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Relationships Between Eating Disorder Characteristics and Love and Sex Attitudes[1]

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The current study explored theories proposing relationship difficulties in women with eating disorder characteristics. Results for the sample of 232 women (82% White-non-Hispanic, 12% White-Hispanic, 4% Black, 2% Oriental and other) indicated that eating disorder characteristics were most consistently positively related to a possessive and game-playing approach to love, and most consistently negatively related to a passionate and companionate love approach. In addition, eating disorder characteristics were positively related to casual and instrumental sexual attitudes, and negatively related to idealistic sexual attitudes. Women who were more endorsing of eating disorders were also lower in sexual self-esteem. Women who were dissatisfied with themselves physically, differed from satisfied women on several measures. Interpersonal features appear to be related to eating disorder characteristics in various ways.

There is a growing interest in the interpersonal/relational aspects of the lives of women with eating disorders (e.g., Thelen, Farmer, Mann, & Pruitt, 1990). Since more women appear to be carrying eating disorders from adolescence to young adulthood or developing eating disorders in young adulthood (Dally, 1984; Garfinkel & Garner, 1982; VandenBroucke & Vandereycken, 1988), a time when relationship formation is extremely important (e.g., Erikson, 1963), eating-disordered behavior and related symptoms are likely to be found in the context of intimate relationships.

A recent longitudinal study of bulimic college women and interpersonal relationships (Thelen, Farmer, Mann, & Pruitt, 1990) found that bulimic be-

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havior was negatively correlated with women's ratings of their interpersonal relationships with men. These findings support theoretical perspectives suggesting that bulimic women have many difficulties in their intimate relationships with men in part because they may have intense fears of rejection and great need for approval (Boskind-Lodahl, 1976; Bruch, 1973). In addition to intimacy-related factors, the role of psychosexual factors in the development of eating disorders has long been of scholarly interest, with some authors proposing a link between eating-disordered behavior and sexual attitudes and behavior (Abraham & Llewellyn-Jones, 1984; Beumont, Abraham, & Simson, 1981; Crisp, 1980; Scott, 1987). In sum, many women with eating disorders are also involved in intimate relationships. Some of the attention focused in this area needs to be directed toward the many women who may not be "clinically disordered" but who nevertheless manifest at least some characteristics of eating disordered behavior.

It has been suggested that only a relatively small sample of women who have abnormal eating attitudes and behaviors qualify for the clinical diagnosis of "eating disordered" (e.g., Williams, Schaefer, Shisslak, Gronwaldt, & Comerci, 1986). In fact, Williams et al. (1986) found a wide range of weight-related concerns in 56% of their sample of 72 junior high and high school aged women. Of this total, 14% reported worrying about weight or dieting all day; 10% reported worrying daily; and 35% reported feeling guilty after eating. Of these women, 12% were classified as dieters (possessing many of the eating attitudes and preoccupations associated with eating disorders), and 75% were classified as normal (possessing only a few of the eating attitudes and preoccupations associated with eating disorders). In a study of eating attitudes and behaviors of adults in the general population, Langer, Warheit, and Zimmerman (1991) found similar results, with 45% of the sample reporting feeling guilty after eating, 44% thinking they had a weight problem, and 8% reporting serious food-related conflicts.

Olmstead and Garner (1986) compared Eating Disorder Inventory subscale scores of (1) women who reported self-induced vomiting to control weight, (2) women who reported no such vomiting, and (3) bulimia nervosa patients. On several of the subscales, the bulimia patients scored higher than the vomiting-only participants, who in turn scored higher than the nonvomiting participants. Various scholars have proposed that normal eating, normal dieting, and eating disorders exist on a continuum (e.g., Polivy & Herman, 1987). Even in a nonclinical population, women with subclinical eating disorder behaviors reported significantly greater levels of psychopathology as their symptoms more closely approximated diagnostic criteria for eating disorders (e.g., Klemchuk, Hutchinson, & Frank, 1990; Kristeller & Rodin, 1989). Thus existing research suggests that weight preoccupation and other aspects of eating disorder characteristics are merely points on a

continuum that ranges from healthy to pathological attitudes and behaviors in relation to food.

Although there has been considerable conjecture about the nature of the links between eating disorders and intimate relationships, there has been little exploration of how aspects of love and sexuality, specifically, might relate to aspects of eating/weight. As noted earlier, eating disorder characteristics are likely to occur while a woman is concurrently involved in an intimate relationship. Both the relationship and the eating disorder characteristics are likely to affect each other, although mechanisms of influence are not clearly understood. Thus current research was designed to explore relationships among aspects of relationship intimacy (attitudes toward love and attitudes toward sexuality) and eating disorder characteristics in a sample of young adult women.

METHOD

Subjects

Participants were recruited from undergraduate psychology classes at a large southwestern university. They were tested in groups, where they were given a research packet consisting of a consent form, a cover letter for the questionnaire section, and several instruments. After completing the packet, participants were free to leave. Participants providing incomplete data were excluded, and the effective sample consisted of 232 women (82% White-non-Hispanic, 12% White-Hispanic, 4% Black, 1% Oriental, and 1% Other).

Instruments

Background Information Sheet. This set of items solicited information about participants' background (e.g., age, family income), personal relationship history (e.g., whether or not currently in a relationship, how many previous times in love), and weight-related history (e.g., whether they'd been teased about weight as a child).

Eating Disorder Inventory (EDI). This instrument (Garner & Olmstead, 1984) is a 64-item, self-report measure with 8 subscales derived from principal components analysis. The scales include Drive for Thinness, Bulimia, Body Dissatisfaction, Ineffectiveness, Perfectionism, Interpersonal Distrust, Interoceptive Awareness, and Fear of Maturity. Criterion as well as convergent and discriminant validity have been reported (see Garner & Olmstead, 1984). Reported alphas ranged from .83 to .93. In nonclinical

populations, the EDI is used as a screening instrument to identify persons likely to be weight preoccupied. This questionnaire is designed using a 6-point Likert format; however, for the current study, a 5-response format was used in order to be congruent with the other measures. The scoring system was modified (by dropping one zero response), and the Perfectionism and Interoceptive Awareness subscales were omitted.

To measure interpersonal/relational aspects of the participants, the following measure was employed.

Love Attitudes Scales. The Love Attitudes Scale (Hendrick & Hendrick, 1986) is a 42-item self-report measure designed to assess the six major love attitudes defined by Lee's (1973) theory of love styles. These include Eros (passionate love), Ludus (game-playing love), Storge (love based on friendship), Pragma (practical love), Mania (dependent, possessive love), and Agape (giving love). The love styles or orientations are relatively independent ways of approaching love (though each person has a bit of each style), and are related to aspects of both personality and attitudes (Hendrick & Hendrick, 1986). Each of the subscales (representing the styles) is composed of 7 questions, designed in a 5-point Likert format. Reported alpha coefficients ranged from .62 to .84 and test–retest reliabilities from .60 to .78 (Hendrick & Hendrick, 1986). To begin to examine psychosexual factors, the following two scales were employed.

Sexual Attitudes Scale. The Sexual Attitudes Scale is a self-report 43-item scale designed to measure four attitude constellations about sexuality. These include Permissiveness (casual, open sexuality), Sexual Practices (responsible, tolerant sexuality), Communion (idealistic sexuality), and Instrumentality (biological sexuality). This scale uses a 5-point Likert format, and reported alpha coefficients ranged from .74 to .93, with test–retest reliabilities ranging from .66 to .88 (Hendrick & Hendrick, 1987).

Sexual Self-Esteem Scale. This is a revision of the Rosenberg Self-Esteem Scale (Rosenberg, 1965, 1979), and it specifically assesses feelings of sexual self-esteem. It is comprised of 10 questions in a 4-point Likert format. Internal reliability was found to be .90 for women (Adler & Hendrick, 1991). Sample items from love, sex, and self-esteem scales are included in Appendix A.

Because the scoring format for the EDI was slightly modified for this study, factor analyses and internal reliability analyses were conducted on the instrument. Using principal components analysis with varimax rotation, the resulting factor structure showed six relatively clear factors, with EDI subscale items loading on the appropriate factor/subscale. Reliability analysis showed alphas ranging from .73 for Interpersonal Distrust to .92 for Body Dissatisfaction. Mean interitem correlations ranged from .29 for Interpersonal Distrust and Maturity Fears to .55 for Body Dissatisfaction. (Additional information can be obtained from the authors.)

RESULTS

The Sample

Findings for selected demographic, relationship history, and weight history questions are reported below. Eighty-one percent of the women were age 19 or younger, and 47% came from families whose annual income was $50,00 or more. Eighty-two percent described themselves as White-non-Hispanic, with 4% identifying as Black, 12% as White-Hispanic, 1% as Oriental, and 1% as Other. Sixty-three percent of the women reported themselves to be in a relationship, and 58% said that they were currently in love. Forty-three percent said that their current relationship was a sexual one. In considering eating/weight-related questions, 47% considered themselves to be currently overweight, and 42% reported that they were moderately to very dissatisfied with their current body proportions. When asked

Table I. Means and Standard Deviations for Primary Variables[a]

Variable	Mean	Standard Deviation
Thin	5.75	3.44
Bulimia	2.44	2.72
Body Dis	11.20	5.58
Ineffect	4.10	4.23
Distrust	3.44	3.32
Mat Fears	5.23	2.94
Eros	2.14	.67
Ludus	3.70	.79
Storge	2.42	.86
Pragma	3.16	.89
Mania	2.90	.78
Agape	2.30	.80
Permiss	4.28	.57
Sex Prac	1.86	.55
Commun	2.06	.58
Instrum	3.55	.75
S S-Esteem	2.23	.62

[a]Thin: Drive for Thinness; Body Dis: Body Dissatisfaction; Ineffect: Ineffectiveness; Distrust: Interpersonal Distrust; Mat Fears: Maturity Fears; Permiss: Permissiveness; Sex Prac: Sexual Practices; Commun: Communion; Instrum: Instrumentality; S S-Esteem: Sexual Self-Esteem. $N = 232$.

about the importance of their physical appearance to their relationship partner, 20% said "very important," and 44% said "somewhat important." Finally, 22% perceived that they had been overweight as children, and 19% reported that they had been at least "moderately" teased about their childhood weight, with another 21% reporting "slight" teasing.

Eating Disorders and Love Styles

Means and standard deviations were computed for the primary variables and are shown in Table I. It should be noted that although there had been slight modifications of the EDI (dropping a 0 in scoring and deleting two subscales), the values are similar to those reported in the EDI manual (Garner & Olmstead, 1984). Correlations were computed between the EDI and all other measures and are shown in Table II. Of the 66 possible significant correlations, 21 were significant.

First considering the love scales and sex scales, Drive for Thinness was positively related only to manic love. Bulimia was positively related to

Table II. Correlations Between EDI Subscales and Other Measures[a]

Measures	Thin	Bulimia	Body Dis	Ineffect	Distrust	Mat Fears
Eros	−.06	−.04	−.12	−.26[c]	−.21[c]	−.17[b]
Ludus	.09	.01	.13	.14	.29[c]	.09
Storge	−.10	−.16	−.18[b]	−.11	−.12	−.02
Pragma	.03	−.06	−.09	−.04	−.02	−.03
Mania	.24[c]	.26[c]	.18[b]	.27[c]	.11	.16
Agape	−.03	.05	−.10	.02	−.09	.00
Permiss	.06	.14	.02	.14	.19[b]	.07
Sex Prac	.04	.08	.06	−.05	−.10	−.05
Commun	−.06	−.04	−.04	−.09	−.16	−.19[b]
Instrum	.15	.21[b]	.12	.20[b]	.20[b]	.30[c]
S S-Esteem	−.28[c]	−.30[c]	−.38[c]	−.53[c]	−.36[c]	−.33[c]

[a]Thin: Drive for Thinness; Body Dis: Body Dissatisfaction; Ineffect: Ineffectiveness; Distrust: Interpersonal Distrust; Mat Fears: Maturity Fears; Permiss: Permissiveness; Sex Prac: Sexual Practices; Commun: Communion; Instrum: Instrumentality; S S-Esteem: Sexual Self-Esteem. The Love Attitudes Scale, Sexual Attitudes Scale, and Sexual Self-Esteem Scale are all scored so that the lower the score, the greater the endorsement. The EDI is scored in the opposite direction. Thus negative correlations between the EDI and other measures represent a positive relationship, and positive correlations represent a negative relationship. Signs in this table have been changed to reflect the actual relationship. $N = 232$.

[b]$p < .01$.

[c]$p < .001$.

manic love and biological sexuality. Body Dissatisfaction was positively related to manic love but negatively to friendship love. Ineffectiveness was positively related to manic love and biological sexuality, but negatively to passionate love. Distrust was positively related to game-playing love and casual and biological sexuality, but negatively related to passionate love. Finally, Maturity Fears was positively related to biological sexuality but negatively to idealistic sexuality and passionate love. All the EDI subscales were also significantly related to sexual self-esteem (the greater the eating disorder characteristics, the lower the self-esteem).

These results were interesting, and indicated that there are indeed links between relationship aspects such as love and sex attitudes, and eating disorder characteristics. However, the nature of these links could not be readily determined. It could be that a woman's eating disorder characteristics impact her intimate relationships. In this case, women who differ in eating/weight-related characteristics might differ in their attitudes toward their intimate relationships. Or it could be that relationship factors impact eating disorders. In this case, women who differ in relationship-related characteristics might differ in their attitude toward eating/weight. Thus, although they did not directly address causal links, two additional questions were explored. First, would women who were dissatisfied with themselves physically (assessed by the question "How dissatisfied are you with your body proportions?") differ on the various measures from women who were satisfied with their physical selves? And second, would those women who were not currently in a relationship differ from those who were in one?

A multivariate analysis of variance (MANOVA) was performed for Question 8, "How dissatisfied are you with your body proportions?" (responses ranging from *extremely dissatisfied* to *not at all dissatisfied*). The results are shown in Table III.

For this analysis only the extreme groups [i.e., *extremely* and *very dissatisfied* (combined; [$N = 28$)] and *not at all dissatisfied* ($N = 21$)] were compared [$F(1, 47) = 10.52$, $p < .0001$]. (Results for comparisons of all four response groups were quite similar to those shown.) For the love scales, the groups differed on three of the six scales, with those who were dissatisfied appearing less endorsing of passionate love and friendship-based love and more endorsing of manic love. There were also trends for the dissatisfied group to be less practical ($p < .08$) and less altruistic ($p < .09$). The groups did not differ on any of the sexual attitude scales; however, the dissatisfied women were lover in sexual self-esteem than were the satisfied women. The groups differed on four of the EDI scales, with the dissatisfied women more endorsing of Drive for Thinness, Bulimia, Body Dissatisfaction, and Ineffectiveness.

Table III. Means and *F* Ratios for Dissatisfaction with Body Proportions for all Dependent Variables[a]

Variables	*F* ratio	Very dissatisfied (N = 28)	Not at all dissatisfied (N = 21)
Eros	5.64[c]	2.38	1.93
Ludus	.58	3.73	3.90
Storge	5.35[c]	2.66	2.03
Pragma	3.22	3.39	2.90
Mania	7.27[b]	2.61	3.16
Agape	3.07	2.32	1.95
Permiss	.73	4.33	4.46
Sex Prac	.79	1.94	2.09
Commun	.05	2.11	2.15
Instrum	.54	3.55	3.71
S S-Esteem	29.52[b]	2.80	1.93
Thin	57.19[b]	8.29	2.62
Bulimia	38.24[b]	5.25	.76
Body Dis	210.47[b]	17.57	4.10
Ineffect	42.11[b]	9.18	2.05
Distrust	1.54	4.50	3.29
Mat Fears	2.03	6.07	4.90

[a]Thin: Drive for Thinness; Body Dis: Body Dissatisfaction; Ineffect: Ineffectiveness; Distrust: Interpersonal Distrust; Mat Fears: Maturity Fears; Permiss: Permissiveness; Sex Prac: Sexual Practices; Commun: Communion; Instrum: Instrumentality; S S-Esteem: Sexual Self-Esteem. The Love Attitudes Scale, Sexual Attitudes Scale, and Sexual Self-Esteem Scale are all scored so that the lower the score, the greater the endorsement. The EDI is scored in the opposite direction.

[b]$p < .01$.

[c]$p < .05$.

A MANOVA was also performed for Question 100 "Are you currently in a relationship? If 'Yes,' how long?" (responses ranging from *No* to *Yes, over one year*), also using the "extreme" groups of respondents (those not in a relationship and those in a relationship over one year's duration). The overall MANOVA was significant [$F(1, 156) = 3.04$, $p < .001$], with those women in a long-term relationship ($N = 73$) more endorsing of passionate, friendship, and altruistic love, and sexual self-esteem, and less endorsing of instrumental sexuality than were the women not in a relationship ($N = 85$; similar to previous research). However, the groups did not differ on any of the scales of primary interest, the EDI subscales.

DISCUSSION

Recent research investigating the intimate relationships of bulimic college women found bulimic behavior to be negatively related to relationship satisfaction with men (Thelen et al., 1990). Such research lends support to theories proposing relationship difficulties in women with eating disorder characteristics (Boskind-Lodahl, 1976; Bruch, 1973), and the results of the current study also support this perspective. Although the correlations were modest, the endorsement of eating disordered attitudes was positively related to a possessive, dependent love style and to a lesser extent, a game-playing one. However, eating-disordered attitudes were negatively related to passionate love and to a lesser extent, friendship-based love. In terms of sexual attitudes, eating-disordered attitudes were positively related to instrumental/biological sexual attitudes and to a lesser extent to casual sexual attitudes (as well as negatively to idealistic sexual attitudes). All of the EDI subscales were also negatively correlated with sexual self-esteem. Taken overall, it is apparent that eating disordered attitudes are more likely to relate to what could be considered the "less desirable" aspects of love and sexual attitudes. Love styles such as passionate and friendship-based love, when they appear at all, are negatively related to eating disorders. More typical is the possessive "hysteria" of Mania and to a lesser extent, the game playing of Ludus. For sexuality also, casual sexuality and self-focused/instrumental sexuality (accompanied by lower sexual self-esteem) seem the only sexual attitudes substantially related to eating disorders.

Additional findings established the importance to women of how they feel about their body proportions. Women who disliked their body proportions were less endorsing of passionate and friendship-based love and sexual self-esteem, and more endorsing of possessive, dependent love and four of the EDI subscales, than were women who did not dislike themselves. Thus these women differed both in eating/weight-related characteristics and in relationship characteristics. Additional findings regarding women who were not in relationships as compared to women in long-term (over one year) relationships did not prove as informative. Although causal links were not directly examined and it cannot be determined from these findings whether women who have eating disorders (or characteristics) are at higher risk for relationship problems or whether women with relationship problems are at higher risk for eating disorder characteristics, it is clear that women who do not like themselves physically are different from women who like themselves, on a number of relationship and eating dimensions. Women who differ in terms of relationship status, however, appear to differ only on relationship dimensions. It would be useful to proceed further, perhaps comparing women who are satisfied in their relationships with women

who are unsatisfied. However, a relationship satisfaction measure was not included in the current study.

In attempting to understand the links between problems in eating and problems in relationships, it can be noted that there are a number of theories that attempt to account for women's eating disorders. Although intrapsychic explanations have been among the most popular ones (e.g., Bruch, 1973), sociocultural explanations are at least as plausible as dynamic (e.g., women's fears of intimacy, women's dependency needs) or sociobiological (e.g., women's attempts to attract a mate) ones. The issue of physical attractiveness is extremely important for women in our society (Hatfield & Sprecher, 1986), and research has indicated that weight and body shape are central factors in women's evaluations of their own physical attractiveness (e.g., Rodin & Striegel-Moore, 1984, cited in Lips, 1988). We are a stereotyping society, and part of the stereotype for women involves physical attractiveness (Lips, 1988). It is small wonder, then, that whether we like or dislike our physical proportions has implications that can spill over into other aspects of our lives, such as our intimate relationships. [Indeed, previous research found that fatter persons were judged to be less passionate in their love relationships than were thinner persons (Harris, 1990).]

It is apparent that pervasive problems with eating and weight, as well as negative feelings about one's own body, cannot help but relate to one's attitudes toward a romantic partner. When we feel negatively about some aspect of ourselves, it is likely that a gestalt is created that influences our self-esteem as well as our attitudes toward love and sexuality. Thus concerns about one's weight and body image may be as much interpersonal concerns as they are intrapersonal ones.

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APPENDIX A

Love Attitudes Scale

Eros	My lover and I were attracted to each other immediately after we first met.

Ludus	I try to keep my lover a little uncertain about my commitment to him/her.
Storge	It is hard for me to say exactly when our friendship turned into love.
Pragma	I considered what my lover was going to become in life before I committed myself to him/her.
Mania	When things aren't right with my lover and me, my stomach gets upset.
Agape	I try to always help my lover through difficult times.

Sexual Attitudes Scale

Permissiveness	I do not need to be committed to a person to have sex with him/her.
Sexual Practices	Birth control is part of responsible sexuality.
Communion	Sex is the closest form of communication between two people.
Instrumentality	Sex is primarily the taking of pleasure from another person.

Sexual Self-Esteem Scale

I feel that I am a person of sexual worth, at least on an equal basis with others.