OBESITY AND PSYCHOLOGICAL DIFFERENTIATION
A COMPARATIVE STUDY OF TWO GROUPS OF WOMEN
- ONE PRESENTLY OBSESE AND THE OTHER PREVIOUSLY OBSESE -
IN RELATIONSHIP TO FIELD-DEPENDENCE-INDEPENDENCE

A thesis submitted in partial satisfaction of the requirements for the degree of Master of Arts in Education, Educational Psychology, Counseling and Guidance

by

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# TABLE OF CONTENTS

<table>
<thead>
<tr>
<th>Chapter or Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>ACKNOWLEDGEMENTS</td>
<td>ii.</td>
</tr>
<tr>
<td>TABLE OF CONTENTS</td>
<td>iii.</td>
</tr>
<tr>
<td>LIST OF TABLES</td>
<td>iv.</td>
</tr>
<tr>
<td>ABSTRACT</td>
<td>v.</td>
</tr>
<tr>
<td>CHAPTER 1 - INTRODUCTION</td>
<td>1</td>
</tr>
<tr>
<td>Significance of the Problem</td>
<td>1</td>
</tr>
<tr>
<td>Statement of the Hypothesis</td>
<td>1</td>
</tr>
<tr>
<td>Definition of Terms</td>
<td>3</td>
</tr>
<tr>
<td>Assumptions and Limitations</td>
<td>3</td>
</tr>
<tr>
<td>CHAPTER 2 - A REVIEW OF THE LITERATURE</td>
<td>6</td>
</tr>
<tr>
<td>The Normal Development of Psychological Differentiation</td>
<td>6</td>
</tr>
<tr>
<td>The Field-Independent Personality</td>
<td>12</td>
</tr>
<tr>
<td>Tests of Field-Dependence-Independence</td>
<td>13</td>
</tr>
<tr>
<td>Psychopathology and Field-Dependency</td>
<td>16</td>
</tr>
<tr>
<td>Field-Dependency and the Obese Personality</td>
<td>22</td>
</tr>
<tr>
<td>CHAPTER 3 - DESIGN OF THE STUDY</td>
<td>31</td>
</tr>
<tr>
<td>Description of the Research Design</td>
<td>31</td>
</tr>
<tr>
<td>Statistical Treatment</td>
<td>3</td>
</tr>
<tr>
<td>Sampling Procedures</td>
<td>32</td>
</tr>
<tr>
<td>Data-Gathering Instruments</td>
<td>35</td>
</tr>
<tr>
<td>Twelve Traditions</td>
<td>38</td>
</tr>
<tr>
<td>Twelve Steps</td>
<td>40</td>
</tr>
<tr>
<td>CHAPTER 4 - ANALYSIS OF THE DATA</td>
<td>45</td>
</tr>
<tr>
<td>CHAPTER 5 - SUMMARY AND CONCLUSIONS</td>
<td>57</td>
</tr>
<tr>
<td>Review of the Procedure</td>
<td>57</td>
</tr>
<tr>
<td>Major Findings and Recommendations</td>
<td>58</td>
</tr>
<tr>
<td>REFERENCES</td>
<td>64</td>
</tr>
<tr>
<td>CHAPTER 6 - APPENDICES</td>
<td>69</td>
</tr>
<tr>
<td>Questionnaire</td>
<td>70</td>
</tr>
<tr>
<td>Medical Histories - Average Weights of Women</td>
<td>74</td>
</tr>
</tbody>
</table>
LIST OF TABLES

Table 1...... Response to Questionnaire at OA Meetings
Table 2...... Norms and Reliabilities
Table 3...... Comparisons of Subjects' Weights
Table 4...... Individual Scores on the EFT
Table 5...... Group 1 - Maintainers: Levels of Compulsiveness in the Past and Present
Table 6...... Group 2 - Obese: Levels of Compulsiveness in the Past and Present
Table 7...... Group 1 - Maintainers: Involvement with Overeaters Anonymous
Table 8...... Group 2 - Obese: Involvement with Overeaters Anonymous
ABSTRACT

OBESITY AND PSYCHOLOGICAL DIFFERENTIATION
A COMPARATIVE STUDY OF TWO GROUPS OF WOMEN
- ONE PRESENTLY OBESE AND THE OTHER PREVIOUSLY OBESE -
IN RELATIONSHIP TO FIELD-DEPENDENCE-INDEPENDENCE

by
Linda B. Bernstein

Master of Arts Degree in Education, Educational Psychology, Counseling and Guidance

This study compares field-dependence-independence (psychological differentiation) on the Embedded Figures Test between 13 subjects, all attending Overeaters Anonymous. All subjects have been obese by at least 20 percent above average weight. Group 1, maintainers, have returned to an average adult weight and have maintained this weight loss for a minimum of 1 year. They are found to be more field-independent, more involved in Overeaters Anonymous and to be less compulsive than members of Group 2 who have been attending Overeaters Anonymous for at least 1 year and who are still obese.
Chapter 1
INTRODUCTION

Significance of the Problem

Primary research into psychological differentiation has been done by Witkin and his associates. They have shown that psychological differentiation (field dependent-independent behavior) differs between persons and tends to progress from a rather undifferentiated state toward greater differentiation and hence, greater autonomy, as one grows chronologically. Psychological differentiation, in itself, is not indicative of any existing pathology. However, research has indicated that certain forms of pathology are indicative of certain levels of field dependency.

Statement of the Hypothesis

The purpose of this study is to further the research related to field-dependency and pathology. It is the specific purpose, set forth at this time, to ascertain whether or not there is any difference in psychological differentiation between presently obese and previously obese women. It is my premise that women who have reduced and maintained their weight loss for at least one year are more psychologically differentiated (more field-independent) than women who have been unable to lose weight and
unable to maintain a weight loss. Specifically, the women chosen for this study have been recruited from Overeaters Anonymous. Seemingly, it is a unique situation for persons who desire assistance with their problems relating to obesity. Presently, obese women have had to attend Overeaters Anonymous meetings for a minimum of one year.

The fact that there are no mandatory fees makes this program accessible to many persons who would ordinarily not pursue solutions to their obesity problem. Most programs are time limited. This one is not, therefore, leaving more room for change to occur because it relieves persons of some of the pressure of succeeding within a prescribed period of time. The standards for success are very individualized. It is not uncommon to meet people involved with Overeaters Anonymous who have been involved for many years.

My own interest has developed over the past three years. Through my own struggles with maintaining an average weight while attending the meetings of Overeaters Anonymous, I became increasingly aware that there must be differences between persons who are able to lose and maintain a weight loss and those who cannot. After assessing the various components that have been studied in relationship to obesity, the area of dependency needs have become one of great interest to me.
Through attendance at the meetings of Overeaters Anonymous, it has become increasingly apparent that the program of Overeaters Anonymous aids in allowing for the fulfillment of unmet dependency needs.

One thing that the program does not attempt to do is to help those who do not ask for help. It is necessary to make one's need known. It is speculated that there are personality differences between those that can ask for help and those who cannot.

Definition of Terms

Before further discussion, two terms must be explained: The first refers to the term obesity. Obesity refers to the physical manifestation of fat in the body. The second term to be defined is compulsive overeater. A compulsive overeater is a person who is mouth-hungry; who eats for purposes other than to relieve hunger. The compulsive overeater does not have to be hungry in order to eat. This person can eat almost anything that is edible, often eating things that are not even liked. After this indiscriminate eating takes place, there is often much recrimination which leads to promises that this will not happen again (Rubin, 1970).

Assumptions and Limitations

The study undertaken involves only persons who have been at least 20 percent above an average adult weight as measured by New York Life Insurance Company's actuary.
The premise is established here that concern with the bodily function of nutrition has too often been used as a pseudosolution for problems and conflicts that lie in an emotional and interpersonal area. (Bruch, 1964). Medicine alone cannot control or prevent obesity. Researchers must deal with personality, social pressure, and cultural background as well (Lolli, 1955).

The assumption that one must be obese in order to be considered a compulsive overeater is not seen to be true. I have known many thin persons who will admittedly classify themselves as being compulsive overeaters. It is not within the scope of this research to find out why they remain thin. This is an area open for further research as it may benefit the obese person.

The 13 subjects in this study were taken exclusively from Overeaters Anonymous. There is a possibility that these persons are not representative of the larger population of obese persons who have sought other means of weight reduction as well as for those who have never sought help for their obesity problem at all.

The persons asked to join this study have all been willing to classify themselves as compulsive overeaters.

The problem which is being explored is the relationship of obesity and psychological differentiation. Through the use of the Embedded Figures Test devised by
Witkin and his associates, the psychological differentiation of obese and previously obese persons can be examined. This test will be described elsewhere.

In addition to evaluating the psychological differentiation of the individuals in this study, the involvement in Overeaters Anonymous as well as the degree of compulsiveness of these persons will be explored.
Chapter II

A REVIEW OF THE LITERATURE

THE NORMAL DEVELOPMENT OF PSYCHOLOGICAL DIFFERENTIATION

In the helpless infant, it is difficult to speak about intentionality. In the course of development, a person acquires the capacity for many types of volitional activity. He develops the ability to act deliberately. This relates to the individual's ability to direct himself. As a person develops, he is able to function autonomously. The capacity to act deliberately and purposefully brings with it new psychological experiences and dimensions of self-awareness. This new sense of self-direction, autonomy or choice is frequently referred to as "will" (Shapiro, 1965).

As a result of their longitudinal studies, Witkin, Goodenough, and Karp explain that one of the earliest developments in the young child's perception is the ability to experience his body as a separate entity, distinct from the environment. Experience, at an early age, indicates a difference between stimulation from within and stimulation from without. This leads to a strengthening of boundaries between the body and the outside world. As the boundaries strengthen, the capacity for initiation of behavior and active coping with environmental stimulation increases.
This, in turn, contributes to the further differentiation between the self and the environment (1967).

At a later point in development, objects in the field can be kept separate from the surrounding framework. This has been studied and differences have been found to exist in the person's ability to differentiate items separate from their field. The individual differences that arise relate to a person's ability to actively cope with or passively accept the environment. Failure to actively cope with the environment may establish a tendency towards passive submission and a lack of development of the self-concept (Witkin, 1950).

In eight year olds studied, differences in perception relate to differences in organizational capacity and the extent of self-differentiation. Failure or difficulty to cope with the environment leads to a passive submission to it. This can make for an arrest in the development of field-independent behavior.

A person who is able to actively distinguish an object from the field is termed analytical, articulated, or field-independent. He copes actively with the environment. At the other extreme is the person who cannot separate an item from the field. This person is referred to as global or field-dependent in his ability and tends to relate passively to the environment (Witkin, et al, 1972).
Consistently, there have been found to be sex differences relating to perceptual style. Boys and men tend to be more analytical (field-independent); whereas, women and girls seem to be more global (field-dependent). Small but definite differences have been found (Witkin, et al 1972).

Field-dependence-independence has definite observable changes over one's life span. There seems to be a marked continuous increase in field-independence between the ages of 8 and 15 years. The rate of change seems to slow down with increasing age (Witkin, et al, 1967). Limited evidence exists that somewhere in the late thirties a change toward greater field-dependence begins. As one grows, field-dependence shows relative stability and the same position is held in relation to one's peers. In young adulthood, field-dependence-independence seems to hold absolute stability even over extended periods of time (Witkin, et al, 1967).

Perception is not only relating to an immediately present stimulus but also relating to how a person deals with symbolic representations. A person who has difficulty disembedding an object from the environment does less well in solving problems which require an ability to isolate elements from their context. One cannot say that a person who is field-independent has a higher intelligence. Nothing has been found to substantiate this (Witkin, et al, 1972).
The relationship of the person to his environment as observed perceptually is termed his "cognitive style". Field-dependence-independence is a narrower term. Cognitive style refers to one's ability overcome an embedding context. The individual differences, at the extremes, contrast various ways of approaching a field. Reference can be made, therefore, to a global versus an analytical dimension of cognitive function (Witkin, et al, 1972, 1967, 1962, 1954).

Individual differences in cognitive style are found to relate to individual differences in body concept, in nature of the self and in the controls and defenses used to cope with the world. The specific characteristics involved seem to form a continuum and at the extremes reflect either a global or autonomous level of differentiation. Value judgments are not drawn as to which style of functioning is better because adaptability refers to cultural expectations and integration within the environment. Studies show that a person with greater analytic ability has had the kinds of experiences within his family and culture which encourage development of self-differentiation (Witkin, et al, 1972).

Body concept refers to the impression an individual has of his body whether cognitive, conscious or unconscious. Studies of body concepts relate to experiencing from within.

The relationship exists that a person who appears to
have an articulated cognitive style, experiences his body as having definite limits. Drawings by a field-dependent person are less differentiated, having less detail. Representations of the self are usually unrealistic. A field-independent person draws a more definitive figure, using more detail (Witkin, 1965, Witkin, et al, 1962).

A person with more articulated cognitive style is seen as having a greater sense of separate identity. He has greater awareness of his own needs, feelings, and attributes. These are recognized as separate from others. The self is experienced as structured.

Internal frames of reference are well drawn. The less developed, more global personality, is seen as relying on external sources for definition and attitudes as well as for judgments and sentiments. Validation is sought for ideas.

The use of defenses differ between the two cognitive styles. An articulated person tends to use specialized defenses, such as isolation and intellectualization. Defenses aid a person in determining what will be allowed into consciousness. This is partially done through regulation of affect and perception. The global personality uses repression and denial as his primary defenses. These are more primitive defenses (Witkin, et al, 1972).
THE FIELD-DEPENDENT PERSONALITY

If one is to describe the stereotype field-dependent personality, no person will match it exactly. When taking a large enough sample from a population, examples of field-dependent-independent behavior fall on a continuum as stated earlier. The defenses primarily used by field-dependent persons are denial or repression. In addition, the sense of identity is diffused. When trying to disembed an object from the surrounding, this person has great difficulty or is unable to complete the task.

The field-dependent personality is portrayed by lack of initiative in challenging the status quo, as submissive to authority and as relatively unaware of his inner feelings, especially those relating to sex and aggression (Doyle, 1975).

He relies heavily on others for his attitudes, judgments, and views about himself. Bell finds that a field-dependent individual is more likely to change his ideas to conform to an authority. Such a person is strongly influenced by the social context of a situation (Linton and Graham, 1959). Since he is more in need of social approval he often seeks to earn the goodwill of others. He is considered to be warm and tactful. In addition, he is more alert to moods and attitudes of others. His attention is especially drawn to facial characteristics (Witkin, et al, 1962).
Bogo finds that the more field-dependent person is more apt to turn against himself rather than against an object (1970).

Since his attitudes are rather passive, at the extreme, the possibilities for achievement are greatly reduced. This leads to lower self-esteem and self-acceptance (Witkin, 1954).

As he is more dependent on others, it is not surprising that the field-dependent person is more self-disclosing. Jourard sees self-disclosure as the "process of making the self known to others". He feels that self-disclosure is essential for the maintenance of a healthy personality. It has been found that women tend to disclose more than men (Sousa-Pozo, 1973).

Dargel and Kirk have investigated the amount of anxiety present in the field-dependent person. They assumed that the field-dependent person experiences greater anxiety when working certain cognitive tasks. Their results show an insignificant difference, however (Joshi, 1974).

THE FIELD-INDEPENDENT PERSONALITY

What characterizes the field-independent person? His style is analytical. As stated previously, he sees his body as well differentiated and views himself realistically. He can separate himself from the environment. When
needing to defend himself, his principal defenses are more specialized, being that of isolation and intellectualization.

In the social context, he is able to distinguish his needs and desires from those of others. He has relatively little need for guidance and support from others. In the face of contradicting values, he more readily maintains his own unique direction (Witkin, et al, 1972, 1962, 1954).

In any given situation, he is more apt to impose his own structure on the situation. His perceptions are organized and definite (Witkin, et al, 1972).

He is not particularly concerned with facial cues. Being desirous of experiencing people in terms of deeper attributes, reflecting a more developed awareness, he has a greater ability to maintain the kind of distance necessary for objective evaluations. At the extreme, he is considered to be markedly cold and distant.

"This capacity for manipulation of the environment can be fostered either by a healthy relation with the environment or a neurotic defense to remain separate from the supposedly hostile world" (Witkin, et al, 1962).

TESTS OF FIELD-DEPENDENCE-INDEPENDENCE

Whether or not a person actively copes with his environment can be measured perceptually in a laboratory setting. A central factor in performance on the perceptual
tests is the person's ability to break up a configuration, to work against the prevailing structure of the field. This is necessary if one is to keep the item separate from the surrounding field.

Witkin and his associates have developed three tests which test field-dependence-independence; the rod and frame test, the body adjustment test, and the embedded figures test. In the rod and frame test (RFT), the subject is seated in a darkened room and must adjust to the upright, a tilted luminous rod, centered within a tilted luminous frame while the frame remains in its initial position of tilt (Witkin and Asch, 1948). In the body adjustment test (BAT), the person is seated in a tilted position within a tilted room and he must adjust his chair to a position where he perceives himself upright. The room remains tilted. The embedded figures test (EFT) is a pencil and paper test, whereby the subject is required to find a simple figure within a complex design (Witkin et al, 1973, Witkin, 1950).

The EFT, in its original version, contains 24 complex colored designs accompanied by 8 simple figures. Within each complex design is one of the simple figures. These figures are based on designs made by Gottschaldt in 1926. A person must be able to find the simple figure within the complex design within a limited amount of time. This is referred to as disembedding.
The perceptual style of the individual, as shown on these tests, shows a high consistency between the three tests. There is a tendency for a person to perceive consistently in a field-dependent or field-independent manner. Karp's findings show that not only is it necessary for a person to disembed an item from its surrounding field, but a subject also has to be able to "break up" an organized field in order to separate out parts of it (1963).

Today, the EFT has been shortened without changing, to any great extent, the internal validity or reliability of the instrument. The shortened form of the test consists of 12 complex designs, together with the same 8 simple figures. The other 12 designs can be used in a test-retest situation.

The BAT and RFT require complex mechanical equipment in order to administer the test. The advantages of using the EFT are its accessibility to study by objective methods without using complex devices. In addition, it is a non-verbal test; therefore, it can be used with differing language groups. It is also free of any associative content (Witkin, et al, 1972).

A more field-independent mode of performing on the EFT does not imply better adjustment or mental health. A field-independent person is as likely to show personality disturbances as is a field-dependent personality. There is some evidence that a higher prevalence of psychopathology is at either extreme rather than in the middle range (Witkin, 1972).
Adjustment is mainly a function of the effectiveness of integration between the person and the environment. The degree to which there is a more or less harmonious working together with the parts of the system and with the environment is indicative of the degree of adjustment. Adjustment results from integration appropriate to whatever the level of differentiation. However, impairment seems to take different forms depending on the level of differentiation (Witkin, et al, 1972).

**PSYCHOPATHOLOGY AND FIELD-DEPENDENCY**

Psychological differentiation, as stated, is not indicative of adaptability. The adaptive value of differentiation may depend on the setting in which the individual is required to function. As stated previously, adjustment is to be found at all levels of differentiation. Impaired integration can develop at any level. Pathology will differ according to the level of differentiation.

With reference to the global cognitive style, one is likely to find severe identity problems, little struggle for maintenance of identity, symptoms often suggestive of deep seated problems of dependency and inadequately developed controls resulting in chaotic functioning (Bailey, Hustmyer & Kristofferson, 1961, Karp & Konstadt, 1965; Karp, Poster & Goodman, 1963; Karp, Witkin & Goodenough, 1965a, Karp, Witkin & Goodenough, 1965b, Witkin, Karp & Goodenough, 1959). Extensive studies with alcoho-
lies have been done which validate the above conclusions. A contradictory study, however, recorded by Donovan, Hague & O'Leary finds their alcoholic subjects to represent all levels of psychological differentiation. Admittedly, this group is skewed to the positive, with the younger and more educated of the group being more field-independent (1975).

Additional research has been done with ulcer patients (Gordon, 1953), asthmatic children (Fishbein, 1963), inadequate personalities (Korchin, unpublished), and patients with cardiac disorders (Soll, 1963, Witkin, et al, 1972). Diabetics have been found to be severely dependent. Clinic patients are found to be more field-dependent than private patients. No correlation has been found between the duration of the symptoms and field-dependency.

Silverstone and Kissin view psychosomatic symptoms of "being sick" as an indirect means of gaining comfort and support from others. It is a means of expressing one's dependency needs in a socially acceptable manner (Witkin, et al, 1972).

Studies done with diabetics and alcoholics indicate the probability that field-dependency exists before the onset of the symptom (Karp, Winters & Pollack, 1969).

A person who overuses cigarettes, food, drugs or alcohol exhibits an addictive personality. These persons often ask for help about their functional psychosomatic symptom, whether it be drugs, alcohol, cigarettes or food.
Preoccupation with the symptom often relates to self protection. It often takes a good deal of time before the main focus of attention switches to the addictive traits rather than the symptom itself (Fischer, 1973).

These objects are probably the ingredients most used in the service of direct self-hate. They are often used as sedatives and anesthetics in an attempt to relieve self-hate. Using these substances will put a person in a temporary haze in order to escape his feelings. Unconscious self-hate sustains the habits.

In our culture, fat is looked down upon. Obesity surely is a certain means of sustaining chronic self-hate (Rubin, 1975). Much of the feeling of self-hate revolves around feelings of fearfulness. "Fear" when it takes hold can spread like a cancer, feeding on the person until he is riddled with lack of self-confidence, with doubt, mistrust, anxiety, and unhappiness (List, 1963).

All people have a variety of dependency needs. However, the addictive person has a pathological need for dependency. The dependence on things is a defense against underlying problems (Fischer, 1973).

An ulcer patient who views himself as independent is usually overstriving in an attempt to compensate for deep-seated feelings of passivity and persistent dependency needs (Witkin, et al, 1972).

Frequent reliance on denial and repression by a
field-dependent person to avoid negative feelings is bound to lead to a constriction of his life. Too many areas of experience become unsafe to encounter so the individual's readiness to participate in new experiences tends to decrease. Further, when repression is used, there is always the threat that it will not be effective. The person, therefore, functions at a lower level of efficiency and the abnormal effort he must maintain to prevent unwanted feelings or awarenesses to emerge, increases his sense of failure. The active relationship between the self and the environment suffers in the process (Witkin, 1954).

Dealing with one's aggressive feelings may be related to the extent of a person's ability to actively cope with his environment. A very dependent personality is more apt to block his aggression, dealing with aggressive feelings through masochistic patterns. Along with this goes lowered self-esteem, a lowered activity level and a kind of confusion between the self and the environment.

Another possible outcome of conflict about aggressive impulses is an intensification of overly aggressive behavior. Often this is accompanied by projection of guilt onto others. The necessity to maintain supremacy makes for a high level of activity, alertness, and mastery of the environment, while the projection of guilt leaves the self-esteem intact. The extremely field-independent personality is apt to handle aggression in this manner (Witkin, et al,
This is not typical of the field-dependent personality.

The methods used to control impulses may affect the capacity for active coping with the environment. Too rigid methods of binding impulses do not allow for effective integration. Inadequate controls create a weakened personality which cannot maintain a stable persistent activity level because of the constant threat of eruption from within. This threat produces anxiety and destructibility which reduces the consistent purposefulness with which an individual can act (Witkin, et al, 1954).

With regard to the alcoholic, after psychiatric treatment or participation in a treatment program, field-dependency has been reduced. There is a tendency toward greater field-dependency after long-term hospitalization. A person less differentiated uses external cues to help monitor his behavior. Therefore, insight therapy is not indicated as a means to help the alcoholic because insight therapy provides less external cues and requires each patient to work on his own problems.

Furthermore, providing external cues within the therapeutic experiences provide the person with the opportunity of becoming more sensitive, in tune to internal cues and feelings and consequently, to be more free from the need to have constant external structure (McWilliams, 1975).
Karp, Kissin and Hustmyer have found differences in field-dependence between groups of alcoholics who have undergone psychotherapy from those who have had drug therapy. Early dropouts from the psychotherapy group are more field-dependent. Drug therapy is very directive, the patient being told what to do. Relatively field-dependent patients did not remain in drug therapy for a long time. This could possibly be attributed to the rate of meetings. Drug therapy allows for maintenance of defenses of denial and repression (1970).

Contrary to McWilliams, Witkin found that field-dependency persisted after the alcoholic was dry for a period of two years. This research tends to stress the stability of field-dependent-independent behavior and suggests that field-dependency survives the elimination of the symptom (Witkin, 1959).

The studies done with the alcoholic have bearing on the study of obesity if the premise is accepted that both symptoms are indicators of an "addictive personality" and each, possibly for culturally determined reasons, chooses a different object.

Regarding the field-independent personality, when integration and adjustment break down, the person can be found to experience delusions, ideas of grandeur, and outward direction of aggression. Paranoids have been found to be articulated in cognitive style. In addition, obsessive-
compulsive personalities, neurotics with an organized symptom picture and ambulatory schizophrenics have been found to be extremely field-independent (Witkin, et al, 1972).

FIELD-DEPENDENCY AND THE OBESE PERSONALITY

In the United States, twenty percent of the population has an obesity problem. There has been no clear cut causal relationship found (Bornstein, 1972).

In the study relating field-dependency to obesity, the results indicate psychological differentiation of obese women are more field-dependent than women of normal weight (Pardes & Karp, 1965). Using the EFT, BAT and RFT as indicators of field-dependency, the EFT has been found to distinguish the obese from the average most effectively. Little relationship to how obese one becomes has been related to field-dependency.

The obese person tends to have a negative self-concept. Even if weight reduction is achieved but there is no change in self-image, it remains doubtful that the person will be able to maintain the weight loss (Kalisch, 1972). According to studies done by Goffman, the obese person often accepts the negative evaluations placed on him by society; therefore, not being treated as a unique individual.

Historically, the Protestant ethic has emphasized impulse control and abstinence from overeating. Gluttony
is considered one of the Seven Deadly Sins. Doctors often discriminate against their obese patients. The obese patient is often labeled as weak-willed and ugly (Kalisch, 1972).

Bruch, who has done extensive research into obesity, sees it as plausible that since the obese person is relatively undifferentiated, it is reasonable that he should choose eating, an oral activity, which can be traced back to having important sources of satisfaction from the period when the person experienced close unity with the mother. Eating is a non-specialized defense and is applied indiscriminately to a wide range of stressful situations (1964).

The compulsive overeater becomes obsessed with food as a defense. The obsession is a preoccupation with an idea or an emotion, while a compulsion is an impulse or feeling of being irresistibly driven towards the performance of some irrational act (List, 1963). This prevents him from dealing with real problems that exist which are himself (Overeaters Anonymous, 1977).

Eating has been shown to be done to external, not internal, cues (Goldman, Jaffa & Schacter, 1968; Schacter, 1971, 1968; Schacter, Goldman & Gordon, 1968, Schacter & Gross, 1968).

Another theory stated by Bruch is that the obese person cannot discriminate between physiological sensa-
tions of hunger from conditions of arousal which often accompany emotional states of anger, fear, or anxiety. The obese tend to eat as a learned response for reducing the levels of anxiety (1961).

Ball finds that the obese's inability to control their eating is felt to not be within their control (1973).

In our society, people believe they can conquer problems, especially weight problems, with a little "will power". Will power is the ability to decide for oneself what one wants to do rationally and then carry it through. However, for the compulsive overeater, it is relatively impossible to eat just a little food. Food seems to stimulate the appetite rather than produce satiation. Often when the compulsive overeater tries to free himself from this preoccupation with food, "food takes a greater hold on him" (Rubin, 1970). Even when he can abstain and does take off weight, more often than not it is quickly regained. Feelings of failure and lowered self-esteem accompany this type of behavior in body perceptions. They characteristically have inner conflicts, and most suffer from their failure to achieve autonomy and independence (1973).

As is true of the other addictions, most obese persons seek help for their symptom, rarely knowing they are chronically ill. Before a person can change his behavior, he must accept the fact that he has an emotional sickness
which, when uncontrolled, produces overweight. To accept this without self-hate and rationalization is the key (Rubin, 1970). Those in the helping professions who are attempting to work and aid the obese client must first look at their own prejudices and myths about obesity. Without unconditional acceptance, there is little hope of helping the obese compulsive overeater. To mention weight reduction until a relationship has been established is doomed to failure. Because of the shame and guilt that is felt, it may be very difficult for the obese client to talk about his feelings (Kalisch, 1972). To date, individual psychotherapy has not proven very successful (Fischer, 1973).

Numerous methods of weight reduction have been undertaken. Results have not been very encouraging (Mayer, 1968; Stunkard & McLaren-Hume, 1959). Claims of successes are short-lived (MacCuish, Munro & Duncan, 1968, Swanson & Dinello, 1969, 1970).

Bruch sees the obese as suffering from a lack of identity, of not owning their own bodies. They lack awareness of bodily urges and are unable to correctly recognize satiation and hunger. The obese do not see themselves objectively and are more concerned with the judgment of a scale than with what they feel or observe (1964).

"It is difficult to go through the conflicts and struggles necessary to establish real values which are the cornerstone of the self" (Rubin, 1970).
From birth, an individual has the ability to differentiate between behavior based on his initiation and that responded to from the environment. The infant is not solely dependent on stimulation from the outside but is active in letting its own needs and wants known, as has been discussed previously.

The interaction with the environment can be termed stimulating or responsive. The interaction can be appropriate or inappropriate, depending on whether it furthers survival or is destructive.

It appears that for normal development, stimulation coming from the outside and confirmation of impulses originated in the child need to be balanced. Deprivation of the regular sequence of experience of felt needs, appropriate responses and felt satisfaction may exert a profound disruption in early learning. The result of this is a disordered bodily function. Such a person will be poorly equipped for orienting himself about his body and his socio-emotional environment.

In further studies done by Bruch, parents of obese children tend to be overprotective, showing concern for the physical well being of the child and often desire to possess them as an object.

Histories rarely give evidence of neglect. The mother is found to often force the child to do her will. The signals indicating nutritional needs are not appropriate
or are appeased. Other signals by the child are often disregarded or evoke an inappropriate response. An appropriate reinforcing response is necessary if a child is to develop a sense of trust in his own activity and impulses. If the child does not get the response necessary from the mother, the individual will learn only to respond to others. She will always be under the influence of or at the service of someone else (Bruch, 1964).

If failure of conformation of the child-initiated behavior is severe, the outcome will be a passive person without experiencing thoughts, sensations or feelings as originating from herself (Bruch, 1964).

It has been shown that the more a person weighs, the less responsive he is to internal cues of hunger (Glass, 1969). In addition, association of power with gross body size has been found by Suczek (1957).

Eating is a cue to feelings of anxiety. It is a defense against anxiety. However, the fatness which results produces self-hate, self-doubt, and a feeling of hopelessness. Relations with people suffer, which in turn creates more frustration, conflict, and anxiety (Rubin, 1970; Witkin, 1965).

As stated, the obese person is not usually conscious of his anger. In circumstances where other people would probably feel anger, obese people will usually be content at giving no evidence of irritation. However, obese
people are very angry and have particular problems with angry feelings. Anger represents a threat to dependent relationships. Frequently, the obese turns on himself because of his inability to express anger at an object in the environment. This is particularly true when anger is directed at a spouse (Rubin, 1970, 1969).

Bruch differentiates between developmental and reactive obesity. Developmental obesity begins in childhood and is associated with emotional and personality disturbances which, in many ways, resemble preschizophrenic development. Often obesity is a protection against more severe mental illness.

Obesity serves as an avoidance of threatening and unacceptable social demands. Indulgence in food allows for a semblance of satisfaction in what is felt as a bleak existence. Responses to the environment exhibit a low frustration tolerance with underlying hostility. There is a sense of helplessness. The obese person is convinced of his inadequate and inner ugliness.

As a response to a certain traumatic experience, a person can experience a sudden gain of weight; usually this occurs in adulthood. Reactive obesity can develop after a severe mental shock such as the death of a loved one, separation, or events involving fear of desertion and loneliness (1964).

Emotionality is related to field-dependency. The
less a person is differentiated the greater the effect of emotion on perception. Too high a level of emotion disrupts the recognition of stimuli. It is felt that this blots out the experience (Minard & Mooney, 1969).

Obesity is a result of a breakdown in integration and adjustment within the environment. When this breakdown occurs, the pattern of consuming more food than the body needs is termed compulsive overeater as eating is done for other reasons than for hunger.

A description of the person's eating pattern in the process of becoming obese is described by Overeaters Anonymous.

A person who compulsively overeats will have some or all of the characteristics listed below:

.. Eat when not hungry.
.. Go on eating binges for no apparent reason.
.. Have feelings of guilt about overeating.
.. Spend too much time thinking about food.
.. Anticipate times when one can eat alone.
.. Resent people who give advice about dieting.
.. Crave food other than at mealtime.
.. Escape from worry or trouble by eating.
.. Have a preoccupation with food that makes himself or others around him unhappy and have possibly been treated by a doctor for overweight (1973).
When practicing compulsive overeating, the person is further enmeshed in a vicious circle leading nowhere except to self-hate.
Chapter III  
DESIGN OF THE STUDY  

Description of the Research Design  

To ascertain if there are any differences in field-dependent-independent behavior, subjects have been assigned to one of two groups. Group 1 is composed of women attending Overeaters Anonymous\(^1\) who have been at least 20 percent above average weight and have successfully reduced to an average weight while members of OA. Methods for determining average weight of the subject have been discussed previously. Those assigned to Group 1 have maintained their average weight for at least one year. This group is to be referred to as the "maintainers".  

Group 2 is composed of women, presently attending OA who have been coming to the meetings for at least one year, also. This group has not been successful in returning to an average weight within the period of one year. They too must have weighed at least 20 percent above average weight to be considered as subjects.  

The variables to be considered are field-dependent-independent behavior which has been tested by use of the Embedded Figures Test, past and present attitudes and feelings related to compulsive overeating, and levels of involvement in the program of OA. This latter information  

\(^1\)In the future, when referring to Overeaters Anonymous, the abbreviation "OA" will be used.
has been obtained by use of a questionnaire.

**Statistical Treatment**

Due to the sample size, the evidence presented cannot be considered to be conclusive. Descriptive statistics have been used to summarize the information. Means are computed when necessary to determine average age, educational level, and EFT score.

**Sampling Procedures**

The final sample includes in Group 1, "maintainers", seven women ranging in age from 34 years to 43 years of age with the mean age being 37.1. Group 2, "obese", has an age range from 34 years to 48 years of age. The mean age is 39.8 years. Within this group, there are six women.

It had been anticipated when planning this study that Group 1 and Group 2 would each have approximately 18 female subjects. This has not been achieved due to unexpected difficulties in obtaining the sample.

In order to obtain the subjects, I attended meetings of OA. Table 1 indicates the response that was achieved at each meeting. During the meetings, women were asked if they would complete a questionnaire. The anonymity of the participants was guaranteed.

The sampling procedures for obtaining the completed questionnaire was changed due to the lack of response at each meeting. This possibly has affected the results of
this study.

Willingness to complete a questionnaire seemed, in part, determined by the person's interest that was leading the meeting.

During the first meeting, it was requested that women who have attended OA for at least one year complete a questionnaire. The leader of this meeting was enthusiastic and stated her interest to the group. Time was allotted during the meeting to complete the questionnaire.

During the second meeting, the leader did not feel that time could be allotted to passing out questionnaires. People were asked to complete questionnaires after the meeting.

While attending the third meeting, a table had been placed outside the door for people to fill out name cards as they entered the meeting. It was at this time that the women were asked if they attended OA for at least one year and if their response was positive, they were then asked to complete a questionnaire and to return it at the end of the meeting.

During the fourth meeting, a personal request was made while standing in front of the group. An explanation was given as to my involvement with Overeaters Anonymous which included some self-disclosure about my own relationship and experience with obesity and familiarity with OA, as I have attended meetings for a three year period.
At the fifth meeting, a personal request was again made which was similar to the way it was approached at the previous meeting.

Due to the little response, it became increasingly difficult to obtain an adequate sample within a reasonable period of time.

It is not known for what reasons people refused to participate in this study. It can be speculated that possible reasons were apathy, failure to have attended meetings for at least one year, fear, low self-esteem, and lack of trust in the research process itself.

There is a possibility that this poor response is indicative of the level of success of the participants within the program. OA has no statistics available. It tends to support the research previously discussed showing obese persons tend to be distrustful, withdrawn, and isolate themselves from others.

### Table 1

Response to Questionnaire at OA Meetings

<table>
<thead>
<tr>
<th>Meeting</th>
<th>Approximate Attendance</th>
<th>Questionnaires Completed</th>
<th>Percent of Response</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>35</td>
<td>9</td>
<td>26%</td>
</tr>
<tr>
<td>2</td>
<td>25</td>
<td>4</td>
<td>16</td>
</tr>
<tr>
<td>3</td>
<td>125</td>
<td>3</td>
<td>2</td>
</tr>
<tr>
<td>4</td>
<td>175</td>
<td>12</td>
<td>7</td>
</tr>
<tr>
<td>5</td>
<td>50</td>
<td>4</td>
<td>8</td>
</tr>
<tr>
<td>Totals</td>
<td>410</td>
<td>32</td>
<td></td>
</tr>
<tr>
<td>Personal Requests</td>
<td></td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>Grand Total</td>
<td></td>
<td>35</td>
<td></td>
</tr>
</tbody>
</table>
Of the 35 women who filled out questionnaires, 22 had to be eliminated because of age, inability to spend additional time as a subject participant, refusal to give telephone numbers and never being at least 20 percent above an average adult weight.

In addition, the amount of time required to administer the EFT and the fact that it had to be given individually further hampered this study. It was virtually impossible to get people to participate who worked full-time. Women who completed the questionnaire and had the qualifications necessary to be considered subjects were contacted by telephone. Testing sessions were arranged which took between one and two hours.

Due to the small sample size, it became increasingly difficult to match subjects according to certain variables. An attempt was made to balance the age of the two groups as well as the educational level of the individuals, however. The average level of education of Group 1 is completion of 2.6 years of college. Group 2 has completed 2.3 years of college.

**Data-Gathering Instruments**

The EFT and the questionnaire, as stated previously, are the two instruments used to gather the data. The EFT has been described. Instructions for administering the EFT have been obtained from the manual written by Witkin and his associates (1972).
During each testing session, the subject is first shown a practice Complex Design card followed by a Simple Figure card in order to understand the procedure. During the test, as well as for the practice, the subject can see the Simple Figure as many times as is necessary. The Simple Figure is never seen at the same time as the Complex Figure card. Review of the Simple Figure is not included within the time limit of three minutes. This is the time allotted for discovery of the Simple Figure for each item. Set A of the EFT, consisting of 12 Complex Designs and 8 Simple Figures, is the form of the test that was administered.

Table 2 furnishes information as to the norms and reliabilities that have been established in previous research (Witkin, et al, 1972).

Table 2
Norms and Reliabilities of the EFT

<table>
<thead>
<tr>
<th>Age</th>
<th>Sex</th>
<th>N</th>
<th>Mean</th>
<th>S.D.</th>
<th>Reliability</th>
</tr>
</thead>
<tbody>
<tr>
<td>College</td>
<td>F</td>
<td>51</td>
<td>66.9</td>
<td>33.6</td>
<td>.79</td>
</tr>
<tr>
<td>College</td>
<td>F</td>
<td>34</td>
<td>69.4</td>
<td>41.0</td>
<td>Unknown</td>
</tr>
<tr>
<td>34.5</td>
<td>F</td>
<td>32</td>
<td>84.2</td>
<td>34.4</td>
<td>.82</td>
</tr>
<tr>
<td>33.8</td>
<td>F</td>
<td>80</td>
<td>63.6</td>
<td>34.9</td>
<td>Unknown</td>
</tr>
</tbody>
</table>

A description of the questionnaire is included to explain the terminology which is peculiar to OA and to inform the reader of its purpose (see Appendix for sample questionnaire).

Items one, four and five on the questionnaire give
the necessary information for determining the subject's desirability as a subject.

Item 7 refers to abstinence from compulsive overeating. OA recommends two eating plans which are referred to as a person's abstinence. It is advised that a doctor be consulted prior to beginning the eating plan.

Item 3, supplied by OA, is an index of how compulsive one is in relation to food. Persons have been asked to evaluate their compulsive overeating as they remembered themselves when they first began the OA program. In addition, they are to evaluate their feelings at the time they answered the questionnaire. Responses to each item have been weighted as follows:

- 0 points = seldom/never
- 1 point = often
- 2 points = constantly

If a person answered "constantly" to each item, they would receive a maximum score of 30 for past feelings of compulsiveness and a score of 30 points for present feelings of compulsiveness.

Items 9 and 10 refer to the components of the OA program of recovery as it is called. OA believes that compulsive overeating is a threefold disease, emotional, physical and spiritual, and recovery must be on all three levels.

Each person has been asked to rate himself regarding his involvement in the OA program. See Tables 7 and 8.
The scale used is a five point scale. A response of one indicates this is an activity rarely participated in, three indicates average involvement, and five suggests frequent involvement in the activity. If a person answers five to each item, a maximum score of 75 is possible. Responses have been totaled to obtain an index of involvement for each person.

In addition, scores for each item are summed in order to determine which areas held the highest priority for these subjects as a group.

The OA program is based on the steps and traditions of Alcoholics Anonymous, and their literature is used as a basis for the OA program as well. When reading AA literature, the words "compulsive overeater" are substituted for "alcoholic".

The Twelve Traditions of Alcoholics Anonymous form the basis for the meetings of OA. There are OA meetings held every day of the week in the Los Angeles area. In recording the Twelve Traditions, the words "compulsive overeater" have been substituted for "alcoholic" (Twelve Steps and Twelve Traditions, 1952).

**Twelve Traditions**

1. Our common welfare should come first; personal recovery depends on OA unity.

2. For our group purpose there is but one ultimate authority - a loving God as He may express Himself in our group conscience. Our leaders are but trusted servants; they
do not govern.

3. The only requirement for OA membership is a desire to stop eating compulsively.

4. Each group should be autonomous, except in matters affecting other groups or OA as a whole.

5. Each group has but one primary purpose - to carry its message to the compulsive overeater who still suffers.

6. An OA group ought never endorse, finance, or lend the OA name to any related facility or outside enterprise, lest problems of money, property and prestige divert us from our primary purpose.

7. Every OA group ought to be fully self-supporting, declining outside contributions.

8. Overeaters Anonymous should remain forever non-professional, but our service centers may employ special workers.

9. Overeaters Anonymous, as such, ought never to be organized, but we may create service boards or committees directly responsible to those they serve.

10. Overeaters Anonymous has no opinion on outside issues, hence the OA name ought never be drawn into public controversy.

11. Our public relations policy is based on attraction rather than promotion; we need always maintain personal anonymity at the level of press, radio, and films.

12. Anonymity is the spiritual foundation of our traditions, ever reminding us to place principles before personalities.

The steps of the OA program are also taken from Alcoholics Anonymous. This is the basis for the individual's program of recovery, whether it be from alcohol or from food.
It is believed by members of OA that members must make a daily commitment to abstain from compulsive overeating. This is done by saying the first three steps of the program. In step 1 the person is willing to give up his control over his eating patterns. In step 2 he affirms his belief that there is help outside of himself, whether it be God, the group of OA, or another individual that can help him abstain from compulsive overeating. Step 3 refers to the fact that the OA member is willing to go to any lengths necessary to abstain from compulsive overeating. Below are listed the steps of OA. "Compulsive overeater" is inserted for the word "alcoholic" where appropriate (Twelve Steps and Twelve Traditions, 1952).

**Twelve Steps**

1. We admitted we were powerless over food - that our lives had become unmanageable.

2. Came to believe that a Power greater than ourselves could restore us to sanity.

3. Made a decision to turn our will and our lives over to the care of God as we understood Him.

4. Made a searching and fearless moral inventory of ourselves.

5. Admitted to God, to ourselves, and to another human being the exact nature of our wrongs.

6. Were entirely ready to have God remove all these defects of character.

7. Humbly asked Him to remove our shortcomings.
8. Made a list of all persons we had harmed, and became willing to make amends to them all.

9. Made direct amends to such people, whenever possible, except when to do so would injure them or others.

10. Continued to take personal inventory, and when we were wrong promptly admitted it.

11. Sought through prayer and meditation to improve our conscious contact with God as we understood Him, praying for knowledge of His will for us and the power to carry that out.

12. Having had a spiritual awakening as the result of these steps, we tried to carry this message to other compulsive overeaters, and to practice these principles in all our affairs.

In addition, by being involved in the OA program in the following ways, a person apparently finds benefit for himself and is considered to be practicing the steps of the program.

Being a food sponsor helps to reinforce one's own abstinence. A food sponsor is a person who has abstained from compulsive overeating for at least 21 days and has worked with a person who has been considered to be his food sponsor. This person helps others with their food plan and with other problems they may have which they want to share. While establishing a new food plan, it is expected that a person will call his food sponsor daily for at least 21 days and report and write down his food plan for that day.
After a person has maintained a clean abstinence for a certain period of time and has completed step 4, he can become a step sponsor (step 4 requires that an inventory be written). An inventory is a written document which includes a person's feelings relating to his patterns of compulsive overeating. This is the time the person explores his fears, resentments, frustrations and guilt feelings relating to people, places and things. It is a discussion of any and all problems as seen by the compulsive overeater in the present and in the past. After completion, it is read to another person, discussed and then destroyed. It is believed that this has a healing effect and allows persons to let go of the problems of their past in order that they may live in the present.

There are various other ways that people can help within OA. They can serve as a secretary, treasurer, or literature person of a group.

Persons can participate in retreats which are held at specific locations, usually for two to three days. At this time, intensive learning experiences are offered.

OA is a loosely-knit organization. However, a coordinating body called inner group meets monthly to discuss the policy of the individual meetings. There is also an office which coordinates national policy. Representatives are members of the various individual groups.

In addition, there is a yearly convention, further
providing the opportunity for an intensive experience in working the OA program.

The 5th tradition is a newsletter, written and distributed by the members of OA.

Below is a description of a typical meeting. This will aid the reader in understanding the important terminology and facilitate understanding of the questionnaire that was completed by the participants.

Each OA meeting is brought to order by a leader. This is a person who acts as the chairperson for one meeting only. There are a few exceptions to this. The group opens with the "Serenity Prayer". After reading from the book of Alcoholics Anonymous, (1939), the leader tells the group about himself, "sharing his experience, strength and hope" (Overeaters Anonymous, 1977). Pitches are next given by others attending the meetings. This is when persons share about themselves. There is never cross-discussion during a meeting; basically, each person presents their ideas. At the conclusion of pitches, some groups have a speaker who is a member that has been working the program for a designated length of time. Again, this person shares about himself and how he works the OA program. As stated previously, there is no cross-discussion. If there is no speaker, the group might choose to discuss some aspects of the OA program or to study one of the steps of the program. There is no cross-discussion during these times. Ideas are
presented one at a time. Each meeting is concluded after reciting the "Lord's Prayer".

The telephone is extremely important in working the program. It is strongly advised that members call other members and establish friendships with others on the program. It is felt that when a problem arises, it is better to call another OA member than to try to solve it oneself or seek advice from others not in OA, because those who are not compulsive overeaters find it difficult to understand a compulsive overeater.
Chapter 4
ANALYSIS OF THE DATA

The hypothesis under scrutiny, as stated, is the belief that Group 1 individuals are more field-independent than Group 2 individuals as reported by the EFT. It is further anticipated that those in Group 1 are generally more involved in the OA program and that members of both groups see themselves as compulsive overeaters.

From Table 3 it can be ascertained that for four out of the six women in Group 2, their adult maximum weight is higher than for persons in Group 1. Five out of the six subjects in Group 2 presently weigh less than they did when first coming to OA. At the present time the person in Group 2 who has attended meetings for the longest length of time is at her maximum weight. Information as to her weight pattern over the past 10 years is not available.
### Table 3
Comparison of Subjects' Weights

<table>
<thead>
<tr>
<th>Group</th>
<th>Maximum Adult Weight</th>
<th>Present Weight</th>
<th>Normal Weight</th>
<th>% Obese</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>lbs. (kgs.)</td>
<td>lbs. (kgs.)</td>
<td>lbs. (kgs.)</td>
<td></td>
</tr>
<tr>
<td>1</td>
<td>174 (79)</td>
<td>125 (71)</td>
<td>130 (59)</td>
<td>38%</td>
</tr>
<tr>
<td>2</td>
<td>175 (79)</td>
<td>122 (55)</td>
<td>132 (60)</td>
<td>38</td>
</tr>
<tr>
<td>3</td>
<td>185 (84)</td>
<td>130 (60)</td>
<td>132 (60)</td>
<td>38</td>
</tr>
<tr>
<td>4</td>
<td>152 (69)</td>
<td>125 (71)</td>
<td>126 (57)</td>
<td>21</td>
</tr>
<tr>
<td>5</td>
<td>154 (70)</td>
<td>130 (60)</td>
<td>132 (60)</td>
<td>20</td>
</tr>
<tr>
<td>6</td>
<td>230 (104)</td>
<td>155 (70)</td>
<td>140 (64)</td>
<td>64</td>
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<tr>
<td>7</td>
<td>185 (84)</td>
<td>140 (64)</td>
<td>132 (60)</td>
<td>40</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>1</td>
<td>175 (79)</td>
<td>160 (73)</td>
<td>135 (61)</td>
</tr>
<tr>
<td>2</td>
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<td>21</td>
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<tr>
<td>3</td>
<td>255 (116)</td>
<td>205 (93)</td>
<td>151 (69)</td>
<td>69</td>
</tr>
<tr>
<td>4</td>
<td>207 (94)</td>
<td>207 (94)</td>
<td>140 (64)</td>
<td>48</td>
</tr>
<tr>
<td>5</td>
<td>248 (112)</td>
<td>225 (102)</td>
<td>136 (62)</td>
<td>82</td>
</tr>
<tr>
<td>6</td>
<td>236 (107)</td>
<td>158 (72)</td>
<td>139 (63)</td>
<td>70</td>
</tr>
</tbody>
</table>

**Note:** Weights are given in lbs. and kgs.
Table 4 indicates the individual scores on the EFT:

Table 4
Individual Scores on the EFT

<table>
<thead>
<tr>
<th>Group 1</th>
<th>Mean Score</th>
<th>Group 2</th>
<th>Mean Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>64.17</td>
<td>1</td>
<td>69.75</td>
</tr>
<tr>
<td>2</td>
<td>49.58</td>
<td>2</td>
<td>66</td>
</tr>
<tr>
<td>3</td>
<td>49.66</td>
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<td>55.67</td>
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<td>4</td>
<td>85.41</td>
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<td>148.92</td>
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<td>97.58</td>
<td>6</td>
<td>68.66</td>
</tr>
<tr>
<td>7</td>
<td>32.8</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

The mean score for Group 1 is 75.8 and for Group 2 the mean score is 81.35. Subject 5 in Group 1, with a mean score of 148.92, has a severe astigmatism. After consulting with Dr. Howard Stone, an Opthamologist in the Beverly Hills area, it has been confirmed that an astigmatism can possibly affect perception. However, the evidence for this to be the case for Subject 5 is not conclusive at this time. If her score is deleted, however, there is a marked decrease in the mean score for Group 1 individuals. The mean score then changes to 63.02.

As stated previously, the questionnaire has determined the educational level of individuals in both of the groups to be relatively high. It can be anticipated, therefore, that they will be involved in various activities. Although none have full-time jobs at the present time, in Group 1
five subjects have part-time jobs away from their homes which occupy their time. From Group 2, five of the individuals have part-time jobs away from the home as well.

Except for one person in both groups, all are married at the present time. The one subject is presently divorced and is in Group 2. No information is available as to the length of their marriages, the number of marriages or the time that has elapsed since divorce.

Tables 5 and 6 summarize information supplied by the questionnaire regarding the degree the individuals of both groups see themselves as compulsive overeaters.

Generally, members of both groups, when first coming to OA, are preoccupied with feeling resentful towards others who feel that they can diet successfully through the use of will power. A change has occurred in this area since involvement in OA; however, not in the suspected direction. The group that has lost and maintained their weight loss is relatively unchanged in their feelings in this area. They are apparently still feeling resentful when confronted with this idea. However, those who have been unable to lose their weight seem relatively unconcerned with others' feelings about losing weight. The possibility does exist that discussion with significant others in the lives of those in Group 2 is not a relevant issue at this time due to preoccupation with OA. It is further possible that social pressure has been lessened since they have
joined the OA program, whereas the social pressure for those in Group 1 still feels relatively intense for varying reasons.

Table 5

Group 1 - Maintainers

Levels of Compulsiveness in the Past and Present

<table>
<thead>
<tr>
<th></th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
<th>Totals</th>
</tr>
</thead>
<tbody>
<tr>
<td>Eat, not hungry</td>
<td>1,0</td>
<td>2,0</td>
<td>0</td>
<td>1,1</td>
<td>2,0</td>
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<td>0</td>
<td>8,3</td>
</tr>
<tr>
<td>Binges</td>
<td>0</td>
<td>2,0</td>
<td>1,0</td>
<td>0</td>
<td>1,0</td>
<td>0</td>
<td>1,1</td>
<td>5,1</td>
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<tr>
<td>Guilt/remorse</td>
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<td>0</td>
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<td>2,2</td>
<td>0</td>
<td>0</td>
<td>2,2</td>
<td>8,8</td>
</tr>
<tr>
<td>Thoughts of food</td>
<td>2,2</td>
<td>1,1</td>
<td>2,2</td>
<td>2,2</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>7,7</td>
</tr>
<tr>
<td>Anticipate eating alone</td>
<td>2,2</td>
<td>1,0</td>
<td>1,0</td>
<td>0</td>
<td>2,2</td>
<td>0</td>
<td>0</td>
<td>6,4</td>
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<tr>
<td>Plan binges</td>
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<td>1,0</td>
<td>0</td>
<td>1,0</td>
<td>0</td>
<td>0</td>
<td>3,0</td>
</tr>
<tr>
<td>Eat alone</td>
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<td>2,0</td>
<td>2,0</td>
<td>2,0</td>
<td>1,1</td>
<td>0</td>
<td>1,1</td>
<td>9,2</td>
</tr>
<tr>
<td>Weight affects life</td>
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<td>2,0</td>
<td>1,1</td>
<td>2,2</td>
<td>0</td>
<td>0</td>
<td>2,2</td>
<td>9,5</td>
</tr>
<tr>
<td>Diets fail</td>
<td>2,0</td>
<td>2,0</td>
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<td>2,2</td>
<td>2,0</td>
<td>2,0</td>
<td>2,2</td>
<td>13,4</td>
</tr>
<tr>
<td>Resentments</td>
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<td>2,2</td>
<td>2,0</td>
<td>2,2</td>
<td>12,10</td>
</tr>
<tr>
<td>Can diet alone</td>
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<td>1,0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>2,2</td>
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<td>4,3</td>
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<tr>
<td>Cravings</td>
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<td>2,0</td>
<td>1,0</td>
<td>1,1</td>
<td>2,2</td>
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<td>0</td>
<td>8,5</td>
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<tr>
<td>Eat to escape</td>
<td>1,1</td>
<td>2,0</td>
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<td>1,1</td>
<td>2,2</td>
<td>0</td>
<td>2,2</td>
<td>7,5</td>
</tr>
<tr>
<td>Medically treated for overweight</td>
<td>1,0</td>
<td>1,0</td>
<td>1,0</td>
<td>0</td>
<td>1,0</td>
<td>0</td>
<td>1,1</td>
<td>5,1</td>
</tr>
<tr>
<td>Unhappy with his reaction of others</td>
<td>2,0</td>
<td>1,1</td>
<td>1,0</td>
<td>1,1</td>
<td>2,2</td>
<td>2,0</td>
<td>1,1</td>
<td>10,5</td>
</tr>
<tr>
<td><strong>Totals:</strong></td>
<td>19,10</td>
<td>21,2</td>
<td>14,8</td>
<td>16,14</td>
<td>19,11</td>
<td>8,4</td>
<td>12,2</td>
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</table>
Table 6
Group 2 - Obese

Levels of Compulsiveness
in the Past and Present

<table>
<thead>
<tr>
<th></th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>Totals</th>
</tr>
</thead>
<tbody>
<tr>
<td>Eat, not hungry</td>
<td>1,1</td>
<td>2,2</td>
<td>1,1</td>
<td>1,1</td>
<td>1,1</td>
<td>2,0</td>
<td>8,6</td>
</tr>
<tr>
<td>Binges</td>
<td>1,1</td>
<td>1,1</td>
<td>0</td>
<td>1,1</td>
<td>2,0</td>
<td>2,0</td>
<td>7,3</td>
</tr>
<tr>
<td>Guilt/remorse</td>
<td>1,1</td>
<td>2,2</td>
<td>2,2</td>
<td>1,1</td>
<td>2,2</td>
<td>1,0</td>
<td>9,8</td>
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<tr>
<td>Thoughts of food</td>
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<td>0</td>
<td>0</td>
<td>2,2</td>
<td>1,1</td>
<td>6,6</td>
</tr>
<tr>
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<td>1,1</td>
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<td>0</td>
<td>1,1</td>
<td>2,2</td>
<td>2,0</td>
<td>7,5</td>
</tr>
<tr>
<td>Plan binges</td>
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<td>0</td>
<td>0</td>
<td>1,0</td>
<td>1,0</td>
<td>4,2</td>
</tr>
<tr>
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<td>1,1</td>
<td>1,1</td>
<td>1,0</td>
<td>5,4</td>
</tr>
<tr>
<td>Weight affects life</td>
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<td>2,2</td>
<td>2,2</td>
<td>1,1</td>
<td>9,9</td>
</tr>
<tr>
<td>Diets fail</td>
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<td>0</td>
<td>2,2</td>
<td>2,2</td>
<td>2,0</td>
<td>2,2</td>
<td>10,6</td>
</tr>
<tr>
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<td>2,2</td>
<td>2,2</td>
<td>2,2</td>
<td>10,1</td>
</tr>
<tr>
<td>Can diet alone</td>
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<td>0</td>
<td>0</td>
<td>0</td>
<td>3,3</td>
</tr>
<tr>
<td>Cravings</td>
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<td>0</td>
<td>0</td>
<td>1,1</td>
<td>2,2</td>
<td>6,6</td>
</tr>
<tr>
<td>Eat to escape</td>
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<td>2,2</td>
<td>1,1</td>
<td>0</td>
<td>1,1</td>
<td>2,0</td>
<td>8,6</td>
</tr>
<tr>
<td>Medically treated for overweight</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Unhappy with his reaction of others</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Note: The first numeral in each pair of numerals in Tables 5 & 6 refer to the subjects' feelings about their compulsive activity upon entering Overeaters Anonymous. The second numeral refers to present activity when they were answering the questionnaire.
This finding is in contradiction to the EFT scores. However, since Group 1 is less field-dependent than Group 2 members, it could be expected that those in Group 2 would be more concerned with the feelings of others. This presents the probability that field-dependence is not a factor of relevance in this area.

Tables 7 and 8 compare involvement in the OA program between those in Group 1 and those in Group 2 as they have rated themselves on the questionnaire.

As stated previously, a possible score of 75 is possible if a person is maximally involved in every area. The results indicate a considerable difference in the level of involvement between the two groups.

Those in Group 1, on the average, are involved 50 percent more than those in Group 2. Five persons in Group 1 have scored between 45 and 55 points when asked how involved they are in the various activities. Of those in Group 2, only one person scored 50 points. The remainder of the group scored between 19 and 32 points.

Below are listed the areas of involvement most important to those in Group 1 in their order of importance. Following each activity are the total number of points this activity received, summing the response of all members for each item within that group:

1. Prayer and calling other OA members (33 points each).
2. Saying steps 1, 2, and 3 (32 points).
3. Socializing (28 points).
4. Pitching at meetings (27 points).
5. Calling their food sponsor (25 points).

Table 7
Group 1
Maintainers—Involvement with Overeaters Anonymous

<table>
<thead>
<tr>
<th>Subjects</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
<th>Totals</th>
</tr>
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<td>OA Literature</td>
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<td>4</td>
<td>5</td>
<td>5</td>
<td>3</td>
<td>2</td>
<td>23</td>
</tr>
<tr>
<td>Writing</td>
<td>2</td>
<td>3</td>
<td>2</td>
<td>2</td>
<td>3</td>
<td>1</td>
<td>1</td>
<td>14</td>
</tr>
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<td>4</td>
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<td>5</td>
<td>2</td>
<td>2</td>
<td>24</td>
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<td>Say Steps</td>
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<td>5</td>
<td>5</td>
<td>5</td>
<td>5</td>
<td>5</td>
<td>3</td>
<td>32</td>
</tr>
<tr>
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<td>5</td>
<td>4</td>
<td>3</td>
<td>1</td>
<td>5</td>
<td>2</td>
<td>25</td>
</tr>
<tr>
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<td>5</td>
<td>5</td>
<td>5</td>
<td>5</td>
<td>5</td>
<td>3</td>
<td>33</td>
</tr>
<tr>
<td>Leading Meetings</td>
<td>4</td>
<td>5</td>
<td>2</td>
<td>1</td>
<td>1</td>
<td>3</td>
<td>3</td>
<td>19</td>
</tr>
<tr>
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<td>2</td>
<td>3</td>
<td>3</td>
<td>5</td>
<td>3</td>
<td>3</td>
<td>23</td>
</tr>
<tr>
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<td>1</td>
<td>1</td>
<td>0</td>
<td>1</td>
<td>1</td>
<td>0</td>
<td>8</td>
</tr>
<tr>
<td>Pitching</td>
<td>5</td>
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<td>2</td>
<td>4</td>
<td>3</td>
<td>5</td>
<td>3</td>
<td>27</td>
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<td>1</td>
<td>3</td>
<td>5</td>
<td>5</td>
<td>3</td>
<td>23</td>
</tr>
<tr>
<td>Prayer</td>
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<td>5</td>
<td>5</td>
<td>4</td>
<td>5</td>
<td>5</td>
<td>5</td>
<td>33</td>
</tr>
<tr>
<td>Go to Other</td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
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<td>Anonymous Meetings</td>
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<td>5</td>
<td>1</td>
<td>3</td>
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<td>3</td>
<td>3</td>
<td>5</td>
<td>5</td>
<td>5</td>
<td>28</td>
</tr>
<tr>
<td>Attend Retreats</td>
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<td>1</td>
<td>3</td>
<td>2</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>10</td>
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<td><strong>TOTALS</strong></td>
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<td>45</td>
<td>50</td>
<td>51</td>
<td>52</td>
<td>39</td>
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</tbody>
</table>

Note: Maximum score is 75 for each person.
<table>
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<tr>
<th>Activity</th>
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<th>Activity 3</th>
<th>Activity 4</th>
<th>Activity 5</th>
<th>Activity 6</th>
<th>Totals</th>
</tr>
</thead>
<tbody>
<tr>
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<td>3</td>
<td>1</td>
<td>1</td>
<td>3</td>
<td>13</td>
</tr>
<tr>
<td>Writing</td>
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<td>3</td>
<td>5</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>16</td>
</tr>
<tr>
<td>AA Literature</td>
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<td>3</td>
<td>14</td>
</tr>
<tr>
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<td>5</td>
<td>1</td>
<td>3</td>
<td>3</td>
<td>16</td>
</tr>
<tr>
<td>Telephoning Others</td>
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<td>9</td>
</tr>
<tr>
<td>Leading Meetings</td>
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<td>1</td>
<td>4</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td>15</td>
</tr>
<tr>
<td>Attending Meetings</td>
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<td>2</td>
<td>1</td>
<td>0</td>
<td>4</td>
<td>12</td>
</tr>
<tr>
<td>Speaker</td>
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<td>1</td>
<td>4</td>
<td>1</td>
<td>0</td>
<td>1</td>
<td>8</td>
</tr>
<tr>
<td>Pitching</td>
<td>1</td>
<td>2</td>
<td>4</td>
<td>1</td>
<td>2</td>
<td>2</td>
<td>12</td>
</tr>
<tr>
<td>Meditate</td>
<td>4</td>
<td>2</td>
<td>4</td>
<td>1</td>
<td>4</td>
<td>1</td>
<td>16</td>
</tr>
<tr>
<td>Prayer</td>
<td>4</td>
<td>2</td>
<td>2</td>
<td>1</td>
<td>5</td>
<td>1</td>
<td>15</td>
</tr>
<tr>
<td>Go to Other Anonymous Meetings</td>
<td>3</td>
<td>1</td>
<td>5</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>10</td>
</tr>
<tr>
<td>Socialize</td>
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<td>5</td>
<td>2</td>
<td>0</td>
<td>2</td>
<td>11</td>
</tr>
<tr>
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<td>0</td>
<td>0</td>
<td>2</td>
<td>3</td>
</tr>
</tbody>
</table>

**TOTALS**: 31 26 50 19 27 32

*Note: Maximum score is 75 for each person*
The following list indicates the areas of involvement considered to be of greatest importance to the individuals in Group 2. The total number of points for each item is included. For each item that is listed in order of importance, it can be seen that Group 1 has fifty percent more participation in the program. The items are not necessarily the same for each group:

1. Meditating, calling food sponsor, and writing (16 points each).
2. Reading AA literature, leading meetings, and prayer (15 points each).
3. Saying steps (14 points).
4. Reading OA literature (13 points).
5. Attending meetings, and pitching (12 points).

There is a correlation that success for members of Group 1 is related to increased involvement in the program of Overeaters Anonymous. However, their focus seems to be in fewer areas and with greater intensity.

The above findings of Groups 1 and 2 indicate that Group 1 is more focused in the area of relationships. Calling other OA members, sharing with a food sponsor, and socializing are strong indications that the individuals in Group 1 relate to others in an ongoing relationship on an individual basis.

The activities that rank highest in priority for the individuals in Group 2 minimize involvement with others.
The areas mentioned indicate that there is a strong tendency for these people to isolate themselves from others, except their food sponsor. Attending OA meetings gives no indication that relationships are being established with other people.

Further, pitching, and leading meetings enable a person to have an outlet for their feelings. However, in these specific situations there is no spontaneous feedback from others. There is no way to immediately check out with others what the reality of the situation really is.

Although calling their food sponsor is not the main emphasis for those in Group 1 at this time, it still ranks high on their list of priorities. It is not known how much emphasis is placed on their eating plan. This does suggest, however, that to maintain their disciplined manner of living and eating, they feel it necessary to keep involvement at a high level. It is most probable that food is not the focus of attention but insofar as these people are called food sponsors, it tends to reinforce them as an authority figure.
Chapter 5  
SUMMARY AND CONCLUSIONS

Review of the Procedure

The purpose of this study is to ascertain any differences in psychological differentiation that might exist between women who have been at least 20 percent above an average weight, returned to an average weight and have retained their weight loss for a minimum of one year, and women who have not been able to return to an average weight within one year. The method of weight reduction that they have in common is that they are all affiliated with Overeaters Anonymous. The other differences under discussion are levels of compulsiveness and participation in the OA program.

In order to determine whether or not the weight of the subjects is above an average weight by 20 percent, the actuary tables of the New York Life Insurance Company have been used.

After reviewing the literature on field-dependent-independent behavior in Chapter 2, it is believed that subjects in Group 1 are more field-independent than those in Group 2.

It has been anticipated that there are differences in the amount of participation in the program. Those having lost their weight are, in all probability, using the tools
of the program to a greater extent.

It is believed that individuals in both groups have many personality traits indicative of compulsive behavior as it surrounds food.

**Major Findings and Recommendations**

Due to the small size of the sample, any trends which are shown to exist are not conclusive. This research has substantiated previous research, in showing that presently obese women are more field-dependent than those women who are of an average weight at the present time. However, being that both groups have a history of obesity, neither Group 1 nor Group 2 individuals are generally extremely field-dependent, as indicated by the mean scores for each group.

This study does not supply information about the possibility of change in psychological differentiation during weight reduction and during the maintenance of a weight loss for a prolonged period of time.

There is a possibility that the subject population does not represent the larger population of obese persons and that under other circumstances the scores on the EFT would indicate greater field-dependency.

In a study done by Karp, et al (1964), AA members, abstainers and present drinkers, were found to be less field-dependent than other drinkers treated by other methods. Abstainers from AA had a mean score of 95.5,
whereas those not abstaining, yet belonging to AA, had a mean score of 127.9. These scores are more extreme than those found in this research which suggest differences do exist between the alcoholic and obese personality.

Necessary to be explored in further research is the possibility that field-dependence-independence is not an accurate predictor of whether or not a person will develop obesity as a symptom of underlying pathology. This has been stated in earlier research as well.

In addition, the level of education of this sample is extremely high, thereby not including a wide cross section of the population for study.

No attempt has been made to control such variables as physical problems such as astigmatism which may have affected the results of this research. As indicated, without the EFT score of subject 5 in Group 1, the mean score of Group 1 is much lower, thereby suggesting that those in Group 1 are more independent and within the average ranges as indicated on Table 2 with greater certainty.

It is not understood how social pressure has helped those in Group 1 lose and maintain their weight loss but it probably is an important factor between the success of Group 1 and the lack of it in Group 2. This is inferred because of the apparent concern of Group 1 members regarding how others see them in relationship to will power and
weight loss.

Further study is indicated in the area of relationship counseling. Establishing and maintaining relationships can be inferred to be an important factor in the return to an average weight by Group 1 members as seen in this study. It is not understood how this is related to the obviously average level of field-dependence of this group or if there is any relationship at all.

In addition, involvement in OA is seen to be much greater for those in Group 1. An exploration of the motivating factors for these individuals might prove very helpful.

It is not known if any of these persons have been in other forms of therapy and what their histories of obesity are to the present in any great detail. This is of further importance for study. This study suggests that after a person returns to an average weight, involvement in a program may be necessary for an extended period of time in order to help in maintaining the weight loss.

This study, further, does not indicate that maintenance of a weight loss becomes easier over time for a person who has an obesity problem for much of his lifetime. To suggest to a person who has been struggling to maintain an average weight that in time it will be easy, may be suggesting they build false hopes. There is no way to tell if this is true without further research.
In comparing the levels of compulsive overeating, Group 1 is exhibiting less compulsive behavior at the present time. The results do not suggest less obsessive thought, only less compulsive activity. There is a possibility that those in Group 1 have simply changed obsessions rather than worked through them. The relationship of a person to his spiritual self as it relates to a belief in a higher power has implications for further research.

OA seems to attract persons who have had long histories of obesity and compulsive overeating who have tried many methods of weight reduction and failed. Fear of failure is another area that needs to be explored as it relates to maintaining a disciplined manner of eating and living. Fear of failure is possibly a very important factor, as research has previously shown.

The process of OA itself is worthy of study. It is a unique program for weight reduction as it spends little time dealing with the obsession of food and much time focusing on new ways of living. It is believed that many of the persons attending Overeaters Anonymous have been so defensive because of their fears that they have never been able to take in information. However, the identification with others that have the same problem makes it safer to explore one's actions and living patterns. To understand the self-help concept is necessary in restoring self-esteem.
Maslow does not suggest that this be the path that should be followed. However, those in OA would probably agree with the statement that "a good many have thrown up their hands altogether and talked about...and concluded that man could be saved only by extra-human forces" (p.165, 1968).

For the purpose of this study, the EFT has not been the best measure to be used as it is necessary for it to be administered under strict controls. The difficulty in obtaining subjects has limited the scope of the research. However, it is suggested that this same group of people be used again as subjects. In the future, results would be better obtainable in a single session.

It is believed that OA helps the obese person to remove some of the stigma associated with obesity, thereby freeing himself to enter more into the activities of the mainstream of society whether or not he returns to an average weight.

Although, within a limited scope, it is felt that this study has made contributions to the study of obesity and compulsive overeating. It is hoped that others who study the obese personality and are desirous of seeking remedies to this problem will study the process and dynamics of an organization like Overeaters Anonymous. Rather than simply focus on eating patterns, it is believed that the latter approach is an injustice against the integrity
of these people.
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CHAPTER 6

APPENDICES

Included in the following pages are a copy of the questionnaire administered to both groups of subjects, as well as a copy of the average weights of adult women extracted from the actuary tables of the New York Life Insurance Company.
APPENDIX A

Questionnaire

First Name______________________________ Telephone_________________

Age________________________

Education completed, circle: K-6 7 8 9 10 11 12

College: 1 2 3 4 5 6 7 8 9

Marital status, circle: single, married, separated, divorced, widowed

1. Circle how long you have been attending OA meetings:

   1-6 months   1-2 years   5-7 years
   7-12 months  3-5 years   8-10 years
   ____________________________
   10 years or longer

2. State your occupation, whether or not you are now employed:

3. Are you a compulsive overeater? Please check "now" if you have this habit at present. Check "past" only if you had the urge when you first came to OA and aren't bothered anymore. In addition, check "seldom/never", "often" or "constantly" to indicate how preoccupied you are with this particular habit.

   _____ now _____ past  a. Do you eat when you are not hungry?
   _____ seldom/never _____ often
   _____ constantly

   _____ now _____ past  b. Do you go on eating binges for no apparent reason?
   _____ seldom/never _____ often
   _____ constantly

   _____ now _____ past  c. Do you have feelings of guilt and remorse after overeating?
   _____ seldom/never _____ often
   _____ constantly

   _____ now _____ past  d. Do you give too much thought and time to food?
   _____ seldom/never _____ often
   _____ constantly

   _____ now _____ past  e. Do you look forward with pleasure to when you can eat alone?
   _____ seldom/never _____ often
   _____ constantly
f. Do you plan secret binges ahead of time? ___ seldom/never ___ often ___ constantly

g. Do you eat sensibly before others and make up for it alone? ___ seldom/never ___ often ___ constantly

h. Is your weight affecting the way you live your life? ___ seldom/never ___ often ___ constantly

i. Have you ever tried to diet, only to fall short of your goal? ___ seldom/never ___ often ___ constantly

j. Do you resent others telling you to use will power to stop overeating? ___ seldom/never ___ often ___ constantly

k. Despite evidence to the contrary, do you think you can diet on your own whenever you wish? ___ seldom/never ___ often ___ constantly

l. Do you crave to eat at a definite time other than mealtime? ___ seldom/never ___ often ___ constantly

m. Do you eat to escape from worries or trouble? ___ seldom/never ___ often ___ constantly

n. Has your doctor treated you for overweight? ___ seldom/never ___ often ___ constantly

o. Does your food obsession make you or others unhappy? ___ seldom/never ___ often ___ constantly

4. My height is

5. Information about my weight:

Present weight __________ Maximum adult weight __________
Goal weight __________

If you are at or within 5 to 7 pounds of goal weight at present, how long have you maintained your weight_________
6. Looking back, at what age do you first recall being a compulsive overeater (skip this question if you are not a compulsive overeater): 
   Age ________________

7. Please circle your longest term of abstinence you have had in OA (include your maintenance program):
   1-2 months
   3-6 mos.
   7-12 mos.
   1-1½ years
   1½-2 years
   2½-4 years
   5-7 years
   7-9 years
   10 years or more

8. I am going to have to spend about 1 hour more, individually, with some of you at your convenience. If you have an hour to spare, please circle: YES  NO
   What is the best time to call?  AM  PM

9. Please check if you have held any of these jobs in OA:
   ____ food sponsor  ____ delegate to inner group
   ____ step sponsor  ____ delegate to convention
   ____ secretary of a group  ____ work on "5th" Tradition
   ____ treasurer of a group  ____ lead beginners meetings
   ____ book/literature chairman  ____ other, explain

10. Using the scale below, indicate the frequency with which you use the OA tools (please circle):
    1 is rarely  3 is average  5 is frequently
        1 2 3 4 5
    read OA literature 1 2 3 4 5
    writing 1 2 3 4 5
    read AA literature 1 2 3 4 5
    say steps 1, 2, 3 1 2 3 4 5
    call food sponsor 1 2 3 4 5
    call other OA members 1 2 3 4 5
    lead meetings 1 2 3 4 5
    attend meetings 1 2 3 4 5
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<th>2</th>
<th>3</th>
<th>4</th>
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<tr>
<td>attend other anonymous meetings</td>
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<td></td>
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<tr>
<td>socialize outside of OA with OA friends</td>
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<td></td>
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<tr>
<td>attend retreats</td>
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Thank you very much for finishing the questionnaire. I will respect the anonymity of Overeaters Anonymous. All information is completely confidential.

Thanks again.
## Table B

**Medical Histories**

**Average Weights (lbs) of Women**

*(in indoor clothing)*

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*Note:* This is an excerpt from New York Life Insurance actuary tables for 1976.