time 2 ($r = -.19$). Moreover, perceived social support from friends was significantly and negatively related to both drive for thinness at time 1 ($r = -.13$) and bulimia at time 1

($r = -.22$). Perceived social support from friends was not significantly related to either of the subscales at time 2.

Table 1

Correlations between NEO-FFI, PSS-fr, PSS-fa, brief COPE and Drive for Thinness and Bulimia at Time 1 and Time 2

	Drive for Thinness	Bulimia	Drive for Thinness (2)	Bulimia (2)
Neuroticism	.45***	.39***	.44***	.15
Extraversion	-.06	-.18**	-.08	.05
Openness	.03	.10	.04	-.03
Agreeableness	-.12	-.14*	-.18*	-.13
Conscientiousness	-.09	-.14*	-.14	-.15
Self-distraction	.28***	.19**	.35***	.27***
Active Coping	-.02	-.08	-.09	-.07
Denial	.22***	.26***	.27**	.10
Substance Use	.25***	.32***	.24**	.18*
Use of Emotional Support	.11	.00	.19*	.07
Use of Instrumental Support	.14*	-.01	.16	.09
Behavioral Disengagement	.20***	.30***	.14	.20*
Venting	.15*	.10	.19*	.22*
Positive Reframing Planning	-.09 .06	-.22*** -.02	-.19* -.02	-.17 -.04
Humor	.13*	.10	.19*	.11
Acceptance	-.05	-.09	-.04	.05
Religion	.06	-.05	.11	-.04
Self-Blame	.40***	.25**	.40***	.05
Perceived Social Support, Family	-.04	-.14*	-.15	-.19*
Perceived Social Support, Friends	-.13*	-.22***	-.08	-.07

Note. N = 270.

*p<.05. **p<.01. ***<.001.

The results of the second correlation analysis exploring the relationship between the NEO-FFI, brief version of the COPE, PSS-fr, and PSS-fa factors and the drive for thinness and bulimia scales were examined using the subjects who completed the 2-month follow-up. Results of the second analysis are presented in Table 2. Results indicated that neuroticism was significantly and positively related to both the drive for thinness and bulimia at time 1 ($r = .50$ and $.47$, respectively). However, neuroticism was significantly and positively related to the drive for thinness subscale at time 2, ($r = .47$). Openness was significantly and positively related to bulimia at time 1, ($r = .19$). Additionally, agreeableness was significantly and negatively related to drive for thinness and bulimia at time 1 ($r = -.21$ and $-.21$, respectively). Moreover, conscientiousness was significantly and negatively related to bulimia at time 1 ($r = -.19$).

With regards to coping, self-distraction was found to be significantly and positively related to the drive for thinness and bulimia subscales at both time 1 and time 2, with coefficients ranging from $.29$ to $.41$. Denial, substance use, and self-blame were all found to be significantly and positively related to both subscales at time 1 as well as the drive for thinness subscale at time 2. Coefficients ranged from $.32$ to $.38$ for the denial subscale, $.33$ to $.47$ for the self-blame subscale, and from $.21$ to $.34$ for the substance use subscale. Behavioral disengagement was found to be significantly and positively related to both the drive for thinness and bulimia subscales at time 1 ($r = .20$ and $.30$, respectively). Behavioral disengagement was also found to be significantly and positively related to the bulimia subscale at time 2 ($r = .23$). Use of emotional support and instrumental support were significantly and positively related to the drive for thinness subscale at time 1 ($r = .19$ and $.21$, respectively). Venting was significantly and

positively related to the bulimia subscale at time 2 ($r = .23$). Additionally, positive reframing was significantly and negatively related to bulimia at time 1 ($r = -.33$) and drive for thinness at time 2 ($r = -.23$).

With regard to perceived social support, both perceived social support from family and friends were significantly and negatively related to the bulimia subscale at time 1 only ($r = -.25$ and $-.23$, respectively).

Table 2

Correlations between NEO-FFI, PSS-fr, PSS-fa, brief COPE and Drive for Thinness and Bulimia at Time 1 and Time 2 (2 months)

	Drive for Thinness	Bulimia	Drive for Thinness (2)	Bulimia (2)
Neuroticism	.50***	.47***	.46***	.14
Extraversion	-.06	-.17	-.17	.04
Openness	.12	.19*	.13	.03
Agreeableness	-.21*	-.21*	-.14	-.12
Conscientiousness	-.05	-.19*	-.10	-.13
Self-distraction	.41***	.29**	.41***	.32***
Active Coping	-.06	-.11	-.14	-.06
Denial	.38***	.34***	.32***	.09
Substance Use	.28 **	.34***	.21*	.15
Use of Emotional Support	.19*	.12	.16	.09
Use of Instrumental Support	.21*	.10	.16	.12
Behavioral Disengagement	.20*	.30**	.14	.23*
Venting	.12	.16	.13	.23*
Positive Reframing	-.16	-.33***	-.23*	-.12
Planning	.09	.03	.02	-.00
Humor	.17	.13	.15	.12
Acceptance	-.07	-.09	-.01	.12
Religion	.10	-.03	.10	-.07
Self-blame	.47***	.33***	.40***	.05
Perceived Social Support, Family	-.18	-.25**	-.15	-.16
Perceived Social Support, Friends	-.18	-.23*	-.14	-.07

Note. N = 112. *p<.05.**p<.01.***<.001.

The results of the third correlation analysis exploring the relationship between the NEO-FFI, brief version of the COPE, PSS-fr, PSS-fa factors and the drive for thinness and bulimia scales were examined using the subjects who completed the 8-month follow-up. Results of the third correlation analysis are presented in Table 3. Interestingly, neuroticism was not significantly related to either the drive for thinness or bulimia subscales at time 1 or time 2. Extraversion was significantly and positively related to the drive for thinness subscale at time 1 ($r = .45$). Conscientiousness was significantly and negatively related to the drive for thinness subscale at time 2 ($r = -.49$). Moreover, openness and agreeableness were found to be significantly and negatively related to the bulimia subscale at time 2 ($r = -.46$ and $-.46$, respectively).

In terms of coping, substance use was significantly and negatively related to the drive for thinness and bulimia subscales at time 2 only ($r = .60$ and $.43$, respectively). Use of emotional support was significantly and negatively related to the bulimia subscale at time 1 only ($r = -.50$). Venting was significantly and positively related to the drive for thinness subscale at time 2 only ($r = .46$). Additionally, positive reframing and acceptance were significantly and negatively related to the bulimia subscale at time 2 only ($r = -.53$ and $-.56$, respectively). Finally, humor was significantly and positively related to the drive for thinness subscale at time 1 only ($r = .56$).

In terms of perceived social support from family and friends, perceived social support from family was significantly and negatively related to the bulimia subscale at time 2 only ($r = -.49$).

Table 3

Correlations between NEO-FFI, PSS-fr, PSS-fa, brief COPE and Drive for Thinness and Bulimia at Time 1 and Time 2 (8 months)

	Drive for Thinness	Bulimia	Drive for Thinness (2)	Bulimia (2)
Neuroticism	.07	-.07	.33	.38
Extraversion	.45*	-.09	.26	.12
Openness	.06	.33	-.26	-.46*
Agreeableness	.09	-.38	-.30	-.46*
Conscientiousness	-.24	.01	-.49*	-.29
Self-distraction	.08	-.25	.08	-.27
Active Coping	.08	.11	.07	-.10
Denial	-.15	.07	-.07	.32
Substance Use	.23	.23	.60**	.43*
Use of Emotional Support	.22	-.50*	.22	.09
Use of Instrumental Support	.33	-.41	.10	-.19
Behavioral Disengagement	.30	.20	.16	-.24
Venting	.27	-.19	.46*	.41
Positive Reframing	.34	.36	-.16	-.53*
Planning	-.02	.04	-.28	-.35
Humor	.56**	.07	.35	.05
Acceptance	-.16	.05	-.31	-.56**
Religion	-.03	-.11	.17	.41
Self-blame	.a	.a	.a	.a
Perceived Social Support, Family	.27	-.26	-.19	-.49*
Perceived Social Support, Friends	.37	-.40	.32	.10

Note. N=22. *p<.05.**p<.01.***p<.001.

.a Cannot be computed because at least one of the variables is constant.

Regression Analyses

To compare the ability of personality, coping skills, and social support to predict eating disorder pathology in the cross-sectional sample, two multiple regression analyses were conducted. The NEO-FFI, brief COPE, PSS-fa and PSS-fr factors were entered as the predictor variables, and the drive for thinness and bulimia scale scores at time 1 served as the criterion variables, respectively. Results from analysis one, exploring the predictive factors for bulimia, indicated that personality, coping styles, and perceived levels of social support accounted for 46% of the variance in bulimia at time 1, which was statistically significant $F(21, 125) = 4.18, p = .000$. The results of this analysis are presented in Table 4. The beta weights for neuroticism, openness, and humor were all significant and positive, whereas the beta weights for positive reframing and perceived social support from friends were both significant and negative.

Results from analysis two indicated that the abovementioned factors accounted for 46% of the variance in drive for thinness at time 1, which was statistically significant, $F(21, 125) = 4.14, p = .000$. The results from this analysis are presented in Table 5. The beta weights for neuroticism, self-distraction, denial, humor, and religion were all significant and positive, whereas the beta weight for positive reframing was significant and negative.

A second set of two regression analyses were conducted in order to explore whether personality, coping, and social support factors at time 1 were predictive of eating disorder symptoms at time 2. Specifically, the personality, coping, and social support factors from time 1 were entered as the predictor variables for each analysis, and time 2 bulimia and drive for thinness scores served as the criterion variables, respectively.

Results indicated that the factors accounted for 30% of the variance for bulimia at time 2, however, such factors were not statistically significant $F(21, 77) = 1.56, p = .082$. Results from the second regression analysis indicated that the factors accounted for 52% of the variance in drive for thinness at time 2, which was statistically significant $F(21, 77) = 4.03, p = .000$. The results from the abovementioned analyses presented in Tables 6 and 7, respectively. The beta weights for self-distraction, humor, and religion were all significant and positive, whereas the beta weight for positive reframing was significant and negative.

A final set of two hierarchical, multiple regression analyses were conducted to explore whether the personality, coping, and social support factors predicted a significant amount of variance in eating disorder pathology over and above the variance accounted for by time 1 levels of eating disorder pathology. In analysis one, bulimia scores at time 1 were entered on the first step and the personality, coping, and social support factors were entered on step 2. Bulimia scores at time 2 served as the criterion variable. Results of this analysis are presented in Table 8. Results indicated that all of the variables accounted for 42% of the variance for bulimia at time 2, which was statistically significant $F(22, 76) = 2.53, p = .002$. Bulimia at Time 1 accounted for 21% of that variance, which was statistically significant, $F(1, 97) = 25.96, p = .000$. The personality, coping, and social support variables accounted for an additional 21% of the variance, but did not add significant predictive power to the overall model, $F(21, 76) = 1.33, p = .185$. The beta weight for bulimia at time 1 was significant and positive.

In analysis two, drive for thinness scores at time 1 were entered on the first step and the personality, coping, and social support factors were entered on step 2. Drive for

thinness scores at time 2 served as the criterion variable. Results of this analysis are presented in Table 9. Results indicated that all of the variables accounted for 82% of the variance for drive for thinness at time 2, which was statistically significant, $F(22, 76) = 15.49, p = .000$. Drive for thinness at time 1 accounted for 76% of the variance, which was statistically significant, $F(1, 97) = 311.28, p = .000$. The personality, coping and social support variables accounted for an additional 6% of the variance, but did not add significant predictive power to the overall model, $F(21, 76) = 1.1, p = .371$.

Table 4

Multiple Regression Analysis for Variables Predicting Bulimia at Time 1

<u>Dependent Measure</u>	<u>Significant Predictors</u>	<u>B</u>	<u>SE B</u>	<u>β</u>
Bulimia	Neuroticism	.12	.05	.30*
	Extraversion	2.71 E-02	.06	.05
	Openness	9.00 E-02	.04	.16*
	Agreeableness	8.84 E-02	.06	.15
	Conscientiousness	-6.35 E-02	.05	-.13
	Self-distraction	.32	.20	.15
	Active Coping	.30	.24	.13
	Denial	.21	.27	.08
	Substance Use	.21	.18	.11
	Use of Emotional Support	3.62 E-02	.26	.02
	Use of Instrumental Support	.19	.24	.10
	Behavioral Disengagement	.19	.26	.08
	Venting	3.34 E-02	.23	.01
	Positive Reframing	-1.07	.23	-.44***
	Planning	.14	.20	.07
	Humor	.42	.18	.22*
	Acceptance	-.27	.18	-.13
	Religion	.14	.13	.09
	Self-blame	-.27	.18	-.15
	Perceived Social Support, Family	3.48 E-02	.05	.06
Perceived Social Support, Friends	-.16	.07	-.22*	

Note. $R^2 = .46$ (N=270)

* $p < .05$. ** $p < .01$. *** $p < .001$.

Table 5

Multiple Regression Analysis for Variables Predicting Drive for Thinness at Time 1

<u>Dependent Measure</u>	<u>Significant Predictors</u>	<u>B</u>	<u>SE B</u>	<u>β</u>
Drive for Thinness	Neuroticism	.20	.07	.33**
	Extraversion	.17	.10	.20
	Openness	5.44E-02	.07	.06
	Agreeableness	4.64 E-02	.09	.05
	Conscientiousness	-3.01 E-02	.08	-.04
	Self-distraction	.97	.31	.30**
	Active Coping	5.18 E-03	.37	.00
	Denial	.98	.42	.24*
	Substance Use	9.50 E-02	.28	.03
	Use of Emotional Support	-.22	.41	-.07
	Use of Instrumental Support	.32	.38	.11
	Behavioral Disengagement	-.78	.41	-.21
	Venting	-.17	.36	-.05
	Positive Reframing	-1.51	.36	-.39***
	Planning	9.49 E-02	.32	.03
	Humor	.64	.28	.22*
	Acceptance	-.45	.28	-.14
	Religion	.49	.21	.20*
	Self-blame	.27	.28	.10
	Perceived Social Support, Family	9.38 E-02	.09	.10
Perceived Social Support, Friends	-.12	.11	-.11	

Note. $R^2 = .46$ (N=270)

* $p < .05$. ** $p < .01$. *** $p < .001$.

Table 6

Multiple Regression Analysis for Variables Predicting Bulimia at Time 2 for Participants Whom Completed Both Time 1 and Time 2 Surveys

<u>Dependent Measure</u>	<u>Significant Predictors</u>	<u>B</u>	<u>SE B</u>	<u>β</u>
	Neuroticism	-3.50 E-02	.10	-.06
	Extraversion	.16	.13	.17
	Openness	-6.97 E-02	.10	-.07
	Agreeableness	1.46 E-02	.12	.02
	Conscientiousness	-.15	.11	-.18
	Self-distraction	1.13	.41	.36**
	Bulimia at Time 2	Active Coping	-.59	.52
Denial		-.82	.62	-.18
Substance Use		-.14	.47	-.04
Use of Emotional Support		-9.81 E-02	.59	-.03
Use of Instrumental Support		.24	.57	.08
Behavioral Disengagement		.57	.53	.15
Venting		.84	.52	.23
Positive Reframing		-.80	.48	-.21
Planning		-.40	.46	-.12
Humor		.17	.38	.06
Acceptance		.52	.38	.16
Religion		1.71 E-02	.29	.01
Self-blame		-.25	.42	-.08
Perceived Social Support, Family		-.10	.12	.10
Perceived Social Support, Friends		-8.97 E-02	.16	-.07

Note. $R^2 = .30$ (N=112, $p < .082$)

* $p < .05$. ** $p < .01$. *** $p < .001$.

Table 7

Multiple Regression Analysis for Variables Predicting Drive for Thinness at Time 2 for Participants Whom Completed Both Time 1 and Time 2 Surveys

<u>Dependent Measure</u>	<u>Significant Predictors</u>	<u>B</u>	<u>SE B</u>	<u>β</u>
Drive for Thinness at Time 2	Neuroticism	.13	.08	.22
	Extraversion	-7.38 E-03	.01	-.01
	Openness	.10	.08	.12
	Agreeableness	9.14 E-02	.09	.11
	Conscientiousness	1.35 E-02	.08	.02
	Self-distraction	1.09	.31	.38***
	Active Coping	-.53	.43	-.14
	Denial	.56	.46	.13
	Substance Use	-.31	.36	-.10
	Use of Emotional Support	-.11	.46	-.04
	Use of Instrumental Support	.35	.44	.13
	Behavioral Disengagement	-.67	.40	-.19
	Venting	.11	.39	.03
	Positive Reframing	-1.59	.36	-.45***
	Planning	-.31	.35	-.10
	Humor	.69	.29	.25*
	Acceptance	-7.90 E-02	.29	-.03
	Religion	.50	.22	.21*
	Self-blame	.44	.32	.16
	Perceived Social Support, Family	4.33 E-02	.09	.05
Perceived Social Support, Friends	-.10	.12	-.09	

Note. $R^2 = .52$ (N=112, $p < .001$)

* $p < .05$. ** $p < .01$. *** $p < .001$.

Table 8

Hierarchical Multiple Regression Analysis for Variables Predicting Bulimia at Time 2 for Participants Whom Completed Both Time 1 and Time 2 Surveys

Dependent Measure	Significant Predictors	B	SE B	β
Bulimia at Time 2	Bulimia at Time 1	.78	.19	.52***
	Neuroticism	-.12	.10	-.19
	Extraversion	.13	.12	.14
	Openness	-.17	.10	-.18
	Agreeableness	-4.32 E-02	.11	-.05
	Conscientiousness	-8.79 e-02	.10	-.10
	Self-distraction	.86	.38	.27*
	Active Coping	-.79	.48	-.20
	Denial	-.98	.56	-.21
	Substance Use	-.32	.43	-.10
	Use of Emotional Support	-.29	.54	-.09
	Use of Instrumental Support	.26	.52	.09
	Behavioral Disengagement	.55	.49	.14
	Venting	.69	.47	.19
	Positive Reframing	.19	.50	.05
	Planning	-.49	.42	-.14
	Humor	-8.18 E-02	.35	-.03
	Acceptance	.72	.35	.23*
	Religion	-.13	.27	-.05
	Self-blame	-.17	.39	-.06
	Perceived Social Support, Family	-.11	.11	-.11
	Perceived Social Support, Friends	1.89 E-02	.10	-.10

Note. $R^2 = .21$ (model 1) $R^2 = .42$ (model 2) (N=112, $p < .001$)

* $p < .05$. ** $p < .01$. *** $p < .001$.

Table 9

Hierarchical Multiple Regression Analysis for Variables Predicting Drive for Thinness at Time 2 for Participants Whom Completed Both Time 1 and Time 2 Surveys

<u>Dependent Measure</u>	<u>Significant Predictors</u>	<u>B</u>	<u>SE B</u>	<u>β</u>
Drive for Thinness at Time 2	Drive for Thinness at Time 1	.73	.07	.81***
	Neuroticism	3.66 E-02	.05	.06
	Extraversion	-8.54	.06	-.10
	Openness	2.08 E-02	.05	.00
	Agreeableness	8.33 E-02	.06	.10
	Conscientiousness	-1.44 E-02	.05	-.02
	Self-distraction	.31	.20	.11
	Active Coping	-.21	.27	-.06
	Denial	-.11	.30	-.03
	Substance Use	-.26	.22	-.09
	Use of Emotional Support	-1.11 E-02	.29	-.00
	Use of Instrumental Support	-.17	.28	-.06
	Behavioral Disengagement	-.23	.25	-.07
	Venting	.29	.24	.09
	Positive Reframing	-.40	.25	-.11
	Planning	-.19	.22	-.06
	Humor	.19	.19	.07
	Acceptance	.14	.18	.05
	Religion	.18	.14	.08
	Self-blame	7.22 E-03	.20	.00
Perceived Social Support, Family	7.09 E-03	.05	.01	
Perceived Social Support, Friends	4.60 E-02	.08	.04	

Note. $R^2 = .76$ (model 1) $R^2 = .82$ (model 2) (N=112, $p < .001$)
 $*p < .05$. $**p < .01$. $***p < .001$.

Chapter 4

Discussion

The current research study attempted to examine the ability of personality, coping, and social support to predict eating disorder pathology using both cross-sectional and longitudinal designs. Using the longitudinal design, participants were followed up at both 2-months and 8-months after the initial data collection. However, due to the limited responses obtained for the 8-month follow-up, regression analyses were unable to be performed for those particular subjects. Thus, longitudinal regression analyses were successfully run only for the subjects who completed the 2-month follow-up.

One purpose of the current study was to examine the ability of personality, coping skills, and social support to predict eating disorder pathology. The results from the current study suggest that personality, coping skills, and social support predictive factors accounted for almost half of the variance in bulimia and drive for thinness scores measured in a cross-sectional design. In terms of personality, neuroticism predicted a significant amount of the variance in bulimia and drive for thinness. Openness also accounted for significant variance, but only in the prediction of bulimia. These results supports the results of previous literature which suggests that neuroticism is the personality factor that is most predictive of eating disorder pathology (Brookings & Wilson, 1994; Gual et al., 2001; Diaz-Marsa et al., 2000).

The results of the current study also indicate that coping styles serve as predictive factors for eating disorder pathology. In particular, positive reframing and humor were

both able to predict significant and unique variance in bulimia. Additionally, positive reframing, self-distraction, and religion were all able to predict significant and unique variance in drive for thinness. This supports previous literature stating that individuals presenting with eating pathology tend to use more emotion-focused coping responses in comparison to problem-focused coping strategies (Ball & Lee, 2000).

Finally, the results of the first set of regression analyses indicated that the perceived level of social support from friends was a predictive factor for bulimia only. These results are both consistent and not consistent with previous literature regarding social support and eating pathology. Specifically, these results are consistent with previous literature suggesting that the perception of social support from friends in women with bulimia tends to differ from non-eating disordered women (Ghaderi & Scott, 1999; Tiller et al., 1995; Rorty et al., 1999). However, when comparing variance accounted for by social support versus personality and coping, social support factors accounted for significantly less variance than has been suggested in previous literature.

The second purpose of the current study was to collect longitudinal data in an effort to more clearly understand the casual relationship between personality, coping, social support and eating disorder pathology. The results of the second set of two regression analyses using the participants who completed the 2-month follow-up indicate support for the hypothesis that coping skills are predictive of bulimia and drive for thinness. Specifically, positive reframing, humor, and religion all accounted for significant and unique variance in drive for thinness, whereas self-distraction accounted for significant and unique variance in both bulimia and drive for thinness. Interestingly, not one of the personality factors or perceived levels of social support from friends and/or

family were significant predictor variables in either model. Thus, the results of these regression analyses indicate that when directly compared to personality and social support factors, coping skills are most predictive of eating pathology.

The final purpose of the study was to examine to what extent personality, coping, and social support factors are predictive of eating pathology over and above the variance accounted for by time one levels of eating disorder pathology. Results of the current study indicate that personality, coping, and social support do not add significant predictive power to a model over and above that accounted for by time one levels of pathology. However, there were differences with regard to the amount of additional variance accounted for by these factors. More specifically, the factors accounted for an additional 21% of the variance in bulimia scores compared to only 6% of additional variance in drive for thinness scores. This suggests that these factors may be more important in predicting symptomology specifically linked to bulimia.

Despite the fact that significant results were found in the current study, there are a number of limitations that should be acknowledged. One of the limitations to the current study lies in the fact that only 22 of the original 123 participants completed the 8-month follow-up, which resulted in the inability to conduct regression analyses for this group. This may inhibit the ability to generalize the findings of this study regarding the predictive relationship between personality, coping styles, social supports and eating pathology beyond a two month time period.

Another limitation of the current study is the fact that the sample consisted of undergraduate college students with a mean age of 21. Although eating disorders are prevalent on college campuses, their onset is more typically seen during early to mid-

adolescence. Thus, it would be beneficial to replicate the results of the current research using a younger sample where we might be able to track the initial onset of eating disorder pathology.

A third limitation to this study was that the sample was comprised of predominately Caucasian, female subjects. This also limits the generalizability of the results to other populations. A more varied sample should be utilized in the future in order to obtain data that includes a wider variety of ethnicity, in order for the results to be more generalizable to the population as a whole.

Finally, although longitudinal in nature, this study utilized follow-up data for longitudinal regression analysis at a 2-month follow-up. A longitudinal model that would allow for longer periods of time in between data collection and analysis would provide more knowledge about the causal relationship between personality, coping styles, social support, and eating disorder pathology.

In summary, the current study has provided beneficial information pertaining to the etiological and risk factors related to eating pathology. This model examined multiple factors, specifically personality, social support, and coping and their relationship to eating disorder pathology. The current findings suggest that neuroticism and emotion-focused coping styles, specifically self-distraction and positive reframing, are predictive of eating disorder pathology.

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