The relation between eating pathology and emotional intelligence in university women.

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THE RELATION BETWEEN EATING PATHOLOGY AND EMOTIONAL INTELLIGENCE IN UNIVERSITY WOMEN

by

Rolan Koifman

A Thesis
Submitted to the College of Graduate Studies and Research
Through the Department of Psychology
in Partial Fulfillment of the Requirements for
the Degree of Master of Arts at the
University of Windsor

Windsor, Ontario, Canada

1999

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ABSTRACT

The present study sought to determine the relations between eating pathology and emotional intelligence. The study attempted to determine how individuals with varying levels of eating pathology differ on the qualities that collectively make up emotional intelligence. 101 female undergraduate psychology students participated in this study. Eating pathology was measured using the Bulimia Test – Revised and the Eating Attitudes Test–26. Emotional intelligence was measured using the Emotional Intelligence Inventory. Results indicated that individuals with an eating pathology are more likely to score lower on the vast majority of subscales that make up the Emotional Intelligence Inventory. These findings could have important implications for both treatment and prevention. For example, knowing that individuals with an eating pathology have a low sense of self-regard and have difficulties managing stressful circumstances can better direct therapists when they are designing treatment programs. Also, having a greater understanding of the factors that individuals with an eating pathology lack can better direct educators towards focussing on these factors for the purpose of prevention.
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INTRODUCTION

Eating Disorders

The crescendo of interest in eating disorders during the past few decades has led to a proliferation of articles and books on the subject, both lay and scientific. This expanding interest comes at a time when the incidences of these disorders are reaching epidemic proportions. Estimates of the occurrence of bulimia in the female population are alarmingly high, ranging from a low of 2% to a high of 5%. Similarly, anorexia is estimated to afflict 1-2% of the female population. In a few decades, bulimia and anorexia have undergone remarkable metamorphoses – from psychological curiosities to publicly recognized mental health emergencies (Gordon, 1990).

Indeed, eating disorders can be described as one of the emotional disturbances that most characterizes and captivates the present time. It is a profound reflection of the psychological strains that are embedded in contemporary life. Underlying bulimia and anorexia is pervasive anxiety and a deep sense of personal ineffectiveness. Eating disordered individuals often lack a sense of identity and self-esteem. Their disorder represents an effort to ensure psychological safety and certainty (Gordon, 1990). Such people may use food to fulfill their feelings of longing and emptiness. Those who develop eating disorders are conveying the deeply held conviction that they are not prepared to continue living the way they are. Moreover, the presence of an eating disorder creates not only personal anguish, but family disruption (Frederick & Grow, 1996; Gordon, 1990).

According to the DSM-IV, the essential features of bulimia nervosa are binge eating and inappropriate compensatory methods to prevent weight gain. Binge eating is
characterized by: eating within a discrete period of time (i.e., within a two hour period),
eating an abnormally large amount of food when compared to others during a similar time
period and under similar circumstances, and a sense of a lack of control over eating during
the eating episode. Inappropriate compensatory behaviours include self-induced vomiting,
the misuse of laxatives, diuretics, enemas, or other medications, fasting, or excessive
exercise. Furthermore, to be diagnosed with bulimia, both binge eating and inappropriate
compensatory behaviours must occur at least twice a week for three months on average and
an individual’s self-evaluation must be inappropriately influenced by body shape and
weight (American Psychiatric Association, 1994). Whereas the typical bulimic may
consume thousands of calories during a binge episode, his/her weight may stay relatively
stable. This occurs because the purging behaviour allows the bulimic to expel a significant
amount of the consumed calories. Thus, individuals with bulimia typically are within the
normal weight range, although some may be slightly underweight or overweight
(American Psychiatric Association, 1994). Bulimia affects approximately one to three
percent of the American population and the vast majority of cases are women (American
Psychiatric Association, 1994). Furthermore, bulimia usually begins in late adolescence or
early adult life and is found in all racial, ethnic, and socioeconomic groups in our society

The grim realities of bulimia are plentiful and multifaceted. Although it can lead to
death, in most situations the eating pathology lowers the quality of life for the afflicted
individual. This occurs because living with the disorder can impair personal relationships,
cause stressful living conditions for family and friends, and leave the bulimic individual an
unproductive member of society.
Anorexia nervosa is characterized by an extreme, self-imposed weight loss. Based on the standards set by the American Psychological Association in 1994, and in accordance with the DSM IV, individuals should be diagnosed as being anorexic if they: weigh at least fifteen percent less than their minimal normal weight, have an intense fear of gaining weight or becoming fat even though they are underweight, have a disturbance in the way in which they feel about their body weight, size, or shape, experience an undue influence of body weight or shape on self-evaluation, and deny the seriousness of their current low body weight. In addition to the aforementioned symptoms, postmenarcheal females must have also stopped menstruating for three consecutive menstrual cycles in order to be diagnosed as anorexic (American Psychiatric Association, 1994:544-545).

According to Patton (1992), anorexics typically focus their entire attention on food, carefully calculating grams of fat and calories in almost everything they consume. The obsession with food and possible weight gain leads some anorexics to become compulsive exercisers, sometimes devoting several hours each day to vigorous exercise (Patton, 1992).

Relative to other eating disorders, anorexia is rare, affecting approximately one to two percent of the American population. Furthermore, it is ten times more likely to occur in women than in men, particularly women in their early and late teens. When the incidence of anorexia is displayed graphically, a bimodal frequency distribution is evident. One peak occurs at 14.5 years of age and the other at 18 years of age. Anorexics are also more likely to be Caucasian and come from the upper echelon of the socioeconomic hierarchy. Since anorexia nervosa only occurs under conditions of adequate food supplies, it is rare in Third World nations. Thus, anorexia nervosa is considered to be an illness of developed countries. Furthermore, it is far more prevalent in major cities than in rural areas (American Psychiatric Association, 1994; Stavrakaki & Williams, 1990).
There has been a lot of research in the area of full syndrome bulimia nervosa but most of the research has failed to recognize the existence of an eating disorder continuum, that is, individuals who suffer from an eating pathology, but do not meet the full DSM-IV criteria. While these individuals still experience substantial distress and impairments, the lack of recognition and research hinders the understanding of eating disorders and as a result, affects prevention, intervention, and treatment. With adequate research, this would permit the isolation of risk factors for eating disorders before they culminate to full syndrome disorders which are more intractable to treatment than less severe problems such as occasional bouts of purging.

The Eating Disorder Continuum

Although there has been a lot of research in the area of full syndrome eating disorders, the eating disorders continuum has not been researched as thoroughly (Shisslak, Crago, & Estes, 1995). The eating disorder continuum hypothesis asserts that the fundamental difference between individuals with full syndrome eating disorders and milder forms of eating pathology are a matter of degree and not of kind (Nylander, 1971; Rodin et al., 1985). Although individuals with different types of eating disorders differ in eating-related behaviours, the continuum hypothesis suggests that the groups on the continuum share similar underlying psychological characteristics. In order words, the groups differ only in the frequency or severity of eating problems. Normal eating falls at one end of the continuum and full-blown anorexia and bulimia fall at the opposite end. In spite of the fact that there is no formal diagnostic criteria for sub-clinical eating pathology, the DSM-IV does recognize the significance of diagnosing an individual with an eating disorder even if s/he does not meet all of the necessary criteria for either anorexia nervosa or bulimia nervosa. For example, if an individual meets all of the necessary criteria for
bulimia nervosa except that s/he does not engage in binge eating and/or inappropriate compensatory behaviours with the frequency and/or duration required for a formal diagnosis of bulimia nervosa, s/he would be given the diagnosis of an “eating disorder not otherwise specified” (American Psychiatric Association, 1994).

Recent research involving non-clinical populations of both adolescent and adult women suggests that these groups are more likely to suffer from an eating pathology that fails to meet the diagnostic criteria for a full-blown eating disorder than they are to suffer from a clinical eating disorder. In clinical populations, an eating pathology that fails to meet the diagnostic criteria for full-blown eating disorders is given to nearly half of all adolescent and adult females seeking evaluation or treatment at eating disorder clinics in the United States (Shisslak, Crago, & Estes, 1995).

The importance of recognizing the eating disorders continuum has been emphasized by a number of researchers. Studying the whole spectrum of eating disturbances in the community is necessary to provide a fuller understanding of the natural history of eating disorders and to identify etiological factors before they become obscured by secondary physical and psychological changes that accompany full syndrome eating disorders (Fairburn & Begling, 1990; Patton, 1988).

It is also important to consider the implications of an eating pathology. If untreated, individuals may degenerate and develop a full-blown eating disorder. In longitudinal studies spanning one to two years, approximately 15% of those individuals previously diagnosed with partial syndrome bulimia had progressed to full syndrome bulimia by the end of the study (Patton, 1988; Patton, Johnson-Sabine, Wood, Mann, & Wakeling, 1990; Schleimer, 1983). In other longitudinal studies ranging from one to four years in length, many of those who were considered at risk during the initial evaluation had
progressed to more severe eating disturbances by the end of the follow-up period (Drewnowski, Yee, & Krahn, 1988; Garner, Garfinkel, Rockert, & Olmstead, 1987; Farmer, and Pruitt, 1993).

Although research on the eating disorders continuum is limited, some studies that have been conducted have reported that individuals with an eating pathology, but who fail to meet the diagnostic criteria for a full-blown eating disorder, are experiencing great distress. Some findings that have been reported include: numerous somatic complaints (Shisslak et al., 1989), a past history of eating disorders symptoms and/or treatments (Clinton & Glant, 1992; Hall & Hay, 1991), and engagement in a variety of abnormal behaviours (Jaffe & Singer, 1989; Williamson et al., 1992). In several recent large-scale epidemiological studies involving a total of more than 26,000 subjects, most of whom were interviewed individually, those with partial syndrome eating disorders tended to be young women of normal weight who wanted to weight less and were experiencing considerable psychological distress (Kishchuk, Gagnon, Belisle, & Laurendeau, 1992), were engaging in most of the problem eating behaviours associated with full syndrome eating disorders (Whitaker, 1992), and differed from full syndrome eating disorders only in frequency of compensatory behaviours such as dieting, fasting, use of laxatives or diuretics, and self-induced vomiting (Garfinkel et al., 1994), and levels of severity (Kendler et al., 1991). In cross-sectional studies, girls with disturbed eating behaviours exhibited more anxiety, depressive symptoms, lower self-esteem, negative body image, and social withdrawal than girls without eating disturbances (Fabian & Thomson, 1989; Fisher, Schneider, Pegler, & Napolitano, 1991; Richards et al., 1991; Rosen, Gross, & Vara, 1987), and were more likely to engage in other health risk behaviours such as
substances use, sexual promiscuity, and unsafe sexual activities (Fisher et al., 1991; Killen et al., 1987; Kurth, Demitrack, & Drewnowski, 1992; Watts & Ellis, 1992).

Given the severe negative implications associated with an eating pathology, the search for knowledge that would enable us to understand, treat, and prevent it, would be of significant value. One way of achieving this knowledge is through increasing our understanding of eating pathology by recognizing the qualities that are associated with it. The purpose of the present study is to determine the relation between eating pathology and emotional intelligence. More specifically, the study will attempt to determine how individuals with varying levels of eating pathology differ on the qualities that collectively make up emotional intelligence.

**What is Emotional Intelligence?**

Recently, the concept of emotional intelligence has been popularized by Dr. Goleman and by Dr. Bar-On, creator of the first measure of emotional intelligence. Emotional intelligence can be described as an array of non-cognitive abilities, capabilities, and skills that influence one’s ability to succeed in coping with environmental pressures and demands. As such, one’s emotional intelligence is an important factor in determining an individual’s ability to succeed in life and directly influences general psychological well-being (Goleman, 1995).

**A Brief History of Emotional Intelligence**

The genesis of the study of emotional intelligence has its roots in Wechsler’s idea of the “non-intellective aspects of general intelligence” (Wechsler, 1940). Wechsler suggested that his intelligence test, first published in 1939, was an attempt to measure non-cognitive as well as cognitive aspects of general intelligence (Wechsler, 1943); he was most likely referring to the inclusion of the Picture Arrangement and Comprehension
subtests which tap social aspects of intelligence. Moreover, Wechsler considered Doll's work (Doll, 1935, 1953) as another early attempt to measure non-cognitive aspects of general intelligence (Wechsler, 1943). Doll developed a structured interview called the Vineland Social Maturity Scale designed to assess social competence. This scale rendered a social quotient (SQ), indicating the level of social maturity obtained by the individual. In essence, Doll was measuring social intelligence. It appears that Wechsler and Doll concurrently began the initial work on emotional intelligence as early as the 1930s.

In 1948, Leeper proposed that emotional thought is part of and contributes to logical thought and intelligence in general (Leeper, 1948). The early thinking by Wechsler, Doll, and Leeper was succeeded half a century later by Gardner, who broadened the traditional conceptualization of intelligence since the early twentieth century (Gardner, 1983). Gardner suggests that intelligence encompasses multiple dimensions, combining a variety of cognitive aspects with elements of emotional intelligence. The emotional dimension of the concept of "multiple intelligence" includes two general components that was referred to as "intrapsychic capacities" and "interpersonal skills" which resemble two of Bar-On's five meta-factors ("intrapersonal" and "interpersonal" factor components).

Other psychologists continued to challenge the conventional view of intelligence. Mayer and Salovey concentrated their research on the "emotional" aspects of intelligence (Mayer, DiPalo, & Salovey, 1990; Mayer, Mamberg, & Volanth, 1988; Mayer & Salovey, 1993, 1995; Mayer & Volanth, 1985). They expanded on Gardner's approach and looked primarily at three components of "emotional intelligence" that are very similar to Bar-On's emotional self-awareness, assertiveness, and empathy.

From the beginning, Bar-On's approach was multi-factorial in order to widen the view of the factors (emotional skills) thought to be involved in non-cognitive intelligence.
Bar-On has been studying between 11 and 15 proposed factorial components of emotional intelligence for nearly two decades.

Recently, Bar-On developed the EQ-i, a test that measures emotional intelligence. The EQ-i is composed of 133 brief items and employs a five-point response format ranging from “Not True of Me” to “True of Me”. It renders a total emotional intelligence (EQ) score and five EQ composite scale scores based on 15 subscales.

Can Emotional Intelligence Be Learned?

Unlike traditional forms of intelligence (I.Q.), emotional intelligence is far more malleable and can be learned by both children and adults (Goleman, 1995). In fact, a number of schools in the United States have as a main focus of education the skills that can be collectively grouped under the emotional intelligence rubric (Goleman, 1995). One school, the Neuva Learning Center, offers what may be a model course in emotional intelligence. The subject in Self Science is feelings – your own and those that erupt in relationships. The topic demands that teachers and students focus on the emotional fabric of a child’s life – a topic that is most often ignored in other school across North America. The strategy at Neuva includes using children’s real life problems as the topic of the day. Teachers speak to issues that affect children’s everyday lives – hurt over being left out or neglected, envy, and being overwhelmed by parental demands. A list of the contents of Self Science is an almost point-for-point match with the ingredients of emotional intelligence. Topics include self-awareness, in the sense of recognizing feelings and building a vocabulary for them, and seeing the links between thoughts, feelings, and reactions; knowing if thoughts or feelings are ruling a decision; seeing the consequences of alternative choices; and applying these insights to decisions about important issues ranging from drugs and sex to smoking and relationships (Goleman, 1995).
Another emphasis is managing emotions: recognizing what is behind a feeling (for example, the hurt that triggers anger), and learning ways to handle anger, anxieties, and sadness. Still another emphasis is on taking responsibility for actions and decisions, and following through on commitments (Goleman, 1995).

An important social ability is empathy, being aware of and understanding others’ feelings. Relationships are also a major focus, including learning how to be a good listener and how to ask the right questions; distinguishing between what someone says or does and your own reactions and judgements; recognizing the benefits of being assertive rather than angry or passive; and learning the arts of cooperation, conflict resolution, and negotiating compromise (Goleman, 1995).

The Self Science curriculum has been in use for almost twenty years and stands as a model for the teaching of emotional intelligence. There are no grades given and the only examination is oral, occurring at the end of grade eight, when students are about to leave Neuva for high school.

Skeptics understandably will ask if a course like Self Science could work in a less privileged setting, or if it is only possible in a small private school like Neuva, where every child is, in some respect, gifted. Essentially, can emotional competence be learned where it may be most urgently needed, in an inner-city public school? The Augusta Lewis Troup Middle School in New Haven, which is far from the Neuva Learning Center both socially and economically demonstrates that emotional intelligence can be learned by all socio-economic classes (Goleman, 1995).

It was in response to the urgencies of this urban nightmare that in the 1980s a group of Yale psychologists and educators designed the Social Competence Program, a set of courses that covers virtually the same agenda as the Neuva Learning Center’s Self Science
Curriculum. However, at Troup, the topics are often more directly applicable to the real life problems and situations many students in this geographic area are likely to face.

One typical lesson that students in this program come across deals with the identification of feelings and being able to distinguish between them. For example, one assignment was to bring in pictures of a person's face from a magazine, name which emotion the face displays, and explain how to identify the person has those feelings. This basic lesson in connecting a name with a feeling, and the feeling with the facial expression that matches it, might seem so obvious that it need not be taught at all. Yet it might serve as an antidote to surprisingly common lapses in emotional literacy. It has been found that schoolyard bullies often strike out of anger because they misinterpret neutral messages and expressions as hostile, and of particular importance to this study, girls who develop eating disorders fail to distinguish anger from anxiety from hunger (Goleman, 1995).

Similar to the lessons learned in the classroom, emotional intelligence can be improved upon in therapy. In fact, having the one-on-one attention that many therapeutic relationships allow can foster a dramatic increase in emotional intelligence. Furthermore, research findings indicate that there are statistically significant differences in emotional intelligence from the onset of therapy to its termination in a clinical sample (Bar-On, 1997a). Knowing what deficits exist at the onset of therapy can have profound positive implications for an individual with an eating pathology.

**Eating Disorders and Emotional Intelligence**

Previous research has found that individuals with an eating disorder score lower on most of the measures found on the EQ-i when compared to a non-eating disordered control group. This trend has been found for all of the measures on the EQ-i with the exception of social responsibility, stress tolerance, and optimism, for which little or no research exists.
For example, using a sample of 71 college women between the ages of 19 and 22, Frederick and Grow (1996) found that eating disorders was associated with both lower levels of self-esteem and autonomy when compared to a non-bulimic sample. More specifically, their study found that underlying deficits in autonomy were associated with reduced self-esteem, which in turn, was related to eating disordered attitudes and behaviours. The relationship between eating disorders and empathy is supported by Geist (1989), who on the basis of individual long-term psychotherapy with 20 eating disordered patients, found a lower level of empathy among eating disordered individuals. Grisset and Norvell’s (1992) study supported the claim that eating disordered individuals have a lower quality of interpersonal relationships than members of the general public. This was based on completed self-report measures with 21 bulimics and 21 controls assessing perceived social support, the quality of relationships, social skills, and psychopathology. Bulimics reported less perceived support from family and friends, more negative interactions and conflict, and less social competence. In addition, bulimics were rated as less socially effective by observers not aware of their group membership. With a sample of 50 female adult patients, Mitchell, Soll, Eckert, and Pyle (1989) using the Eating Disorders Questionnaire (Mitchel et. al, 1985) also concluded that eating disordered individuals have compromised interpersonal relationships. Their study indicated that between the years 1981 and 1987 a greater percentage of eating disordered individuals reported impaired interpersonal relationships, increasing from 72% in 1981 to 96% in 1987. Although they were unable to offer a clear reason for this increase, they speculated that the increase was possibly the result of attracting an increasing number of patients who did not have insurance coverage. The patients came to their facility because they were able to offer either reduced fees or free treatment for participation in research. Favazza, DeRosear, and
Conterio (1989), through the use of literature reviews, patient interviews, and case reports concluded that there was a significant relationship between eating disorders and impulse control. More specifically, the lower level of impulse control found in eating disordered individuals was demonstrated through their self-mutilating behaviour. This finding was further supported by Lacey and Evans (1986) who, on the bases of literature reviews, also concluded that individuals with an eating disorder had greater difficulty controlling their impulses. According to their review, eating disordered individuals are more likely to abuse alcohol, use ‘street drugs’, steal, and display suicidal acts than control groups. On the basis of clinical experience with 33 eating disordered women between the ages of 16 and 34 years, Riebel (1985) concluded that they had significantly lower levels of happiness and a limit on their self-actualization abilities. Although most were attractive, intelligent, had good verbal skills, and demonstrated admirable school or work performance, behind this façade, however, they had a devastating lack of self-esteem and a desperate attempt to prove themselves as acceptable. A study by Soukup, Beiler, and Terrell confirmed their belief that 33 eating disordered inpatients were less able to solve problems when compared to their non-eating disordered counterparts. Williams, Power, Millar, and Freeman (1993) demonstrated that a sample of 30 eating disordered individuals had a lower level of assertiveness when compared to 35 normal controls. Katzman, Weiss, and Wolchick (1986), in developing a therapy program that helps bulimics overcome many of the common characteristics associated with an eating disorder, also found that bulimics display a lower level of assertiveness when compared to their non-eating disordered controls. McCane’s (1985) study also found a lower level of assertiveness among untreated eating disordered patients when compared to a group of patients undergoing therapy and a control group. Finally, Kalodner and Scarano (1992) in reviewing the literature on the continuum
of non-clinical eating disorders, found a lower level of self-awareness among individuals with an eating disorder when compared to normal eaters.

Although no research could be found between individuals with bulimia and/or anorexia and how they would score on measures of social responsibility, stress tolerance, and optimism, they would likely score lower than their non-eating disordered counterparts. Eating disordered individuals are too preoccupied with their eating pathology to be socially responsible citizens, to have the ability to tolerate stress, and to have any hope or optimism.

The Eating Disorder Continuum and Emotional Intelligence

In spite of the fact that there have been numerous studies that have measured the relationships between full syndrome eating disorders and most of the variables found on the EQ-i, there is a lack of research with these variables and eating pathology in general. However, having this information could have significant implications for prevention and treatment. For example, if it is known that individuals with an eating pathology are lacking in assertiveness, self-regard, and impulse control then these deficiencies can be addressed in therapy. Furthermore, having a greater understanding of the factors that individuals with an eating pathology lack when compared to non-eating disturbed individuals can better direct educators towards focusing on these factors for the purpose of prevention.

The purpose of the present study is to determine the relations between eating pathology and the variables that collectively make up the emotional intelligence inventory for the purposes of both treatment and prevention. This study is particularly important because it is the first study that attempts to discriminate how individuals with increasing levels of eating pathology differ on emotional intelligence. Knowing how they differ can
have profound implications for both treatment and prevention. For example, if the present study reveals a positive relationship between eating pathology and assertiveness, self-regard, and impulse control, then these deficiencies can be focused on in therapy. Furthermore, this knowledge can better direct educators towards focusing on these factors for the purpose of prevention.

Eating pathology is going to be studied instead of full syndrome eating disorders in this study for four main reasons. First, individuals who are exhibiting an eating pathology are experiencing a great deal of distress (Shisslack et al., 1995) and any information that could help both the treatment of prevention of this eating disturbance would be of significant value. Second, individuals with an eating pathology often degenerate to experience a full syndrome eating disorder without intervention (Shisslack et al.). Third, although much information is already known about the relationship between full syndrome eating disorders and many of the variables in the EQ-i, there is limited research on eating pathology and these same variables. Finally, such a sample will be easier to obtain in an undergraduate university population given the time constraints associated with a master's thesis.

Hypothesis

The purpose of the present study is to determine the relations between eating pathology and emotional intelligence. It is hypothesized that individuals with greater levels of eating pathology will score lower on each of the 15 subscales that make up the emotional intelligence inventory.
METHOD

Participants

101 female subjects participated on a voluntary basis. All subjects were recruited from a participant pool and were undergraduate psychology students at the University of Windsor. Subjects were offered 1 bonus point to participate in the study. The average age of the subject pool was 20 years.

Materials

The Bulimia Test – Revised and the Eating Attitudes Test - 26 were used to measure eating pathology. The EQ-i was used as a measure of emotional intelligence. An additional cover page (see Appendix A) was used to gather information on each subject’s age, weight, height, ethnicity, socio-economic status, whether the individual ever received treatment for bulimia or another eating disorder, and if they have ever been diagnosed with bulimia or another eating disorder. These variables can also provide useful information towards getting a comprehensive understanding of the relationship between eating pathology and emotional intelligence.

The Bulimia Test – Revised (BULIT-R)

The BULIT-R is a self-report inventory containing 36 multiple-choice questions that assess binge eating and purging. The BULIT-R was designed as a revision to the original instrument, the Bulimia Test (BULIT; Smith & Thelen, 1984). This revision was made to accommodate the changes made to the criteria for bulimia in the DSM-III-R. The correspondence between the two scales is very high. The correlation between the original BULIT and the BULIT-R is .99 (Thelen et al., 1991). The BULIT-R was also designed to identify bulimic individuals in clinical and non-clinical samples. A study by Thelen, Mintz, and Vander Wal (1996) confirmed that the BULIT-R is just as valid for determining
bulimia nervosa using DSM-IV criteria as it was using DSM-III-R criteria. This is due to the fact that the criteria changes from the DSM-III-R to the DSM-IV were sufficiently small that they have no effect on the validity of the BULIT-R (Thelen, et al., 1996).

Of the 36 questions on the BULIT-R, eight are filler items and are not included when computing the total bulimia score. Examples of items used in computing the bulimia score include, “There are times when I rapidly eat a very large amount of food” and “How often do you intentionally vomit after eating?” The responses are specific to the question content and are rated on a five point Likert scale from 5, indicating extreme bulimic symptomology, to 1 which indicates the absence of the behaviour or attitude. There is one overall score derived from the responses on the items. The possible scores range from 28 to 140, with the higher scores indicating more severe eating disordered behaviours. In a study comparing university control women with bulimic women on the BULIT-R, their mean scores were respectively, 119.26 and 53.31 (Thelen et al., 1996). Thelen et al. suggest that for research purposes, and to reduce the number of false negatives, a cutoff score of 85 should be used. Anyone scoring above 85 would be considered to have partial syndrome bulimia nervosa.

The BULIT-R has been demonstrated to discriminate women diagnosed with bulimia from female university students (Thelen et al., 1996). It is also a reliable and valid predictor of bulimia in a non-clinical sample. Its test-retest reliability was .95 over a two month period and it correlated highly with other measures of bulimia (Thelen et al., 1991). In a study of its psychometric properties, the BULIT-R demonstrated good internal consistency, with a coefficient alpha of .92 (Brethsford, Hummel, & Burrios, 1992). Its construct validity was further supported by its high correlation with a measure of self-monitored frequency of binge eating and purging (Brethsford et al., 1992). The BULIT-R
was chosen for the present study because it represents a reliable, valid, and efficient means of assessing partial syndrome bulimia nervosa (Thelen et al., 1996).

**Eating Attitudes Test -26 (EAT-26)**

The EAT-26 (Garner, Olmsted, Bohr, & Garfinkel, 1982) is one of the most popular self-report eating disturbance inventories in clinical and research settings (Raciti & Norcross, 1987; Garner, 1995). The EAT-26 (see Appendix D) is a global measure of eating disorder symptoms and represents an abbreviated form of the original 40-item version (Garner & Garfinkel, 1979). Factor analysis of the 40-item EAT indicated that items loaded on three factors labeled ‘dieting’, ‘bulimia and food preoccupation’, and ‘oral control’. The 14 items which did not load on these three factors were eliminated and Garner et al. (1982) found that the resulting 26-item scale correlated highly with the original scale (r = 0.98).

When completing the inventory, participants are requested to indicate how frequently they experience each of the EAT-26 items on a scale ranging from 1 (Always) to 6 (Never). Items are scored using the following procedure described by Garner and Garfinkel (1979): 1 = 2, 2 = 2, 3 = 1, 4, 5, and 6 = 0. Item 25 is reverse scored as follows: 6 = 3, 5 = 2, 4 = 1, and 3, 2, and 1 = 0. A total score is the sum of the item values. Examples of items include “Have gone on eating binges where I feel that I may not be able to stop” and “Vomit after I have eaten”.

The EAT-26 has been used both as a continuous and a categorical measure of eating pathology. Garner et al. (1982) and Dancyger and Garfinkel (1995) recommended a cut-off score of 20 based on their findings that the EAT-26 significantly predicted group membership using this criterion. In the present study, participants scoring at or above 20
were judged to fall within the partial syndrome range, and those below the cut-off were judge to score within non-significant range.

The authors of the EAT-26 report that the scale has demonstrated excellent internal consistency with an alpha of 0.90. Their results also provide preliminary support for the convergent and divergent validity of the EAT-26. Specifically, Garner et al. (1982) report that the total EAT-26 scores tend to correlate significantly with measures of similar constructs and tend to be unrelated to scores on measures assessing symptoms characteristic of other disorders (e.g. anxiety, obsessionality). The EAT-26 was chosen for the present study because it represents a reliable, valid, and efficient means of assessing partial syndrome bulimia nervosa (Dancyger & Garfinkel, 1995).

**Bar-On Emotional Quotient Inventory (EQ-i)**

Based on 17 years of research and tested on over 14,000 individuals worldwide, the Emotional Quotient Inventory (EQ-i) is the first scientifically developed and validated measure of emotional intelligence. It is composed of 133 brief items and employs a five-point response format ranging from “Not True of Me” to “True of Me”. It is in a self-report format and can be administered without supervision and with minimal training. It takes approximately 30 to 40 minutes to complete. The reading level has been assessed at the North American sixth grade level. The EQ-i is suitable for individuals 17 years of age and older and renders a total EQ score and five EQ composite scale scores based on 15 subscale scores described below (Bar-On, 1997a).

**EQ-i Subscales**

**Intrapersonal Components**

Emotional Self-Awareness (ES): The ability to recognize and understand one’s feelings.
Assertiveness (AS): The ability to express feelings, beliefs, and thoughts and defend one’s rights in a nondestructive manner.

Self-Regard (SR): The ability to be aware of, understand, accept, and respect oneself.

Self-Actualization (SA): The ability to realize one’s potential capacities.

Independence (IN): The ability to be self-directed and self-controlled in one’s thinking and actions and to be free of emotional dependency.

Interpersonal Components

Empathy (EM): The ability to be aware of, to understand, and to appreciate the feelings of others.

Social Responsibility (RE): The ability to demonstrate oneself as a cooperative, contributing, and conservative member of one’s social group.

Interpersonal Relationship (IR): The ability to establish and maintain mutually satisfying relationships that are characterized by emotional closeness, intimacy, and by giving and receiving affection.

Adaptability Components:

Reality Testing (RT): The ability to assess the correspondence between what is emotionally experienced and what objectively exists.

Flexibility (FL): The ability to adjust one’s emotions, thoughts, and behaviour to changing situations and conditions.

Problem Solving (PS): The ability to identify and define problems as well as to generate and implement potentially effective solutions.

Stress Management Components:

Stress Tolerance (ST): The ability to withstand adverse events, stressful situations, and strong emotions without “falling apart” by actively and passively coping with stress.
Impulse Control (IC): The ability to resist or delay an impulse, drive, or temptation to act, and to control one’s emotions.

General Mood Components:

Optimism (OP): The ability to look at the brighter side of life and to maintain a positive attitude, even in the face of adversity and negative feelings.

Happiness (HA): The ability to feel satisfied with one’s life, to enjoy oneself and others, and to have fun and express positive feelings.

Bar-On’s research strategy involved four major stages: (1) logically clustering various variables and identifying underlying key factors purported to determine effective and successful functioning as well as positive emotional health (based on the author’s experience as a clinical psychologist and review of the mental health literature); (2) operationally defining these factors; (3) constructing an inventory designed to examine these factors; and (4) interpreting the results and their implications for this approach based on examining the reliability and validity of the inventory.

Raw scores on the EQ-i are tabulated and converted into standard scores with a mean of 100 and a standard deviation of 15. Average to above average scores on the EQ-i indicate an emotionally healthy, well-functioning, and potentially successful individual. The higher the score, the more positive the prediction for general success in meeting environmental demands and pressures. Conversely, an inability to succeed in life and the possible existence of emotional problems are suggested by low scores on this inventory (Bar-On, 1997a). Examples of items include “I am unable to express my ideas to others”, and “When facing a problem, the first thing I do is stop and think”.

The EQ-i also provides the following four validity indicators: (1) omission rate (considers the number of unanswered questions), (2) inconsistency index (considers
alternative responses to similar questions), (3) positive impression (answering questions in an unrealistically positive manner), and (4) negative impression (answering questions in an unrealistically negative manner). The inventory also has a build-in correction factor which automatically adjusts the scale and subscale scores based on the scores obtained on the positive and negative impression indicators (Bar-On, 1997a).

The author of the EQ-i reports that the scale has demonstrated very good internal consistency with an average Cronbach alpha coefficient of 0.76. This finding indicates that the items contributing to the scoring of each factor correlate highly together to measure what the factor is measuring. Research also indicates that specific portions of the EQ-i also correlate significantly with measures of similar constructs demonstrating convergent validity. Conversely, the EQ-i is virtually unrelated to measures of cognitive intelligence correlating non-significantly with the Wechsler Adult Intelligence Scale (r=0.12) demonstrating divergent validity. The EQ-i was chosen for the present study because it represent a reliable, valid, and efficient means of assessing emotional intelligence.

Procedure

All subjects met at an arranged location and completed the EAT-26, the BULIT-R, and the EQ-i. When all data was collected the results were analyzed using a Pearson’s Product Moment Correlation in SPSS. Upon completing the questionnaires all subjects were debriefed.

Data Analysis

Using SPSS a correlation matrix was performed in order to determine the relations between eating pathology and each of the 15 subscales that make up the Emotional Intelligence Inventory (i.e., emotional self-awareness, assertiveness, self-regard, self-
actualization, independence, empathy, social responsibility, interpersonal relationship, reality testing, flexibility, problem solving, stress, tolerance, impulse control, optimism, and happiness).
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RESULTS

The ranges, means, and standards deviations for all of the subject descriptive information and for all of the measures are shown in Table 1. Also included are the internal reliability Cronbach alpha coefficients for the measures. 79.2% of participants were Caucasian, 10.9% were Asian, 3% were African-Canadian, and 6.9% either did not disclose their ethnic background or were in the “other” category. Of all participants (N=101) three had received prior treatment for an eating disorder. None of the participants met the diagnostic criteria for a full syndrome eating disorder.

Relations between scores on the EAT-26, BULIT-R, and full-scale EQ-i

The results support the stated hypothesis and suggest that there is a negative relation between eating pathology and emotional intelligence. More specifically, there was a moderate relation between individuals’ scores on the EQ-i and the BULIT-R: \( r = -0.41, p < 0.01 \), and a somewhat smaller relation between the EQ-i and the EAT-26: \( r = -0.26, p < 0.01 \). Analysis also reveals a strong positive relation between individuals’ scores on the BULIT-R and the EAT-26: \( r = 0.77, p < 0.01 \). See Table 2.

Relations between scores on the EAT-26, BULIT-R, and core EQ-i subscales

Among the five core EQ-i subscales, all were negatively correlated with the BULIT-R and the EAT-26. The greatest relations occurred between the “intrapersonal” subscale of the EQ-i and the BULIT-R: \( r = -0.43, p < 0.01 \), the “adaptability” subscale of the EQ-i and the BULIT-R: \( r = -0.39, p < 0.01 \), and the “general mood” subscale of the EQ-i and the BULIT-R: \( r = -0.34, p < 0.01 \). See Table 3.
Relations between scores on the EAT-26, BULIT-R, and specific EQ-i subscales

Among the 15 specific EQ-i subscales (these are the subscales that make up the five core subscales), all were negatively correlated with the BULIT-R and the EAT-26 with the exception of the "empathy" subscale which was insignificantly correlated with either the BULIT-R or the EAT-26: \( r = -.04 \) and \( r = .01 \), and the "problem solving" subscale which was unrelated to the EAT-26: \( r = .00 \). With the exception of these two subscales the stated hypotheses were confirmed. The greatest relations occurred between the "self regard" subscale of the EQ-i and BULIT-R and the EAT-26: \( r = -.52, p<.01 \) and \( r = -.41, p<.01 \). Table 4 reveals the relations between the 15 EQ-i specific subscales and the BULIT-R and EAT-26.

Comparisons between participants whose scores met or exceeded 20 on the EAT-26 and 85 on the BULIT-R with the remainder of the participant pool

Previous research has indicated that individuals who meet or exceed scores of 20 on the EAT-26 and 85 on the BULIT-R are significantly more likely to meet the criteria for a clinical eating disorder (Smith & Thelen, 1984; Garner et al., 1982). In the present study, five participants met this criteria. Although none of them could be diagnosed as either being clinically bulimic or anorexic, a comparison between these five participants and the remainder of the participant pool yields interesting results. In addition to having significantly higher means on the BULIT-R (100.2 vs. 49.82) and the EAT-26 (30.8 vs. 8.99), these selected participants had a significantly lower overall emotional intelligence score (81 vs. 91.74), and scored lower on all of the major emotional intelligence subscales than participants who scored below the 20 and 85 cutoff scores. See table 5.
Comparisons between participants whose combined family income was either in the highest or lowest category on the global EQ-i score

An analysis was conducted in order to determine if individuals who were at either extreme of the income continuum differed in their overall emotional intelligence scores. 19 participants reported combined family incomes in the highest range (above $100,000), while seven participants reported combined family incomes in the lowest range (below $30,000). An equivalency test was conducted and the results indicated that there is not enough evidence to support that the high and low income earners differed significantly in their level of emotional intelligence: minimum $z = -.01$, traditional $z = -1.22$. 
Table 1

Ranges, Means, and Standard Deviations of Age, Weight, Height, Income, Education, and all of the Measures (N=101), and Reliability Alpha Coefficients of the Measures

<table>
<thead>
<tr>
<th>Variable</th>
<th>Range</th>
<th>Mean</th>
<th>Standard Deviation</th>
<th>Internal Reliability (Cronbach alpha)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age</td>
<td>18 – 29</td>
<td>19.97</td>
<td>1.65</td>
<td></td>
</tr>
<tr>
<td>Weight¹</td>
<td>100 – 295</td>
<td>136.95</td>
<td>28.95</td>
<td></td>
</tr>
<tr>
<td>Height²</td>
<td>60 – 73</td>
<td>65.74</td>
<td>2.74</td>
<td></td>
</tr>
<tr>
<td>Income³</td>
<td>$30 – 100+</td>
<td>$67,250</td>
<td>$18,200</td>
<td></td>
</tr>
<tr>
<td>Education⁴</td>
<td>1 – 6</td>
<td>1.71</td>
<td>1.00</td>
<td></td>
</tr>
<tr>
<td>Eating Attitudes</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Test – 26</td>
<td>0 - 43</td>
<td>8.99</td>
<td>8.56</td>
<td>.85</td>
</tr>
<tr>
<td>The Bulimia</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Test – Revised</td>
<td>29 - 105</td>
<td>49.82</td>
<td>18.33</td>
<td>.94</td>
</tr>
<tr>
<td>The Emotional</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Intelligence</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Inventory</td>
<td>59 - 127</td>
<td>91.74</td>
<td>17.05</td>
<td>.93</td>
</tr>
</tbody>
</table>

¹ Weight is expressed in pounds  
² Height is expressed in inches  
³ Income is expressed in thousands and represents combined family income  
⁴ Expressed as the number of years in university
Table 2

Relations Between The Emotional Intelligence Inventory, The Bulimia Test-Revised, and The Eating Attitudes Test – 26 (N = 101, p<.01)

<table>
<thead>
<tr>
<th></th>
<th>EAT-26(^1)</th>
<th>BULIT-R(^2)</th>
<th>EQ-i(^3)</th>
</tr>
</thead>
<tbody>
<tr>
<td>EAT-26</td>
<td>---</td>
<td>.77</td>
<td>-.26</td>
</tr>
<tr>
<td>BULIT-R</td>
<td>.77</td>
<td>---</td>
<td>-.41</td>
</tr>
<tr>
<td>EQ-i</td>
<td>-.26</td>
<td>-.41</td>
<td>---</td>
</tr>
</tbody>
</table>

\(^1\) Eating Attitudes Test – 26  
\(^2\) The Bulimia Test – Revised  
\(^3\) Emotional Intelligence Inventory
Table 3

Relations Between Emotional Intelligence Core Subscale Scores, The Bulimia Test – Revised and the Eating Attitudes Test – 26 (N = 101, p<.01)

<table>
<thead>
<tr>
<th></th>
<th>BULIT-R¹</th>
<th>EAT-26²</th>
</tr>
</thead>
<tbody>
<tr>
<td>Intrapersonal Subscale</td>
<td>-.28</td>
<td>-.43</td>
</tr>
<tr>
<td>Interpersonal Subscale</td>
<td>-.14</td>
<td>-.21</td>
</tr>
<tr>
<td>Stress Management Subscale</td>
<td>-.20</td>
<td>-.32</td>
</tr>
<tr>
<td>Adaptability Subscale</td>
<td>-.24</td>
<td>-.39</td>
</tr>
<tr>
<td>General Mood Subscale</td>
<td>-.26</td>
<td>-.34</td>
</tr>
</tbody>
</table>

¹ The Bulimia Test – Revised
² Eating Attitudes Test - 26
Table 4

Relations Between The 15 Specific Emotional Intelligence Subscale Scores, The Bulimia Test – Revised and The Eating Attitudes Test – 26 (N = 101)

<table>
<thead>
<tr>
<th></th>
<th>BULIT-R(^1)</th>
<th>EAT-26(^2)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Emotional Self-Awareness</td>
<td>-.19(^*)</td>
<td>-.34(^**)</td>
</tr>
<tr>
<td>Assertiveness</td>
<td>-.20(^*)</td>
<td>-.32(^**)</td>
</tr>
<tr>
<td>Self-Regard</td>
<td>-.41(^**)</td>
<td>-.52(^**)</td>
</tr>
<tr>
<td>Self-Actualization</td>
<td>-.11</td>
<td>-.21(^*)</td>
</tr>
<tr>
<td>Independence</td>
<td>-.10</td>
<td>-.27(^**)</td>
</tr>
<tr>
<td>Interpersonal Relationships</td>
<td>-.17(^*)</td>
<td>-.20(^*)</td>
</tr>
<tr>
<td>Social Responsibility</td>
<td>-.12</td>
<td>-.21(^*)</td>
</tr>
<tr>
<td>Empathy</td>
<td>-.01</td>
<td>-.04</td>
</tr>
<tr>
<td>Problem Solving</td>
<td>.00</td>
<td>-.13</td>
</tr>
<tr>
<td>Reality Testing</td>
<td>-.29(^**)</td>
<td>-.37(^**)</td>
</tr>
<tr>
<td>Flexibility</td>
<td>-.17(^*)</td>
<td>-.25(^**)</td>
</tr>
<tr>
<td>Stress Tolerance</td>
<td>-.24(^**)</td>
<td>-.35(^**)</td>
</tr>
<tr>
<td>Impulse Control</td>
<td>-.15</td>
<td>-.28(^**)</td>
</tr>
<tr>
<td>Happiness</td>
<td>-.25(^**)</td>
<td>-.32(^**)</td>
</tr>
<tr>
<td>Optimism</td>
<td>-.22(^*)</td>
<td>-.29(^**)</td>
</tr>
</tbody>
</table>

\(^1\) The Bulimia Test – Revised  
\(^2\) Eating Attitudes Test - Revised  
\(^*\)Correlation is significant at the .05 level  
\(^**\)Correlation is significant at the .01 level
Table 5

A Comparison of Means and Standard Deviations of Participants Meeting or Exceeding Scores of 20 on the EAT-26\(^1\) and 85 on the BULIT-R\(^2\) with the Remainder of the Participant Pool.

<table>
<thead>
<tr>
<th>Variable</th>
<th>Group 1(^3)</th>
<th>Group 2(^4)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>N=5</td>
<td>N=96</td>
</tr>
<tr>
<td>EAT-26</td>
<td>M=30.8</td>
<td>M=8.99</td>
</tr>
<tr>
<td></td>
<td>SD=8.90</td>
<td>SD=8.56</td>
</tr>
<tr>
<td>BULIT-R</td>
<td>M=100.3</td>
<td>M=49.82</td>
</tr>
<tr>
<td></td>
<td>SD=4.44</td>
<td>SD=18.33</td>
</tr>
<tr>
<td>EQ-i(^5)</td>
<td>M=81</td>
<td>M=91.74</td>
</tr>
<tr>
<td></td>
<td>SD=16.26</td>
<td>SD=17.05</td>
</tr>
<tr>
<td>Intrapersonal</td>
<td>M=80.2</td>
<td>M=93.28</td>
</tr>
<tr>
<td>Subscale</td>
<td>SD=15.43</td>
<td>SD=17.86</td>
</tr>
<tr>
<td>Interpersonal</td>
<td>M=94.6</td>
<td>M=96.75</td>
</tr>
<tr>
<td>Subscale</td>
<td>SD=17.08</td>
<td>SD=15.72</td>
</tr>
<tr>
<td>Stress</td>
<td>M=82.8</td>
<td>M=91.17</td>
</tr>
<tr>
<td>Management</td>
<td>SD=13.92</td>
<td>SD=16.71</td>
</tr>
<tr>
<td>Subscale</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Adaptability</td>
<td>M=85.8</td>
<td>M=93.71</td>
</tr>
<tr>
<td>Subscale</td>
<td>SD=11.48</td>
<td>SD=14.86</td>
</tr>
<tr>
<td>General</td>
<td>M=83.2</td>
<td>M=91.62</td>
</tr>
<tr>
<td>Mood Subscale</td>
<td>SD=18.67</td>
<td>SD=17.10</td>
</tr>
</tbody>
</table>

\(^1\) Eating Attitudes Test – 26  
\(^2\) The Bulimia Test – Revised  
\(^3\) Group 1 includes those participants whose scores met or exceeded 20 on the EAT-26 and 85 on the Bulit-R  
\(^4\) Group 2 includes the entire participant pool  
\(^5\) Participants global scores on the EQ-i
DISCUSSION

Relations between eating pathology and emotional intelligence

It was hypothesized that there would be a negative relation between eating pathology and emotional intelligence. The current results support this hypothesis on three levels. First, eating pathology was negatively related to individual’s global emotional intelligence score. Second, eating pathology was negatively related to individuals’ scores on all five core emotional intelligence subscales. Third, among the 15 specific EQ-i subscales (these are the subscales that makeup the five core subscales), all were negatively correlated to eating pathology with the exception of the “empathy” subscale and the “problem solving” subscale, which were both unrelated to eating pathology.

Although it is not possible to infer a causal relation between any particular emotional intelligence subscale and eating pathology, a closer examination of the stronger relations can serve a number of benefits. Among the five core EQ-i subscales, all were moderately related to eating pathology with the exception of the “interpersonal” subscale which was related only in a minor way. Among the 15 specific EQ-i subscales, the strongest relations occurred between eating pathology and self regard, assertiveness, happiness, emotional self-awareness, and reality testing.

Nevertheless, the reader should be cognizant of the fact that the statistical analyses that were conducted do not allow one to conclude that deficits in one’s emotional intelligence necessarily contributes to an eating pathology. It is entirely possible that an eating pathology contributes to a deficit in emotional intelligence. Despite this shortcoming, past research has demonstrated that deficits in the qualities that make up emotional intelligence do in fact contribute to an eating pathology. However, the reader is
encouraged to be aware that the results from this study alone do not lend credence to this conclusion.

Implications for treatment

Given the negative implications an eating pathology can have on the quality of one's life, health care professionals are continuously trying to achieve a greater understanding of it. By acquiring a greater understanding, health care professionals would put themselves in a better position to treat it, to prevent it, and to be able to identify various risk factors that may eventually culminate in an eating pathology or a clinical eating disorder. Past researchers and clinicians have argued that an eating pathology is a symptom of another underlying problem. As such, in order to treat the eating pathology, it is essential to treat this underlying pathology, or the root of the problem, in order to manage the problematic eating behaviours. By treating the root of the problem, the eating pathology would disappear. Conversely, failing to treat the root of the problem and focusing on the problematic eating, would result in something that is commonly referred to as symptom substitution, or the emergence of another symptom in place of an eating pathology. Although the eating pathology may disappear another symptom will appear because the root of the problem has not been properly dealt with.

In order to deal with the root of the problem it is important understand which variables are most related to the eating pathology. According to the results of this present research, along with the support of previous research, it can be hypothesized that individuals with an eating pathology are lacking in self-regard, assertiveness, emotional self-awareness, reality testing, and happiness. As such, therapists must focus on these factors in order manage the eating pathology. It can be argued that main difference
between individuals with an eating pathology and individuals without, is their sense of self, their ability to assert themselves, their level of emotional awareness, their ability to test reality, and their overall level of happiness. By alleviating these deficiencies through therapy the eating pathology will dissipate. As such, therapists must work with their clients to build on these qualities.

It is important to recognize that the above discussion was based on common themes that were found in the research. Furthermore, they are also likely to be true for the population at large. However, not every individual suffering from an eating pathology is going to fit this exact mold. In fact, it is more likely that individual differences will exist. As such, therapists should always do individualized assessments prior to the commencement of any treatment or therapy and use this information as a guide and make the necessary modifications prior to treating any particular individual.

There are a number of ways therapists can work with their clients in order to improve upon these deficits. Techniques and procedures would vary depending on the school of thought the therapist subscribes to. For example, in order to improve a clients self-esteem a cognitive-behavioural therapist might focus on helping their client understand their irrational self-loathing thoughts and challenge them through real life examples the client has brought up in previous therapy sessions. Such a therapist might also bring to his/her clients attention that their self-esteem is too highly based on their body shape and weight and work with them to try and encourage them to consider other personal qualities and accomplishments when making evaluations of themselves. Through a supportive environment and increased self-awareness, a hard working client can make
lasting changes to their self-concept, the benefits of which could contribute to a decreased level of eating pathology.

**Implications for prevention**

In addition to the treatment implications this research has, educators could make use this information when designing eating disorder prevention programs. Knowing exactly what deficits are likely to exist in individuals who have an eating pathology, educators could work with children and adolescents by focusing on these qualities. Given the significant deficits in assertiveness, self-regard, emotional self-awareness, adaptability, and happiness in individuals with an eating pathology, prevention programs could work to teach children and adolescents how to be assertive, how to recognize their own emotions and how they impact on their thoughts, feelings, and behaviours, and attempt to bridge the relations between one’s self-regard and their personal accomplishments such as school performance, sports, and friendships, instead of tying one’s self-regard solely to their appearance. Because eating disorders are commonly conceptualized as a symptom of another underlying problem, focusing on the root of the problem will relinquish any need for an individual to resort to an eating pathology to achieve their desired goals. Instead, the healthy individual can focus their energies on more adaptive thoughts and behaviours, that will enable them to live a life that is free from an eating pathology and instead, channel their energies towards productive means. By attempting to improve on these aforementioned qualities, the child or adolescent will not only be increasing her chance of preventing the development of an eating pathology, but it is also enabling her to be stronger and more resilient to other forms of psychopathology.
Implications for identifying risk factors

In addition to treatment and prevention, health care professionals are beginning to recognize the importance of identifying early signs or risk factors for the development of an eating pathology or clinical eating disorder. By identifying the qualities that are associated with the development of an eating pathology enables practitioners to deal with the potential problem before it exacerbates. Furthermore, because clinical eating disorders are more resistant to treatment than are less severe forms of eating pathology, by identifying those individuals who may be at risk, health care professions are in a better position to manage the potential problem prior to it getting worse. In effect, by identifying those individuals who are at risk and intervening at that point, practitioners are in a much better position to lead the afflicted individual towards a productive life that is free from an eating pathology.

Implications for the group of participants whose scores met or exceeded 20 on the EAT-26 and 85 on the BULIT-R

As mentioned previously, five members of the participant pool obtained scores of at least 20 on the EAT-26 and 85 on the BULIT-R. Previous research has suggested that individuals meeting these cutoff scores are significantly more likely to meet the diagnostic criteria for a clinical eating disorder as stated in the DSM-IV. Although none of these participants met the diagnosis for a clinical eating disorder their elevated scores on the EAT-26 and the BULIT-R was also consistent with a lower global emotional intelligence score and lower scores on each of the five core emotional intelligence subscales. This finding not only validates the idea that individuals with lower scores on the EQ-i are more likely to exhibit greater eating pathology, but also supports the notion that if proper
intervention had taken place earlier and the roots of their problems dealt with, they would have had a lower level of eating pathology or no eating pathology at all at the time of this study.

Limitations of the present study

There are several limitations to the present study. Undergraduate women may have specific and unique characteristics that differentiate them from other groups of women, and therefore, may not necessarily be representative of the population at large. The majority of participants were in their first or second year of university, and their responses to the questionnaires could have been partially influenced by the challenges and stressors that are associated with moving away from home and adapting to university life. Future research might test similar hypotheses in a slightly older sample.

Another limitation of the current study pertains to the correlational nature of the design. Correlational research does not allow one to infer causal relations between variables because it is difficult to tease out which variable is influencing which. For instance, it is entirely possible that a higher family income is responsible for a higher level of emotional intelligence rather than the absence of an eating pathology. Ideally, future research should examine these variables longitudinally, in an effort to answer causality questions with respect to these relationships. Longitudinal research would also serve a number of additional purposes. First, it would aid in identifying risk factors for eating disorders over time and in different age groups. This would allow for the isolation of risk factors for eating disorders before they culminate in full syndrome disorders which are more intractable to treatment than less severe eating problems. Furthermore, focusing on the whole spectrum of eating pathology would provide a fuller understanding of the natural
history of eating disorders and make it clear to identify etiological factors before they become obscured by secondary physical and psychological symptoms associated with full syndrome disorders. Second, prospective longitudinal studies would help determine which females are more vulnerable to eating disorders by identifying more rigorously the personality factors that are commonly associated with its occurrence. Finally, longitudinal studies can also help identify protective factors by exposing which personality and situational qualities are consistent with healthy eating behaviours.

Future research should also include males. Do males experience eating disturbances for the same reasons as women? What are the risk factors for males? What are the protective factors? Longitudinal studies that consider the entire spectrum of eating disturbances would help answer these questions.
REFERENCES


APPENDIX A

Background Information

Please provide answers to the following questions:

Age ______ years

How much do you weigh in pounds? ______ or kilograms? ______

What is your height in feet and inches (e.g., 5'2) ______ or in centimeters ______

What is your highest level of education completed?
High School
1st year university
2nd year university
3rd year university
Other (please specify) ______

What is your ethnic background?
Caucasian
African-Canadian
Asian
Native-Canadian
Other (please specify) ______

What is your family’s combined yearly income?
Under $30,000
$30,000-$44,999
$45,000-$59,999
$60,000-$64,999
$65,000-$79,999
$80,000-$100,000
Over $100,000

Have you ever received treatment for an eating disorder?
Yes
No
If you did receive treatment, how long were you in treatment? ________

Where did you receive treatment? ________________________________

What type of eating disorder did you have? ________ Were you diagnosed? ________

Who were you diagnosed by? __________________________ (e.g., psychologist, psychiatrist)
APPENDIX B

The Bulimia Test - Revised

Answer each question by circling the appropriate number. Please respond to each item as honestly as possible; remember, all the information you provide will be kept strictly confidential.

1. I am satisfied with my eating patterns.
   1. Agree
   2. Neutral
   3. Disagree a little
   4. Disagree
   5. Disagree strongly

2. Would you presently call yourself a “binge eater”?
   1. Yes, absolutely
   2. Yes
   3. Yes, probably
   4. Yes, possibly
   5. No, probably not

3. Do you feel you have control over the amount of food you consume?
   1. Most of the time
   2. A lot of the time
   3. Occasionally
   4. Rarely
   5. Never

4. I am satisfied with the shape and size of my body.
   1. Frequently or always
   2. Sometimes
   3. Occasionally
   4. Rarely
   5. Seldom or never

5. When I feel that my eating behaviour is out of control, I try to take rather extreme measures to get back on course (strict dieting, fasting, laxatives, diuretics, self-induced vomiting, or rigorous exercise).
   1. Always
   2. Almost always
   3. Frequently
   4. Sometimes
   5. Never or my eating behaviour is never out of control
6. I use laxatives or suppositories to help control my weight.
   1. Once a day or more
   2. 3-6 times a week
   3. Once or twice a week
   4. 2-3 times a month
   5. Once a month or less (or never)

7. I am obsessed about the size and shape of my body.
   1. Always
   2. Almost always
   3. Frequently
   4. Sometimes
   5. Seldom or never

8. There are times when I rapidly eat very large amount of food.
   1. More than twice a week
   2. Twice a week
   3. Once a week
   4. 2-3 times a month
   5. Once a month or less (or never)

9. How long have you been binge eating (eating uncontrollably to the point of stuffing yourself)?
   1. Not applicable; I don’t binge eat
   2. Less than 3 months
   3. 3 months to 1 year
   4. 1-3 years
   5. 3 or more years

10. Most people I know would be amazed if they knew how much food I can eat at one sitting.
    1. Without a doubt
    2. Very probably
    3. Probably
    4. Possibly
    5. No

11. I exercise in order to burn calories.
    1. More than 2 hours per day
    2. About 2 hours per day
    3. More than 1 but less than 2 hours per day
    4. Once hour or less per day
    5. I exercise but not to burn calories or I don’t exercise
12. Compared with women your age, how preoccupied are you about your weight and body shape?
   1. A great deal more than average
   2. Much more than average
   3. More than average
   4. A little more than average
   5. Average or less than average

13. I am afraid to eat anything for fear that I won’t be able to stop.
   1. Always
   2. Almost always
   3. Frequently
   4. Sometimes
   5. Seldom or never

14. I feel tormented by the idea that I am fat or might gain weight.
   1. Always
   2. Almost always
   3. Frequently
   4. Sometimes
   5. Seldom or never

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

16. I eat a lot of food when I’m not even hungry.
   1. Very frequently
   2. Frequently
   3. Occasionally
   4. Sometimes
   5. Seldom or never

17. My eating patterns are different from the eating patterns of most people.
   1. Always
   2. Almost always
   3. Frequently
   4. Sometimes
   5. Seldom or never
18. After I binge eat I turn to several strict methods to try to keep from gaining weight (vigorous exercise, strict dieting, fasting, self-induced vomiting, laxatives, or diuretics).
   1. Never or I don't binge eat
   2. Rarely
   3. Occasionally
   4. A lot of the time
   5. Most or all of the time

19. I have tried to lose weight by fasting or going on strict diets.
   1. Not in the past year
   2. Once in the past year
   3. 2-3 times in the past year
   4. 4-5 times in the past year
   5. More than 5 times in the past year

20. I exercise vigorously and for long periods of time in order to burn calories.
   1. Average or less than average
   2. A little more than average
   3. More than average
   4. Much more than average
   5. A great deal more than average

21. When engaged in an eating binge, I tend to eat foods that are high in carbohydrates (sweets and starches).
   1. Always
   2. Almost always
   3. Frequently
   4. Sometimes
   5. Seldom or never

22. Compared to most people, my ability to control my eating behaviour seem to be:
   1. Greater than others’ ability
   2. About the same
   3. Less
   4. Much less
   5. I have absolutely no control

23. I would presently label myself a “compulsive eater” (one who engages in episodes of uncontrolled eating).
   1. Absolutely
   2. Yes
   3. Yes, probably
   4. Yes, possibly
   5. No, probably not
24. I hate the way my body looks after I eat too much.
   1. Seldom or never
   2. Sometimes
   3. Frequently
   4. Almost always
   5. Always

25. When I am trying to keep from gaining weight, I feel that I have to resort to vigorous exercise, strict dieting, fasting, self-induced vomiting, laxatives, or diuretics.
   1. Never
   2. Rarely
   3. Occasionally
   4. A lot of the time
   5. Most of the time

26. Do you believe that it is easier to vomit than it is for most people?
   1. Yes, it's no problem at all for me
   2. Yes, it's easier
   3. Yes, it's a little easier
   4. About the same
   5. No, it's less easy

27. I use diuretics (water pills) to help control my weight.
   1. Never
   2. Seldom
   3. Sometimes
   4. Frequently
   5. Very frequently

28. I feel that food controls my life.
   1. Always
   2. Almost always
   3. Frequently
   4. Sometimes
   5. Seldom or never

29. I try to control my weight my eating little or no food for a day or longer.
   1. Never
   2. Seldom
   3. Sometimes
   4. Frequently
   5. Very frequently
30. When consuming a large quantity of food, at what rate of speed do you usually eat?
   1. More rapidly than most people have ever eaten in their lives
   2. A lot more rapidly than most people
   3. A little more rapidly than most people
   4. About the same rate as most people
   5. More slowly than most people (or not applicable)

31. I use laxatives or suppositories to help control my weight.
   1. Never
   2. Seldom
   3. Sometimes
   4. Frequently
   5. Very frequently

32. Right after I binge I feel:
   1. So fat and bloated I can’t stand it
   2. Extremely fat
   3. Fat
   4. A little fat
   5. OK about how my body looks or I don’t binge eat

33. Compared to other people of my sex, my ability to always feel in control of how much I eat is:
   1. About the same or greater
   2. A little less
   3. Less
   4. Much less
   5. A great deal less

34. In the last 3 months, on the average how often did you binge eat (eat uncontrollably to the point of stuffing yourself)?
   1. Once a month or less (or never)
   2. 2-3 times a month
   3. Once a week
   4. Twice a week
   5. More than twice a week

35. Most people I know would be surprised how fat I look after I eat a lot of food.
   1. Yes, definitely
   2. Yes
   3. Yes, probably
   4. Yes, possibly
   5. No, probably not or I never eat a lot of food
36. I use diuretics (water pills) to help control my weight.
   1. 3 times a week or more
   2. Once or twice a week
   3. 2-3 times a month
   4. Once a month
   5. Never

37. In the last three months, on the average how often did you use laxatives or diuretics (water pills) to prevent weight gain?
   1. Once a month or less (or never)
   2. 2-3 times a month
   3. Once a week
   4. Twice a week
   5. More than twice a week

38. In the last three months, on the average how often did you fast, use enemas, or exercise excessively in order to prevent weight gain?
   1. Once a month or less (or never)
   2. 2-3 times a month
   3. Once a week
   4. Twice a week
   5. More than twice a week
APPENDIX C

Eating Attitudes Test - 26

Please indicate on the line at the left the answer which applies best to each of the numbered statements. All of the results will be strictly confidential. Most questions relate to food or eating, although other types of questions have been included. Please answer each question carefully.

1 = Always   2 = Very often   3 = Often   4 = Sometimes   5 = Rarely   6 = Never

_____ 1. Am terrified about being overweight.
_____ 2. Avoid eating when I am hungry.
_____ 3. Find myself preoccupied with food.
_____ 4. Have gone on eating binges where I feel I may not be able to stop.
_____ 5. Cut my food into small pieces.
_____ 6. Aware of the caloric content of the food that I eat.
_____ 7. Particularly avoid foods with a high carbohydrate content (e.g. bread, potatoes, rice, etc.).
_____ 8. Feel that others would prefer if I ate more.
_____ 9. Vomit after I have eaten.
_____ 10. Feel extremely guilty after having eaten.
_____ 11. Am preoccupied with a desire to be thinner.
_____ 12. Think about burning calories when I exercise.
_____ 13. Other people think I am too thin.
_____ 15. Take longer than others to eat my meals.
_____ 16. Avoid eating foods with sugar in them.
_____ 17. Eat diet foods.
_____ 18. Feel that food controls my life.
_____ 19. Display self control around food.
_____ 20. Feel that others pressure me to eat.
_____ 21. Give too much thought and time to food.
_____ 22. Feel uncomfortable after eating sweets.
_____ 23. Engage in dieting behaviour.
_____ 24. Like my stomach to be empty.
_____ 25. Enjoy trying rich new foods.
_____ 26. Have the impulse to vomit after meals.
APPENDIX D

Emotional Intelligence Inventory

This inventory consists of several different kinds of items in the form of short sentences. It will provide you with an opportunity to describe yourself by indicating the degree to which each statement is true of the way you are, feel, think or act most of the time and in most situations. Each sentence is followed by five possible responses:

1. Very Seldom or Never true of me
2. Seldom true of me
3. Sometimes true of me
4. Often true of me
5. Very Often or Always true of me

Choose a response that best describes you, and then mark its corresponding number. There are no “right” and “wrong” answers, no “good” and “bad” responses. Respond openly and honestly, indicating how you actually are and not how you would like to be or how you would like to be seen. There is no time limit, but work quickly and make sure that you respond to every statement.

YOUR RESPONSES ON THIS INVENTORY WILL BE KEPT IN STRICT CONFIDENTIALITY

1. My approach to overcoming difficulties is to move step by step.
   1   2   3   4   5
2. Looking out for myself is more important than worrying about those around me.
   1   2   3   4   5
3. It’s hard for me to enjoy life.
   1   2   3   4   5
4. I prefer a job in which I’m pretty much told what to do.
   1   2   3   4   5
5. I know how to deal with an upsetting problem.
   1   2   3   4   5
6. I like everyone I meet.
   1   2   3   4   5
7. I try to make my life as meaningful as I can.
   1   2   3   4   5
8. It’s fairly easy for me to express my feelings.
   1   2   3   4   5
9. I try to see things as they really are, without fantasizing about them.
   1   2   3   4   5
10. I’m unable to show affection.
    1   2   3   4   5
11. I feel sure of myself in most situations.
   1   2   3   4   5
12. I have a feeling that something’s wrong with my mind.
   1   2   3   4   5
13. It’s a problem controlling my anger.
   1   2   3   4   5
14. It’s difficult for me to begin new things.
   1   2   3   4   5
15. I feel good about my general health.
   1   2   3   4   5
16. When faced with a difficult situation, I like to collect all the information about it that I can.
   1   2   3   4   5
17. I like helping people.
   1   2   3   4   5
18. It’s hard for me to smile.
   1   2   3   4   5
19. When working with others, I tend to rely more on their ideas than on my own.
   1   2   3   4   5
20. I believe I can stay on top of tough situations.
   1   2   3   4   5
21. I haven’t made a mistake in my life.
   1   2   3   4   5
22. I really don’t know what I’m good at.
   1   2   3   4   5
23. I’m unable to express my ideas to others.
   1   2   3   4   5
24. I avoid blowing things out of proportion.
   1   2   3   4   5
25. It’s hard for me to share my deep feelings with others.
   1   2   3   4   5
   1   2   3   4   5
27. I think I’ve lost my mind.
   1   2   3   4   5
28. When I start talking, it’s hard to stop.
   1   2   3   4   5
29. It’s hard for me to make adjustments in general.
   1   2   3   4   5
30. I feel good about my physical fitness.
   1   2   3   4   5
31. I like to get a general overview of a problem before trying to solve it.
   1   2   3   4   5
32. It doesn’t bother me to take advantage of people, especially if they ask for it.
   1   2   3   4   5
33. I'm a fairly cheerful person.
   1  2  3  4  5
34. I prefer to make the important decisions in my life.
   1  2  3  4  5
35. I can handle stress without getting too nervous.
   1  2  3  4  5
36. I have good thoughts about everyone.
   1  2  3  4  5
37. In the past few years I've just been standing still.
   1  2  3  4  5
38. When I'm angry with others, I can tell them about it.
   1  2  3  4  5
39. I've had strange experiences that can't be explained.
   1  2  3  4  5
40. It's easy for me to make friends.
   1  2  3  4  5
41. I have good self-respect.
   1  2  3  4  5
42. I do very weird things.
   1  2  3  4  5
43. My impulsiveness creates problems.
   1  2  3  4  5
44. It's difficult for me to change my opinion about things.
   1  2  3  4  5
45. I'm pleased with the medical care I receive.
   1  2  3  4  5
46. I believe that when facing a problem, the first thing to do is stop and think.
   1  2  3  4  5
47. Others find it hard to depend on me.
   1  2  3  4  5
48. I am satisfied with my life.
   1  2  3  4  5
49. It's hard for me to make a decision on my own.
   1  2  3  4  5
50. I don't hold up well under stress.
   1  2  3  4  5
51. I've never done anything bad in my life.
   1  2  3  4  5
52. I don't get enjoyment from what I do.
   1  2  3  4  5
53. It's hard to express my intimate feelings.
   1  2  3  4  5
54. People don't understand the way I think.
   1  2  3  4  5
55. My friends can tell me intimate things about themselves.
   1  2  3  4  5
56. I don't feel good about myself.
   1  2  3  4  5
57. I see strange things that others don't see.
   1  2  3  4  5
58. People tell me to lower my voice in discussions.
   1  2  3  4  5
59. It's easy for me to adjust to new conditions.
   1  2  3  4  5
60. I'm happy with the people I live with.
   1  2  3  4  5
61. When trying to solve a problem, I look at each possibility and then decide on the best way.
   1  2  3  4  5
62. I'm fun to be with.
   1  2  3  4  5
63. I like to do things on my own, without outside help.
   1  2  3  4  5
64. I feel it's hard for me to control my anxiety.
   1  2  3  4  5
65. Nothing disturbs me.
   1  2  3  4  5
66. I don't get that excited about my interests.
   1  2  3  4  5
67. When I disagree with someone, I'm able to say so.
   1  2  3  4  5
68. I tend to fade out and lose contact with what happens around me.
   1  2  3  4  5
69. I don't get along well with others.
   1  2  3  4  5
70. It's hard for me to accept myself the way I am.
   1  2  3  4  5
71. I feel cut off from my body.
   1  2  3  4  5
72. I'm impatient.
   1  2  3  4  5
73. I'm able to change old habits.
   1  2  3  4  5
74. I'm unhappy with where I presently live.
   1  2  3  4  5
75. It's hard for me to decide on the best solution when solving problems.
   1  2  3  4  5
76. If I could get away with breaking the law in certain situations, I would.
   1  2  3  4  5
77. I get depressed.
   1  2  3  4  5
78. I like to plan things on my own.  
   1 2 3 4 5
79. I know how to keep calm in tight situations.  
   1 2 3 4 5
80. I have not told a lie in my life.  
   1 2 3 4 5
81. I try to continue and develop those things that I enjoy.  
   1 2 3 4 5
82. It's hard for me to say "no" when I want to say so.  
   1 2 3 4 5
83. I get carried away with my imaginations and fantasies.  
   1 2 3 4 5
84. My close relationships mean a lot to me and to my friends alike.  
   1 2 3 4 5
85. I'm happy with the type of person I am.  
   1 2 3 4 5
86. I think that someone controls my thoughts.  
   1 2 3 4 5
87. I have strong impulses that are hard to control.  
   1 2 3 4 5
88. It's generally hard for me to make changes in my daily life.  
   1 2 3 4 5
89. I'm happy with my sex life.  
   1 2 3 4 5
90. In handling situations which arise, I try to think of as many approaches as I can.  
   1 2 3 4 5
91. I'm able to respect others.  
   1 2 3 4 5
92. I'm not happy with my life.  
   1 2 3 4 5
93. I'm more of a follower than a leader.  
   1 2 3 4 5
94. It's hard for me to face the unpleasant things in life.  
   1 2 3 4 5
95. I have not broken a law of any kind.  
   1 2 3 4 5
96. I enjoy those things which interest me.  
   1 2 3 4 5
97. It's fairly easy for me to tell people what I think.  
   1 2 3 4 5
98. I tend to exaggerate.  
   1 2 3 4 5
99. I have good relations with others.  
   1 2 3 4 5
100. I feel comfortable with my body.  
   1 2 3 4 5
101. I am a very strange person.
   1  2  3  4  5
102. I’m impulsive.
   1  2  3  4  5
103. It’s hard for me to change my ways.
   1  2  3  4  5
104. I’m unhappy with my financial situation.
   1  2  3  4  5
105. I feel it’s impossible to deal with most problems.
   1  2  3  4  5
106. I think it’s important to be a law-abiding citizen.
   1  2  3  4  5
107. I enjoy weekends and holidays.
   1  2  3  4  5
108. I tend to cling to others.
   1  2  3  4  5
109. I believe in my ability to handle most upsetting situations.
   1  2  3  4  5
110. I have never felt embarrassed for things I’ve done.
    1  2  3  4  5
111. I try to get as much out of the things that I enjoy.
    1  2  3  4  5
112. Others think that I lack assertiveness.
    1  2  3  4  5
113. People think that I’ve sociable.
    1  2  3  4  5
114. I’m happy with the way I look.
    1  2  3  4  5
115. I have strange thoughts that no one can understand.
    1  2  3  4  5
116. I’ve got a bad temper.
    1  2  3  4  5
117. I can change my mind if convinced that I’m wrong.
    1  2  3  4  5
118. I’m satisfied with the money I have to live on.
    1  2  3  4  5
119. I generally get stuck when thinking about different ways of solving problems.
    1  2  3  4  5
120. It’s hard for me to see people suffer.
   1  2  3  4  5
121. I like to have fun.
   1  2  3  4  5
122. I seem to need others more than they need me.
   1  2  3  4  5
123. I get anxious.
   1  2  3  4  5
124. I have never had a bad day in my life.
   1  2  3  4  5
125. I don’t have a good idea of what I want to do in life.
   1  2  3  4  5
126. It’s difficult for me to stand up for my rights.
   1  2  3  4  5
127. It’s hard for me to keep things in their rights perspective.
   1  2  3  4  5
128. I don’t keep in touch with friends.
   1  2  3  4  5
129. Looking at both my good and bad points, I feel good about myself.
   1  2  3  4  5
130. People think I’m crazy.
   1  2  3  4  5
131. I tend to blow up easily.
   1  2  3  4  5
132. I feel good about my family life.
   1  2  3  4  5
133. I responded openly and honestly to the above sentences.
   1  2  3  4  5
APPENDIX E

University Participant Consent Form

I am a Psychology graduate student from the University of Windsor and I would like you to participate in a study that assesses your attitudes toward eating and how they relate to your personality.

If you decide to participate in the study, it will take approximately one hour of your time. You will be requested to fill out three questionnaires, involving eating disordered behaviours (e.g. bingeing, self-induced vomiting, dieting), and about your personality (e.g. I often engage in risky behaviour, I am sensitive to the needs of others). Volunteering in this study may educate you about the relationship between eating behaviours and personality variables. At any point, if you have any questions regarding the study please feel free to ask me.

Your participating is voluntary and you may withdraw from the study at any time. Your grades will not be affected in any way. Several additional things should be mentioned. First, your participation is voluntary; however, you will receive 1 bonus point (i.e., 1%) toward your course grade in 46-115 Introductory Psychology. Second, your responses are anonymous so that individual’s cannot be identified. Third, your responses will be kept confidential. If you wish you may contact the Chairperson of the Ethics Committee (Dr. D. Shore) at the University of Windsor, Department of Psychology – (519) 253-4232 Ext. 2249.

If you have any questions please contact me (at 254-8728), or my thesis supervisor, Dr. Cheryl Thomas (Department of Psychology – (519) 253-4232, Ext. 2252). Once the study has been completed, you may receive a copy of the study results if you wish, by leaving your name and address on a sign-up sheet after completing the questionnaires. Thank you for your cooperation.

Please read and sign the following declaration of informed consent if you agree:

I, ____________________________ (name of participant), have read the description of the study, understand its purpose, and recognize that there are no known or expected discomforts or risks involved in my participation. I understand that my answers will be kept confidential and that my name will not be associated with my answers. I voluntarily consent to participate.

____________________________
(Participant’s Signature)

____________________________
(Date)
APPENDIX F

Debriefing Form

Title of project: The Relation between Eating Pathology and Emotional Intelligence in University Women

Researcher: Rolan Koifman

Thank you for participating in my study. As you may already know from my title, I am interested in exploring the differences in emotional intelligence between women who have partial syndrome bulimia nervosa and those who do not. Emotional intelligence can be described as an array of non-cognitive abilities, capabilities, and skills that influence an individual’s ability to succeed in coping with environmental pressures and demands. I have hypothesized that women with partial syndrome bulimia nervosa will score lower on a measure of emotional intelligence. More specifically, I believe that women who have partial syndrome bulimia nervosa will have, for example, a lower sense of self-regard, will be less assertive, and will demonstrate a lower level of independence. I am hoping that these results will have implications for the treatment and prevention of partial syndrome bulimia nervosa. For example, if the present study reveals that individuals with partial syndrome bulimia nervosa are lacking in self-regard, assertiveness, and independence, these deficiencies can be focused on in therapy. Furthermore, this knowledge can better direct educators towards focussing on these factors for the purpose of prevention.

If you have any concerns about your own eating behaviour (or that of someone close to you), the following are the phone numbers of a few campus and community agencies which may be of service to you:

University of Windsor Psychological Services Centre 253-4232 ext. 7012

University of Windsor Health Services Centre 253-4232 ext. 7002

The Bulimia and Anorexia Nervosa Society (BANA) 253-7421
VITA AUCTORIS

Rolan Koifman was born in Israel in 1974. He graduated Summa Cum Laude from York University where he obtained an Honours Bachelors of Arts in Psychology in 1997. Rolan went on to become a graduate student in adult clinical psychology at the University of Windsor where he has been enrolled in since 1997.