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Perception of Parental Acceptance in Women With Binge Eating Disorder

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ABSTRACT. The authors contribute to the validating literature for binge eating disorder (BED) by examining perceptions of parents and satisfaction with life among obese women with and without BED. Participants were female patients, recruited through a private medical clinic, who were assigned to groups on the basis of body mass index (BMI) and scores on the Questionnaire on Eating and Weight Patterns (QEWP; R. L. Spitzer et al., 1992). Groups consisted of (a) obese women with BED ($n = 32$), (b) obese women who had no eating disorders ($n = 51$), and (c) nonobese women with no eating disorders ($n = 30$). All participants completed the Parental Acceptance/Rejection Questionnaire (PARQ; R. P. Rohner, 1986), the Satisfaction with Life Scale (SWLS; J. Fischer & K. Corcoran, 1994), and the Beck Depression Inventory (BDI; A. T. Beck & R. A. Steer, 1987). Obese women with BED perceived their fathers as more rejecting than did women in the other groups. Moreover, obese women with BED perceived their fathers as significantly more rejecting than their mothers. The BED group indicated lower satisfaction with life and higher levels of depression than the groups without eating disorders. These findings further validate the diagnostic category of BED. Obese women with BED appear to be a distinct subgroup of the obese population. The results indicate a need for further assessment of the father-daughter relationship in connection to BED and other eating disorders.

BINGE EATING DISORDER (BED) has become the focus of a growing body of research since its inclusion in "Appendix B: Criteria Sets and Axes Provided for Further Study" of the fourth edition of the *Diagnostic and Statistical Manual of Mental Disorders (DSM-IV)*; American Psychiatric Association, 1994). People with BED regularly engage in binge eating in the absence of extreme compensatory behavior used to control body shape and weight (Fairburn & Wilson, 1993).

Between one quarter and one half of obese patients presenting for treatment

report significant problems with binge eating (Devlin, Walsh, Spitzer, & Hasin, 1992). Obese individuals who engage in binge eating exhibit more eating- and weight-related pathology, more psychopathology in general, and greater psychosocial impairment than obese persons who do not engage in binge eating (de Zwaan & Mitchell, 1992; Marcus, 1993). Those with BED are also likely to present with depressive symptomatology, early onset of obesity, frequent weight loss, and family history of obesity (Marcus, Smith, Santelli, & Kaye, 1992). Moreover, there appears to be an association between BED and a lifetime prevalence of major depression, panic disorder, borderline personality disorder, and avoidant personality disorder (Yanovski et al., 1992).

Several studies have revealed support for a trend in the progression of severity of pathology in comparisons of individuals with obesity without binge eating, obesity with binge eating disorder, and obesity with bulimia nervosa (Fichter, Quadflieg, & Brandl, 1993; Fitzgibbon & Kirschenbaum, 1991; Kirkley, Kolotkin, Hernandez, & Gallagher, 1992). This body of research suggests that among those three distinct populations, binge-purgers exhibit the greatest psychological disturbance and obese nonbingers exhibit the least (Johnson & Torgrud, 1996).

The significance of the parent-child relationship in the development of an eating disorder is well established in psychological theory and empirical research. Although the preponderance of literature has focused on the connection between mother, food, early infant bonding, and eating disorders (Carmicle, 1995), preliminary findings have suggested that a daughter's perceptions of her father play a role in the development of eating disorders as well (Wonderlich, Ukestad, & Perzacki, 1994). According to Sours (1980), parents of those who develop eating disorders discourage separation and autonomy and may take little pleasure in their parenting. Other researchers concur that the struggle for autonomy is a primary component of disordered eating (Masterson, 1977; Minuchin, Rosman, & Baker, 1978; Sours, 1980; Stein, Woolley, Cooper, & Fairburn, 1994; Winnicott, 1965).

Underlying the significance of the parent-child relationship in eating disorder development is an insufficient level of parental affection and acceptance. Individuals with BED often do not experience being truly loved for themselves and have, in essence, given up on having empathic connections with people (Aronson, 1993). Research related to families of individuals with eating disorders confirms perceptions that those families are more conflictual, *disorganized*, nonnurturing, and controlling, and less affectionate than families of individuals who did not have eating disorders (Humphrey, 1987, 1988; Johnson & Flach, 1985; Kog & Vandereycken, 1989; Palmer, Oppenheimer, & Marshall, 1988; Wonderlich & Swift, 1990).

The roles of the mother and father in the etiology of eating disorders remain unclear. Shulman (1991) concluded that the binge "is" the mother, and the purge is an act to reject the mother. Carmicle (1995) hypothesized that purging may be a symbolic rejection of the father, the perceived behavior of the father, or both. A father who is seen as domineering, cruel, or abusive may be symbolically rejected by the act of purging. Carmicle's research indicated that bulimic women who did not purge experienced their fathers as more loving than did bulimic women who did purge.

Parental acceptance-rejection theory (PAR theory; Rohner, 1975, 1980, 1986; Rohner & Rohner, 1980) supports the significant role of perceptions of one's own parents in the development of psychopathology. In brief, the theory attempts to explain and predict major consequences of perceived parental acceptance and rejection. It addresses, for example, the warmth dimension of parenting and its impact on the behavioral, cognitive, and emotional development of children and on the eventual adaptiveness of personality of adults.

The warmth dimension of parenting referred to in PAR theory is defined on a continuum, with rejection (perceived absence of parental warmth and affection) at one end of the spectrum and acceptance (perceived presence of warmth and nurturing) at the other end (Campo & Rohner, 1992). Accepting parents may express love and affection for their children both physically and verbally. Rejecting parents, on the other hand, exhibit dislike of, disapproval of, resentment of, or indifference toward their children. According to Campo and Rohner, individuals "can experience themselves as rejected even without direct behavioral indicators of parental coldness, aggression, or neglect" (p. 431).

In addition to the impact on children, PAR theory's personality aspect predicts that parental acceptance and rejection will affect the adaptiveness of personality of adults who recall being rejected as children (Rohner, 1975, 1980, 1986). More specifically, according to Campo and Rohner (1992), "PAR theory predicts that individuals who experience themselves to be rejected or psychologically maltreated tend to be more hostile and aggressive or to have greater problems with the management of hostility and aggression, more dependent or 'defensively independent' (depending on degree of rejection), lower in self-esteem and self-adequacy, more emotionally unstable, more emotionally unresponsive, and more negative in their world view" (p. 431).

Campo and Rohner (1992) postulated that substance abuse may be one logical result of the parental rejection process. Individuals may turn to one substance or another to decrease the intense psychological pain resulting from perceived parental rejection. Campo and Rohner concluded that perceived rejection appears to elicit in the child a variety of aversive personality and behavioral characteristics that, in turn, provoke the susceptible parent to further reject the child. The child responds to the further rejection, and the exchange eventually leads to development of a mechanism to cope with the pain. In the case of BED, food may be the substance of choice to numb this internal pain.

Stigma associated with obesity has been well documented (Allon, 1975; Cahnman, 1968; DeJong, 1980; Hiller, 1981; Webber, 1994; Worsley, 1981). This stigma has led to negative characterization of obese individuals, and the most negative attitudes appear to be directed toward obese women (Harris, Harris, & Bochner, 1982; Harris & Smith, 1982; Hiller, 1981). The stigma and discrimination that obese women encounter in a variety of situations would be expected to have a negative impact on their satisfaction with life. Nevertheless, a search of the psychological literature revealed no published research on satisfaction with life among persons with eating disorders. Previous literature on obesity and satisfaction with life has focused on external indicators of satisfaction rather than perceptions of the obese individuals themselves.

In contrast, a good deal of research has addressed the connection between depression and eating disorders. Researchers have consistently found that depression is associated with bulimia (Hinz & Williamson, 1987; Strober & Katz, 1988). Prather and Williamson (1988) found a similar association between depression and compulsive binge eating. Webber (1994) found that binge eaters—whether obese or of normal weight—had significantly higher levels of depression than obese and nonobese people who did not binge. Finally, Specker, de Zwaan, Raymond, and Mitchell (1994) reported similar results among obese women with and without BED. In their study, a significantly higher percentage of obese women with BED met the criteria for major depression. The link between clinical depression and eating disorders is congruent across studies that used both objective and interview-based indices of depression. One interpretation of this linkage is that the physical and psychosocial concomitants of depression increase the predisposition toward eating disorders (Garfinkle & Garner, 1982; Strober & Katz, 1988).

Our review of the literature suggests that children's relationships with their parents play a significant role in the development of eating disorders. The present study was designed to establish whether those relationships have a similar role in the development of BED. Specifically, we assessed whether the perception of parental acceptance or rejection among women with BED would distinguish them from women without eating disorders. This information would contribute to the validation of the BED diagnosis and further establish obese women with BED as a distinct subgroup of obese women. The study was designed to address four research hypotheses:

1. Obese women with BED perceive their parents as more rejecting than do obese and nonobese women without BED.
2. Obese women with BED perceive their mothers as more rejecting than their fathers.
3. Obese women with BED report less satisfaction with life than do obese and nonobese women without BED.
4. Obese women with BED report higher levels of depression than do obese and nonobese women without BED.

Method

Participants

The participants were 113 female volunteers from a private medical clinic (105 Caucasian, 5 African American, 2 Native American, and 1 Latina). Sixty-two percent were married, 20% were single, and 12% were divorced, separated, or widowed. The remaining 6% did not disclose marital status. The mean age for all participants was 45.12 ($SD = 10.99$). Fifty percent had obtained a college degree. Less than 3% of the sample had not completed high school. Among the 113 participants meeting inclusion criteria, 83 were obese, based on body mass index ($BMI \geq 28$), and 30 were not obese (non-O group; $BMI \leq 25$). Of the 83 obese participants, 32 met the diagnostic criteria for BED (BED group). The prevalence of BED in this obese sample, therefore, was 38.6%. Fifty-one obese participants had no diagnosable eating disorder (non-BED group).

Measures

The Questionnaire on Eating and Weight Patterns (QEWP) is a four-page, abbreviated form of the original questionnaire developed by Spitzer et al. (1992, 1993). It is currently the only diagnostic instrument used exclusively for identifying BED (Johnson & Torgrud, 1996). The QEWP contains 13 items that classify individuals with BED, purging bulimia nervosa, or nonpurging bulimia nervosa (Spitzer et al., 1993). Psychometric data on the questionnaire show good diagnostic stability over a 3-week period ($\kappa = .58$; Nangle, Johnson, Carr-Nangle, & Engler, 1994). The QEWP compares favorably to diagnoses based on structured interview (de Zwaan & Mitchell, 1992). In addition, the QEWP's predictive efficiency for high- and low-binge eaters ranges from .71 to .73 (Nangle et al.).

The Parental Acceptance/Rejection Questionnaire (PARQ-F, father version; PARQ-M, mother version), a self-report measure developed by Rohner (1986, 1991), was designed to assess an individual's perception of acceptance-rejection by his or her parents during childhood. It is a 60-item, Likert-type inventory. Scores on the four subscales—parental warmth, hostility, neglect, and undifferentiated rejection—are combined to determine a composite score, which can range from 60 to 240 (midpoint = 150). Individuals who score higher than 150 perceive more rejection than acceptance from the rated parent. Reliability studies (Rohner, 1991) have yielded Cronbach's alpha coefficients for the subscales ranging from .86 to .95. Further research has produced evidence of concurrent, convergent, and discriminant validity (Rohner, 1991).

The Satisfaction with Life Scale (SWLS; Fischer & Corcoran, 1994) is a five-item scale that assesses subjective life satisfaction. Unlike other measures that apply an external standard, the SWLS score represents the individual's own subjective judgment of his or her quality of life. The SWLS has been recom-

mended for use in addition to other measures when psychopathology or emotional well-being is being assessed (Pavot & Diener, 1993). Each of the five items is scored from 1 to 7 and then summed, for a total score ranging from 5 to 35. Higher scores reflect more satisfaction with life. Internal consistency of the SWLS is very good ($\alpha = .87$). This instrument also has shown excellent test-retest reliability over a 2-month period, with a correlation of .82 (Diener, Emmons, Larsen, & Grifflins, 1985).

The Beck Depression Inventory (BDI; Beck & Steer, 1987) is among the most widely accepted and commonly used instruments for assessing level of depression (Zemore & Rinholm, 1989). It effectively measures intensity of depression in psychiatric patients (Piotrowski, Sherry, & Keller, 1985) as well as in normal populations (Steer, Beck, & Garrison, 1985). This 21-item self-report inventory has well-established reliability and validity (Beck, Steer, & Garbin, 1988; Bumberry, Oliver, & McClure, 1978). Scores range from 0 to 63, with the single numerical score allowing classification of the degree of depression as minimal (0–9), mild (10–16), moderate (17–29), or severe (30–63). A strong negative correlation ($r = .72$) has been found between the SWLS and the BDI (Blais, Vallerand, Pelletier, & Briere, 1989).

Procedure

Announcements were posted in the clinic, and interested women were given detailed written information about the study. Inclusion and designation to the appropriate group were based on information from the completed QEWP. BMI, a measure of weight relative to ideal, was calculated (kg/m^2) according to reported height and weight. Participants were screened according to the following inclusion criteria: female; not pregnant; 18 years of age or older; BMI between 18 and 25 inclusive with no eating disorder present for the nonobese group, or BMI of 28 or greater with no eating disorder present except BED for the obese groups. Obese women who met full diagnostic criteria for BED were separated from obese women with no eating disorders.

Of the 131 female volunteers who completed all measures, 18 were excluded for not meeting the inclusion criteria: 10 were excluded with BMI indices of 26 or 27, which placed them in the slightly overweight range; 3 met diagnostic criteria for bulimia nervosa; 3 who met BMI criteria for the nonobese group met diagnostic criteria for BED; and 2 were pregnant. After screening, 32 participants were assigned to the group of obese binge eaters (BED group); 51 to the group of obese nonbinge eaters (non-BED group); and 30 to the group of nonobese, nonbinge eaters (non-O group), for a total of 113 participants.

Results

Univariate analyses of variance (ANOVAs) demonstrated no significant differences between the groups with respect to age, education, or marital status. As

would be expected, BMI scores for the BED group ($M = 36.90$) and the non-BED group ($M = 35.68$) were significantly higher than for the non-O group ($M = 21.76$), $F(2, 112) = 71.57$, $p < .0001$. All participants were also asked to report their highest weight. As would be expected, there was a significant ANOVA between groups for body weight, $F(2, 110) = 46.0$, $p < .001$. Subsequent analyses confirmed significantly higher weight for the BED group ($M = 257.71$, $SD = 61.74$) and the non-BED group ($M = 227.72$, $SD = 41.82$) compared with the non-O group ($M = 153.07$, $SD = 28.78$). Participants were also asked to rate the extent to which they had been on a diet in their lifetime (rated on a 5-point scale: 1 = *none or hardly any of the time*, 2 = *about a quarter of the time*, 3 = *about half the time*, 4 = *about three quarters of the time*, and 5 = *nearly all the time*). Again, women with BED ($M = 3.78$, $SD = 1.07$) and non-BED obese women ($M = 3.19$, $SD = 1.43$) reported spending a significantly greater proportion of time dieting than nonobese women did ($M = 1.87$, $SD = 1.20$), $F(2, 110) = 18.44$, $p < .001$.

Hypothesis 1 stated that obese women with BED perceive their parents as more rejecting than obese and nonobese women without BED. (See Table 1 for means, standard deviations, and ANOVA results for all measures and groups.) The overall PARQ-F ANOVA was significant. Post hoc Tukey tests revealed that BED women reported their fathers to be significantly more rejecting than non-obese women did ($= 32.05$, $p < .05$; Table 1).

Given the significant overall PARQ-F finding, subsequent ANOVAs were conducted for all four subtests of the PARQ-F. There were no significant overall differences between groups on the warmth and aggression subscales; however, the neglect subscale, $F(2, 102) = 3.95$, $p < .05$, and the rejection subscale, $F(2, 102) = 4.85$, $p < .01$, produced significant overall between-groups differences. Post hoc Tukey tests revealed that BED women reported greater paternal neglect ($= 8.21$, $p < .05$) and greater paternal rejection ($= 5.41$, $p < .05$) than nonobese women did. There were no differences between non-BED obese women and the other two groups on these subscales. An ANOVA between groups for the PARQ-M revealed no significant differences.

Hypothesis 2 stated that obese women with BED perceive their mothers as more rejecting than obese and nonobese women without BED. This hypothesis was not supported by the present results. *T* tests for paired samples using overall PARQ-F and PARQ-M scores revealed significant within-group differences for the BED group alone. However, contrary to our prediction, obese women with BED reported more rejecting and less warm fathers ($M = 139.73$) than mothers ($M = 105.28$), $t(29) = 4.16$, $p < .001$.

Hypothesis 3, which predicted that obese women with BED would report less satisfaction with life than obese and nonobese women without BED would, was confirmed. A one-way ANOVA for SWLS scores revealed significant differences between groups, $F(2, 108) = 3.11$, $p < .05$. Subsequent analyses confirmed significantly lower SWLS scores in the BED group compared with the non-O group ($= 5.30$, $p < .05$). There were no significant differences between the non-

TABLE 1
Between-Group Comparisons for All Dependent Measures

Measure	BED		Non-BED		Non-O		<i>df</i>	<i>F</i>
	<i>M</i>	<i>SD</i>	<i>M</i>	<i>SD</i>	<i>M</i>	<i>SD</i>		
PARQ-F	139.73	4.16	121.48	46.11	107.15	45.20	2, 102	3.72*
Warmth	49.30	17.05	54.25	18.76	59.37	18.02	2, 102	2.20
Aggression	30.47	12.72	25.90	11.73	22.74	11.57	2, 102	3.03
Neglect	36.67	10.68	32.13	12.05	28.04	11.80	2, 102	3.95*
Rejection	21.90	7.84	17.98	7.39	15.74	11.80	2, 102	4.85**
PARQ-M	105.28	37.69	112.18	42.73	110.37	48.14	2, 106	.26
Warmth	66.91	13.95	61.02	17.11	61.67	16.37		
Aggression	26.66	9.71	26.94	11.76	26.78	13.59		
Neglect	25.84	9.06	27.80	10.52	27.07	11.53		
Rejection	19.69	7.68	18.66	6.87	18.59	9.03		
BDI	13.75	8.70	10.00	9.63	7.83	5.68	2, 110	3.92*
SWLS	19.28	7.49	22.04	7.92	24.03	6.72	2, 108	3.11*

Note. BED = obese women with binge eating disorder. Non-BED = obese women without binge eating disorder. Non-O = nonobese women. PARQ-F = Parental Acceptance/Rejection Questionnaire–Father version. PARQ-M = Parental Acceptance/Rejection Questionnaire–Mother version. BDI = Beck Depression Inventory. SWLS = Satisfaction with Life Scale. BED $n = 32$. Non-BED $n = 51$. Non-O $n = 30$.

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

BED obese group and the other two groups with respect to level of satisfaction with life.

Hypothesis 4 stated that obese women with BED would report higher levels of depression than obese and nonobese women without BED. This hypothesis was confirmed. A one-way ANOVA for BDI scores between groups was significant, $F(2, 110) = 3.92$, $p < .05$. Again, follow-up Tukey tests showed that the women with BED reported significantly more depression than the non-O women ($= 6.00$, $p < .05$), whereas the non-BED obese women did not differ significantly from either group with regard to depression.

Discussion

Our main goal in this research was to contribute to the validation of BED as a distinct eating disorder and necessary diagnostic category. The differences between the BED group and the nonobese non-BED group were significant on three measures, confirming three of the four hypotheses.

The hypothesis that obese women with BED perceive their parents as more rejecting than do obese and nonobese women without BED was confirmed with regard to the father but not the mother. The BED group scores indicating per-

ceived rejection were significantly higher overall and for each subtest than the scores of the nonobese non-BED group were. Although the women in the BED group reported greater perceived rejection than those in the non-BED obese group, the difference was not statistically significant. Thus, the obese women with BED appeared to perceive their fathers as significantly more rejecting than nonobese women with no binge eating disorders did. More specifically, the women with BED viewed their fathers as lacking in warmth and acceptance, being aggressive, being neglectful, and as primarily rejecting them. These findings are somewhat surprising in light of the virtual absence of published research examining the role of the father–daughter relationship in the development of eating disorders. It appears that emphasis has been placed on the *mother–daughter* relationship to the exclusion of father–daughter research. These preliminary findings clearly indicate a need for further assessment of the father–daughter relationship and its connection to BED and other eating disorders.

There were no significant differences between groups with respect to perceived acceptance or rejection by the mother. The substantial body of research connecting mother–daughter relationships to eating disturbances makes this a surprising result. It is possible that individuals with BED differ, in terms of parental experience, from individuals with no eating disorder and from individuals with different eating disorders. It is also possible that mother–daughter relationships play a less significant role in the development of BED.

Consistent with previous research (Carmicle, 1995; Shulman, 1991), we hypothesized that obese women with BED would perceive their mothers as more rejecting than their fathers. This hypothesis was based on the conclusion that the binge “is” the mother (Shulman, 1991) and that purging is a symbolic rejection of the father, the perceived behavior of the father, or both (Carmicle). This hypothesis was not confirmed. To the contrary, the women with BED perceived their fathers as significantly more rejecting than their mothers. This may indicate that binge eating is more varied and complex in its etiology and function than was previously thought. Binge behavior may carry different meanings among people with different eating disorders and even among different individuals. Although some have argued (Aronson, 1993; Garfinkle & Garner, 1982) that BED is equivalent to the diagnosis of nonpurging bulimia nervosa, our findings indicate the possibility that there are substantive differences between BED and nonpurging bulimia nervosa, and the data support further consideration of BED as a distinct diagnosis.

The results confirmed the hypothesis that obese women with BED would report less satisfaction with life than nonobese women without BED. The fact that the BED group’s scores were lower, though not significantly, than the obese non-BED group’s indicates that decreased satisfaction was not merely a result of obesity. It may be helpful for researchers to rethink the axiom that higher body weight in obese individuals leads to lower satisfaction with life. The difference in satisfaction with life may also be a function of other characteristics of BED,

such as feeling out of control and frequently eating what is regarded as an unusually large amount of food.

As expected, the hypothesis that, compared with obese and nonobese women without BED, women with BED would report higher levels of depression was confirmed. Women with eating disorders may be more inclined to manifest depressive symptoms (Strober & Katz, 1988). It is noteworthy, however, that BDI scores for the BED group were in the borderline-to-mild range and not suggestive of clinical depression. This may indicate that women with BED are less depressed than individuals with other eating disorders (Garfinkle & Garner, 1982; Hudson, Laffer, & Pope, 1982; Johnson & Connors, 1987; Strober, Salkin, Burroughs, & Morrell, 1982). Again, it appears that the depression is not the result of obesity alone. It must also be noted here that the participants in the non-obese group came from a medical clinic population. Thus, there may have been a higher level of reported depression than would have been found in a nonclinical, normal-weight population.

Results of this study need to be interpreted in light of several methodological concerns. One factor that may have influenced the results is the possibility of response bias across groups. Issues of eating and weight such as those in the QEWP are sensitive ones. Although we made every effort to encourage honesty by ensuring confidentiality and anonymity, the tendency to answer such questions in a socially desirable manner may have had some impact on the accuracy of the data.

Another potential confounding variable is the length of the questionnaire. The questionnaire was 13 pages long, and fatigue may have affected responses near the end. Interestingly, the PARQ-M was the final section, and this yielded an unexpected result.

In addition, we did not screen for medications. Use of antidepressant medications may have affected both Satisfaction with Life Scale and Beck Depression Inventory scores. Use of obesity treatment medication within the preceding 6 months may have altered eating patterns, resulting in our assigning participants to the non-BED group when, unmedicated, they could have met criteria for the BED group. Moreover, we did not control for the presence of child abuse in the participants' histories. A history of abuse could certainly have affected the women's perceptions of their parents. No demographic data were collected regarding the parents; such information would be helpful in identifying correlates of perceived acceptance and rejection.

Despite the limitations of this study, these results do make a *significant contribution* to the literature on eating disorders, specifically to the validation and understanding of BED. These findings support inclusion of BED as a distinct diagnostic category. There appears to be a need for continued research on the father-daughter relationship and its role in the development of eating disorders. It would be helpful to determine if this strong paternal influence is present in eating disorders other than BED.

A closer look at subgroups of the obese population, obese women with BED

and without BED, would assist in understanding the impact of higher body weight on satisfaction with life and quality of life. Such information could shed new light on previous conclusions regarding quality of life for obese individuals. Future research on obesity would be significantly enhanced by the inclusion of a group of women with bulimia nervosa. This would provide an established eating disorder for comparison as well as an upper reference point on the proposed continuum of psychopathology. Finally, researchers should continue to evaluate the validity of BED as an official diagnostic category. Additional research should be directed to consideration of effective prevention and treatment methods.

REFERENCES

- Allon, N. (1975). The stigma of overweight in everyday life. In G. A. Bray (Ed.), *Obesity in perspective*, 2 (DHEW Publication No. NIH 75-708). Washington, DC: U.S. Government Printing Office.
- American Psychiatric Association. (1994). *Diagnostic and statistical manual of mental disorders* (4th ed.). Washington, DC: American Psychiatric Association.
- Aronson, J. K. (1993). *Insights in the dynamic psychotherapy of anorexia and bulimia*. Northvale, NJ: Jason Aronson.
- Beck, A. T., & Steer, R. A. (1987). *Beck Depression Inventory*. San Antonio, TX: The Psychological Corporation.
- Beck, A. T., Steer, R. A., & Garbin, M. (1988). Psychometric properties of the Beck Depression Inventory: Twenty-five years of evaluation. *Clinical Psychology Review*, 8, 77-100.
- Blais, M. R., Vallerand, R. J., Pelletier, L. G., & Briere, N. M. (1989). L'Echelle de satisfaction de vie: Validation Canadienne-Francais "Satisfaction With Life Scale" [French-Canadian Validation of Satisfaction With Life Scale]. *Canadian Journal of Behavioral Science*, 21, 210-223.
- Bumberry, W., Oliver, J. M., & McClure, J. N. (1978). Validation of the Beck Depression Inventory in a university population using psychiatric estimate as the criterion. *Journal of Consulting and Clinical Psychology*, 46, 150-155.
- Cahnman, W. J. (1968). The stigma of obesity. *Sociological Quarterly*, 9, 283-299.
- Campo, A. T., & Rohner, R. P. (1992). Relationships between perceived parental acceptance-rejection, psychological adjustment, and substance abuse among young adults. *Child Abuse & Neglect*, 16, 429-440.
- Carmicle, L. (1995). The perception of parental love in purging and nonpurging bulimic women. *Texas Counseling Association Journal*, 23, 1-8.
- DeJong, W. (1980). The stigma of obesity: The consequences of naive assumptions concerning the causes of physical deviance. *Journal of Health and Social Behavior*, 81, 75-87.
- Devlin, M. J., Walsh, B. T., Spitzer, R. L., & Hasin, D. (1992). Is there another binge eating disorder? A review of the literature on overeating in the absence of bulimia nervosa. *International Journal of Eating Disorders*, 11, 333-340.
- de Zwaan, M., & Mitchell, J. E. (1992). Binge eating in the obese. *Annals of Medicine*, 24, 303-308.
- Diener, E., Emmons, R. A., Larsen, R. J., & Grifflins, S. (1985). The Satisfaction with Life Scale. *Journal of Personality Assessment*, 49, 71-75.
- Fairburn, C. G., & Wilson, G. T. (Eds.). (1993). *Binge eating: Nature, assessment, and treatment*. New York: Guilford Press.
- Fichter, M. M., Quadflieg, N., & Brandl, B. (1993). Recurrent overeating: An empirical

- comparison of binge eating disorder, bulimia nervosa, and obesity. *International Journal of Eating Disorders*, 14, 1–16.
- Fischer, J., & Corcoran, K. (1994). *Measures for clinical practice: A sourcebook* (2nd ed., Vol. 2: Adults). New York: The Free Press.
- Fitzgibbon, M. L., & Kirschenbaum, D. S. (1991). Distressed binge eaters as a distinct subgroup among obese individuals. *Addictive Behaviors*, 16, 441–451.
- Garfinkle, P. E., & Garner, D. M. (1982). *Anorexia nervosa: A multidimensional perspective*. New York: Brunner/Mazel.
- Harris, M. B., Harris, R. J., & Bochner, S. (1982). Fat, four-eyed, and female: Stereotypes of obesity, glasses, and gender. *Journal of Applied Social Psychology*, 12, 503–516.
- Harris, M. B., & Smith, S. D. (1982). Beliefs about obesity: Effects of age, ethnicity, sex, and weight. *Psychological Reports*, 51, 1047–1055.
- Hiller, D. V. (1981). The salience of overweight in personality characterization. *The Journal of Psychology*, 108, 233–240.
- Hinz, L. D., & Williamson, D. A. (1987). Bulimia and depression: A review of the affective variant hypothesis. *Psychological Bulletin*, 102, 150–158.
- Hudson, J. I., Laffer, P. S., & Pope, H. G. (1982). Bulimia related to affective disorder by family history and response to the dexamethasone suppression test. *American Journal of Psychiatry*, 137, 695–698.
- Humphrey, L. L. (1987). A comparison of bulimic-anorexic and non-distressed families using structural analysis of social behavior. *Journal of the American Academy of Child and Adolescent Psychiatry*, 26, 248–255.
- Humphrey, L. L. (1988). Relationships within subtypes of anorexic, bulimic, and normal families. *Journal of the American Academy of Child and Adolescent Psychiatry*, 27, 544–551.
- Johnson, C., & Connors, M. E. (1987). *The etiology and treatment of bulimia nervosa*. Northvale, NJ: Jason Aronson.
- Johnson, C., & Flach, A. (1985). Family characteristics of 105 patients with bulimia. *American Journal of Psychiatry*, 142, 1321–1324.
- Johnson, W. G., & Torgnord, L. J. (1996). Assessment and treatment of binge eating disorder. In J. K. Thompson (Ed.), *Body image, eating disorders, and obesity: An integrative guide for assessment and treatment* (pp. 321–343). Washington, DC: American Psychological Association.
- Kirkley, B. G., Kolotkin, R. L., Hernandez, J. T., & Gallagher, P. N. (1992). A comparison of binge-purgers, obese binge eaters, and obese nonbinge eaters on the MMPI. *International Journal of Eating Disorders*, 12, 221–228.
- Kog, E., & Vandereycken, W. (1989). Family interaction in eating disorder patients and normal controls. *International Journal of Eating Disorders*, 8, 11–23.
- Marcus, M. D. (1993). Binge eating in obesity. In C. G. Fairburn & G. T. Wilson (Eds.), *Binge eating: Nature, assessment, and treatment*. New York: Guilford Press.
- Marcus, M. D., Smith, D., Santelli, R., & Kaye, W. (1992). Characterization of eating disordered behavior in obese binge eaters. *International Journal of Eating Disorders*, 12, 249–255.
- Masterson, J. F. (1977). Primary anorexia nervosa in the borderline adolescent—An object relations view. In P. Hartocollis (Ed.), *Borderline personality disorders* (pp. 230–251). New York: International Universities Press.
- Minuchin, S., Rosman, B., & Baker, L. (1978). *Psychosomatic families: Anorexia nervosa in context*. Cambridge, MA: Harvard University Press.
- Nangle, D. W., Johnson, W. G., Carr-Nangle, R. E., & Engler, L. E. (1994). Binge eating disorder and proposed DSM-IV criteria: Psychometric analysis of the Questionnaire of Eating and Weight Patterns. *International Journal of Eating Disorders*, 16, 147–157.

- Palmer, R. L., Oppenheimer, R., & Marshall, P. D. (1988). Eating disordered patients remember their parents: A study using the Parental-Bonding Instrument. *International Journal of Eating Disorders*, 7, 101–106.
- Pavot, W., & Diener, E. (1993). Review of the Satisfaction with Life Scale. *Psychological Assessment*, 5, 164–172.
- Piotrowski, C., Sherry, D., & Keller, J. W. (1985). Psychodiagnostic test usage: A survey of the Society for Personality Assessment. *Journal of Personality Assessment*, 49, 115–119.
- Prather, R. C., & Williamson, D. A. (1988). Psychopathology associated with bulimia, binge eating, and obesity. *International Journal of Eating Disorders*, 7, 177–184.
- Rohner, R. P. (1975). *They love me, they love me not: A worldwide study of the effects of parental acceptance and rejection*. New Haven, CT: Human Relations Area Files.
- Rohner, R. P. (1980). Worldwide tests of parental acceptance-rejection theory. *Behavior Science Research*, 15, 1–21.
- Rohner, R. P. (1986). *The warmth dimension: Foundations of parental acceptance-rejection theory*. Newbury Park, CA: Sage.
- Rohner, R. P. (1991). *Handbook for the study of parental acceptance and rejection*. Storrs, CT: University of Connecticut, Center for the Study of Parental Acceptance and Rejection.
- Rohner, R. P., & Rohner, E. C. (Eds.). (1980). Worldwide tests of parental acceptance-rejection theory [Special issue]. *Behavior Science Research*, 15, 1–88.
- Shulman, D. (1991). A multitiered view of bulimia. *International Journal of Eating Disorders*, 10, 333–343.
- Sours, J. (1980). *Starving to death in a sea of objects: The anorexia nervosa syndrome*. New York: Jason Aronson.
- Specker, S., de Zwaan, M., Raymond, N., & Mitchell, J. (1994). Psychopathology in subgroups of obese women with and without binge eating disorder. *Comprehensive Psychiatry*, 35, 185–190.
- Spitzer, R. L., Devlin, M., Walsh, B. T., Hasin, D., Wing, R., Marcus, M. D., Stunkard, A., Wadden, T., Yanovski, S., Agras, S., Mitchell, J., & Nonas, C. (1992). Binge eating disorder: Multisite field trial of the diagnostic criteria. *International Journal of Eating Disorders*, 11, 191–203.
- Spitzer, R. L., Yanovski, S., Wadden, T., Wing, R., Marcus, M. D., Stunkard, A., Devlin, M., Mitchell, J., Hasin, D., & Hrone, R. L. (1993). Binge eating disorder: Its further validation in a multisite study. *International Journal of Eating Disorders*, 13, 137–153.
- Steer, R. A., Beck, A. T., & Garrison, B. (1985). Applications of the Beck Depression Inventory. In N. Artorius & T. A. Ban (Eds.), *Assessment of depression* (pp. 121–142). New York: Springer-Verlag.
- Stein, A., Woolley, H., Cooper, S. D., & Fairburn, C. G. (1994). An observational study of mothers with eating disorders and their infants. *Journal of Child Psychology and Psychiatry and Allied Disciplines*, 35, 733–748.
- Strober, M., & Katz, J. L. (1988). Depression in the eating disorders: A review and analysis of descriptive, family and biological findings. In D. M. Garner & P. E. Garfinkle (Eds.), *Diagnostic issues in anorexia nervosa and bulimia nervosa* (pp. 80–111). New York: Brunner/Mazel.
- Strober, M., Salkin, B., Burroughs, J., & Morrell, W. (1982). Validity of the bulimia-restrictor distinction in anorexia nervosa. *Journal of Nervous and Mental Disease*, 170, 345–351.
- Webber, E. M. (1994). Psychological characteristics of bingeing and nonbinging obese women. *The Journal of Psychology*, 128, 339–351.
- Winnicott, D. W. (1965). *The family and individual development*. London: Tavistock.

- Wonderlich, S. A., & Swift, W. J. (1990). Borderline versus other personality disorders in the eating disorders. *International Journal of Eating Disorders*, 9, 617–628.
- Wonderlich, S., Ukestad, L., & Perzacki, R. (1994). Perceptions of nonshared childhood environment in bulimia nervosa. *Journal of the American Academy of Child and Adolescent Psychiatry*, 33, 740–747.
- Worsley, A. (1981). Teenagers' perceptions of fat and slim people. *International Journal of Obesity*, 5, 15–24.
- Yanovski, S. Z., Leet, M., Yanovski, J. A., Flood, M., Gold, P. W., Kissileff, H. R., & Walsh, B. T. (1992). Food selection and intake of obese women with binge eating disorder. *American Journal of Clinical Nutrition*, 56, 975–980.
- Zemore, R., & Rinholm, J. (1989). Vulnerability to depression as a function of parental rejection and control. *Canadian Journal of Behavioural Science*, 21, 364–376.