

# Motivations for Dieting: Drive for Thinness Is Different From Drive for Objective Thinness

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Drive for thinness is a cardinal feature of bulimia nervosa. However, the widely used Drive for Thinness (DFT) subscale of the Eating Disorder Inventory (Garner, 2004; Garner, Olmstead, & Polivy, 1983) appears to measure a desire to be thinner, not a desire to be objectively thin. We developed the Drive for Objective Thinness (DFOT) Scale and compared unrestrained and restrained eaters and those with bulimia nervosa on the DFT subscale, Goldfarb's Fear of Fat Scale (GFFS; Goldfarb, Dykens, & Gerrard, 1983), and the DFOT Scale. Restrained eaters had higher scores than unrestrained eaters on the DFT subscale and the GFFS, but both groups had low scores on the DFOT Scale. Only the group with bulimia nervosa showed elevated scores on the DFOT Scale. We conclude that restrained eaters diet mostly to avoid weight gain, that individuals with bulimia nervosa diet to achieve thinness and avoid fatness, and that the drive for objective thinness is a unique feature of bulimia nervosa.

*Keywords:* drive for thinness, dieting, restrained eating, bulimia nervosa, motivation

Dieting, particularly among normal-weight women, has become a controversial topic over the past 25 years (Lowe & Timko, 2004; Polivy & Herman, 1987). One concern is that chronic dieting may lead to eating and weight dysregulation, as suggested by the work of Herman and Polivy (1984). A second concern is that chronic dieting may culminate in the development of a frank eating disorder (Fairburn, Marcus, & Wilson, 1993). To the extent that chronic dieting does in fact contribute to dysregulated or disordered eating, it is important to understand the nature of the motivation to diet to aid in the development of approaches to reduce unhealthy dieting behavior (Lowe & Levine, 2005). This article addresses two comparisons of relevance in understanding weight-related motivations to diet, one involving normal-weight restrained and unrestrained eaters and the other involving restrained eaters and individuals with bulimia nervosa.

In the case of restrained eaters, the restraint model of Polivy and Herman (1987) has long argued that societal norms favoring extreme thinness are largely to blame for dieting in nonobese women. Moreover, the restraint literature suggests that this societal preference for thinness is translated into a personal drive to become thin in restrained eaters. For example, it has been noted that because of weight concerns, "women are induced to strive toward a condition of ruddy cheeked emaciation" (Polivy & Herman, 1987, p. 635).

Newer findings have questioned traditional restraint theory on a number of grounds (Lowe & Kral, 2006; Lowe & Levine, 2005; Stice, Cooper, Schoeller, Tappe, & Lowe, 2007). Of particular relevance to the current study is the assumption that restrained eaters are motivated to diet to reach an unrealistically low body weight. There are a

number of reasons to question this assumption. Most restrained eaters are not dieting to lose weight (Lowe, 1993), and restrained eaters do not eat less than unrestrained eaters in the natural environment (Stice et al., 2007). Measures of restrained eating and dieting often predict future weight gain but never predict future weight loss (Lowe et al., 2006). As has been previously noted (Lowe & Levine, 2005), these and similar results suggest that restrained eaters may be motivated to diet more by a predisposition toward weight gain than by a drive to become skinny.

In the case of bulimia nervosa, both restraint theory and the cognitive behavioral model (Fairburn et al., 1993) suggest that individuals with bulimia are highly motivated to control their weight and shape. We have already discussed the restraint model's assumption that dieting is primarily motivated by a drive for extreme thinness. The cognitive behavioral model of bulimia (Fairburn et al., 1993) is more agnostic about the weight-related motivation for dieting (i.e., to lose weight or to avoid gaining it), although concepts such as drive for thinness and internalization of the thin ideal are key dimensions that are widely viewed as contributing to the etiology and maintenance of bulimia nervosa. The weight histories of individuals with bulimia nervosa suggest that their dieting may be motivated by both a desire to be thin and a fear of weight gain—that is, evidence indicates that many individuals with bulimia nervosa have a history of weighing both considerably more (e.g., Butryn, Lowe, Safer, & Agras, 2006; Russell, 1979) and considerably less (e.g., Garner & Fairburn, 1988) than they do when they come to the attention of clinicians or clinical researchers.

In sum, the construct of drive for thinness and related dimensions (e.g., internalization of the thin ideal) have been implicated as etiological or maintenance factors in bulimia nervosa. However, existing measures of this construct appear to reflect a desire to be thinner, not the radical dieting mentality thought to contribute to disordered eating (i.e., a strong desire to be thin). For example, the Eating Disorder Inventory Drive for Thinness (DFT; Garner, 2004;

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Garner, Olmstead, & Polivy, 1983) subscale includes questions that target fear of weight gain, instead of a drive for objective thinness (e.g., "I am terrified of gaining weight"). Similarly, Stice's Thin-Ideal Internalization Scale (Thompson & Stice, 2001) also does not mention a desire to attain an unhealthy level of thinness (e.g., "slender women are more attractive"). Given that approximately two thirds of American women are overweight or obese and that some of those still in the normal weight range may be understandably concerned about becoming overweight in such an obesogenic environment, it is not surprising nor necessarily pathological that most women would like to be thinner and in better shape than they are. This again suggests that a measure assessing motivation to reach an objectively thin body weight would be useful to help differentiate weight-related dieting motivations that may reflect an eating-disordered mentality from those that do not. Because such a measure does not exist, we developed the Drive for Objective Thinness (DFOT) Scale to measure the primary construct of interest in this study.

The DFOT Scale was designed to assess respondents' motivation to achieve an objectively thin body weight, defined as being 15% below a medically ideal body weight for the respondent's height. We also compared the new DFOT Scale and two more traditional measures of weight-related dieting motivations (the DFT subscale and Goldfarb, Dykens, & Gerrard's, 1985, Fear of Fat Scale [GFFS]) among unrestrained eaters, restrained eaters, and individuals with bulimic spectrum eating disorders. Our goal was to test the hypothesis that restrained relative to unrestrained eaters are motivated more by a fear of weight gain than by a desire for objective thinness, whereas bulimic relative to restrained individuals would be more motivated by a desire to become objectively thin.

## Method

### Participants and Procedures

Participants were 100 women, selected into three groups, two of which were composed of female college freshmen divided into unrestrained and restrained eaters (nonclinical group) and one of which was a group of women who had clinical or subclinical bulimic eating disorder (the bulimia nervosa spectrum [BNS] group) and who were in treatment at an intensive outpatient treatment facility for eating disorders (clinical group).

Participants in the nonclinical group were at least 18 years of age. Because the great majority of individuals with bulimia are in the normal to slightly overweight range, body mass index (BMI) in the nonclinical group was limited to 27 or under so its members would have BMIs that were comparable to those in the clinical group. Potential nonclinical participants who reported a prior history of an eating disorder or a current frequency of binge eating greater than once per week (via a self-report screening measure) were excluded from the sample. Participants in the nonclinical group were contacted using mass e-mailing and campus advertisements at a large mid-Atlantic university. Completion of the self-report measures was conducted online and submitted over a secure connection. Participants were weighed on a digital scale and had their height measured with a stadiometer by an experimenter to determine BMI ( $BMI = [kg/m^2]$ ). The Restraint Scale (Polivy, Herman, & Howard, 1988) was used to classify participants, with a score of 14 or lower as unrestrained eaters and 15 or higher as

restrained eaters, a convention established in previous literature (Herman, Polivy, Lank, & Heatherton, 1987).

Participants in the clinical group were undergoing treatment at an intensive outpatient program for eating disorders. They were contacted by the investigators as part of a treatment outcome study that was occurring at their treatment program. All participants in this group were at least 14 years of age and met *Diagnostic and Statistical Manual for Mental Disorders* (4th ed., text rev. [*DSM-IV-TR*]; American Psychiatric Association, 2000) criteria for current bulimia nervosa or eating disorder not otherwise specified—bulimic spectrum (EDNOS-BN), assessed by the Structured Clinical Interview for the *DSM-IV* (SCID-IV; First, Spitzer, Gibbon, & Williams, 1996). A diagnosis of EDNOS-BN indicated that participants met all criteria for bulimia nervosa except that binge eating or inappropriate compensatory behaviors occurred at a frequency ranging from once per month to once per week. Self-report questionnaires were administered in a private room.

### Assessment

**Body mass index.** BMI was calculated using measured weight (on a digital scale accurate to .2 kg) and height measured with a stadiometer.

**Structured Clinical Interview for the *DSM-IV*.** The SCID-IV is a structured diagnostic interview used to make psychiatric diagnoses based on the *DSM-IV* (First et al., 1996). Only individuals in the clinical group were assessed using the SCID-IV. All assessors were advanced graduate students in clinical psychology and research coordinators specializing in the area of eating disorders who received 10 hours of training by a doctoral level psychologist with extensive experience in training assessors in the administration of the SCID-IV.

**Restraint Scale.** Level of dietary restraint in the nonclinical group was determined using the Restraint Scale (Polivy et al., 1988), meant to identify chronic dieters by assessing the level of concern about body weight and dieting as well as weight fluctuations. The Restraint Scale has demonstrated adequate reliability and validity in normal-weight samples (Lowe, 1993).

**Drive for Objective Thinness Scale.** The DFOT Scale is a 15-item self-report measure designed to assess respondents' motivation to achieve objective thinness, defined as being 15% below the medically ideal body weight for a respondent's height; it is intended for use only with individuals whose current weight is greater than 85% of the appropriate weight for their height. This measure does not include any items evaluating fear of fatness or avoidance of weight gain.

The DFOT Scale uses a Likert-type scale (1 for *strongly disagree* to 5 for *strongly agree*), where higher scores are indicative of a greater drive for objective thinness. A pool of 25 sample items was generated by the investigators to tap the strength of one's desire to weigh 15% less than the appropriate weight for one's height. This criterion was selected because it corresponds to the *DSM-IV-TR* weight-loss threshold for diagnosing anorexia nervosa (85% of expected body weight) for diagnosing anorexia nervosa. The expert-judge method was used to evaluate, rate, and narrow the pool of items to include in the measure. This method is often used in the construction of new measures to establish their relevance to and representativeness of the content domain being tested (Sireci & Geisinger, 1995). The 25 items were distributed to

17 experts in the field of body image and eating disorders. Eight expert reviewers replied with ratings on a Likert-type scale of how appropriate each item was to the intended construct. A criterion of at least 3.7 out of 5.0 was used to select the 15 items. This criterion corresponded to a rating between 3 (*moderately*) and 4 (*very much*) for each sample item. Cronbach's alpha was calculated among the 15 items for the DFOT Scale ( $\alpha = .95$ ) in a sample of normal-weight females. Cronbach's alphas for the GFFS and the DFT subscale in the same sample were .91 and .77, respectively.

In an ongoing study on weight-gain prevention in female college freshmen, we examined the test-retest reliability of the DFOT Scale over two time spans in the control condition, which received no treatment. Test-retest reliability was examined among 59 participants over 6 weeks and among 34 of these participants over 6 months. The test-retest reliability was acceptable ( $r = .51, p < .001$ ;  $r = .52, p < .005$ , respectively), especially in light of the fact that the test-retest reliability of the DFT subscale over 6 weeks in this sample was  $r = .53, p < .001$ . In terms of validity ( $N = 117$ ), the DFOT Scale was significantly correlated in the expected direction with the Dutch Restrained Eating Questionnaire Restraint subscale (van Strien, Frijters, Staveren, Defares, & Deurenberg, 1986) and the Appearance Evaluation, Body Areas Satisfaction, and Overweight Preoccupation subscales of the Multidimensional Body-Self Relations Questionnaire (Cash, 2000;  $ps < .05$ ).

Additional assessments were conducted to test the validity of the DFOT Scale only in the clinical group because individuals with BNS may uniquely endorse this construct and display a wider range of scores. A silhouette method derived from the Body Image Assessment (Williamson, Davis, Bennett, Goreczny, & Gleaves, 1989) was used to measure self-evaluation of current body size and ideal body size in the BNS group. Participants were asked to select silhouettes that depicted their current body size and ideal body size out of nine silhouettes depicting women ranging from emaciated to very obese. Controlling for current BMI, higher scores on the DFOT Scale were found to be significantly negatively correlated with ideal body size ( $r = -.46, p < .05$ ), but not to current body size ( $r = .29, p > .05$ ). Individuals in the clinical group had an average rating of ideal body size that was 1.5 points above the most emaciated silhouette on a scale of 1–9 ( $M = 2.5, SD = 0.85$ ), suggesting individuals in this group preferred a very thin body.

A second validity test was included by asking clinical participants the extent to which they attempted to control their weight because it was important for them "to be thin" versus "not to be fat" on a Likert-type scale. A significant correlation was found between the DFOT Scale and the question assessing importance of being thin ( $r =$

$.79, p < .001$ ), whereas there was no significant correlation between the DFOT Scale and the question assessing desire not to be fat ( $r = .23, p > .05$ ). The foregoing results support both the convergent and discriminant validity of the DFOT Scale.

Last, in a recent study on treatment outcome in individuals with bulimia nervosa in an inpatient treatment facility, the DFOT Scale (measured at intake) was found to be significantly correlated with all the subscales and the total score on the Eating Disorder Examination Questionnaire (Fairburn & Beglin, 1994), the questionnaire version of the Eating Disorder Examination (Cooper & Fairburn, 1987).

**Goldfarb Fear of Fat Scale.** The GFFS is a 10-item self-report measure that assesses an individual's fear of fatness (e.g., "my biggest fear is becoming fat"). The GFFS has been shown to significantly differentiate between individuals with bulimia nervosa, chronic dieters, and nondieting women (Goldfarb et al., 1985). The GFFS has good test-retest reliability and discriminant validity (Goldfarb et al., 1985).

**Eating Disorder Inventory Drive for Thinness subscale.** The DFT subscale includes seven self-report items that are designed to measure "excessive concern with dieting, preoccupation with weight and entrenchment in an extreme pursuit of thinness" (Garner et al., 1983, p. 17). The DFT subscale has good test-retest reliability ( $r = .92$ ) and internal consistency, with Cronbach's alpha ranging from .80–.91 in clinical samples (Garner, 2004).

## Results

### Descriptive Statistics

The BMIs of the unrestrained eater, restrained eater, and BNS groups were 21.70 ( $SD = 2.1$ ), 23.10 ( $SD = 2.8$ ), and 22.30 ( $SD = 2.3$ ), respectively; their ages were 18.7 ( $SD = 0.42$ ), 18.67 ( $SD = 0.39$ ), and 21.45 ( $SD = 3.39$ ) years, respectively. Restrained eaters had higher BMIs than unrestrained eaters ( $p < .05$ ), and those in the BNS group were significantly older than both restrained and unrestrained eaters ( $p < .001$ ). Individuals diagnosed with bulimia nervosa ( $N = 22$ ) did not significantly differ from individuals diagnosed with EDNOS-BN ( $N = 14$ ) on age, BMI, the DFT subscale, the GFFS, or the DFOT Scale.

### Initial Analysis

Table 1 lists the means and standard deviations for the DFT subscale, the GFFS, and the DFOT Scale. The DFT subscale and the GFFS were very highly and significantly correlated among the

Table 1  
Descriptive Statistics

Group	N	Drive for Thinness subscale		Goldfarb's Fear of Fat Scale		Drive for Objective Thinness Scale	
		M	SD	M	SD	M	SD
Unrestrained eaters	38	21.8 <sub>a</sub>	6.9	18.1 <sub>a</sub>	5.5	35.2 <sub>a</sub>	13.2
Restrained eaters	26	30.1 <sub>b</sub>	6.4	25.8 <sub>b</sub>	5.5	37.8 <sub>a</sub>	15.4
Patients with bulimia nervosa	36	33.6 <sub>b</sub>	3.5	33.2 <sub>c</sub>	4.3	51.4 <sub>b</sub>	12.3
Total	100	28.4	7.8	25.6	8.2	41.7	15.3

Note. Means that share the same subscript within each measure are not significantly different ( $\alpha = .05$ ).

nonclinical group ( $r = .87, p < .001$ ), among the clinical group ( $r = .57, p < .01$ ), and across groups ( $r = .85, p < .001$ ). For the DFOT Scale and the DFT subscale, a different pattern emerged; the DFOT Scale was correlated with the DFT subscale ( $r = .64, p < .001$ ) and the GFFS ( $r = .42, p < .05$ ) in the clinical group, but not in the nonclinical group ( $r = .14, p > .05; r = .10, p > .05$ , respectively).

### Primary Analysis

The between-subjects factor was group classification as unrestrained eater, restrained eater, or individual with BNS. The within-subjects factor was level of endorsement of each type of weight-related dieting motivation. To be able to directly compare scores on the three measures, raw scale scores were converted to  $z$  scores.

A mixed-model analysis of covariance was used to compare the groups on each of the three measures of weight-related dieting motivation, controlling for BMI and age. A significant main effect of group was detected  $F(2, 94) = 49.5, p < .001$ , qualified by a significant interaction between motivation to diet and group,  $F(4, 188) = 6.8, p < .001$  (see Figure 1 for a graphical depiction of the interaction). BMI and age did not account for significant variance in this analysis ( $ps > .05$ ). The interaction remained significant when BMI and age were removed from the model.

To decompose the interaction, individual analyses of variance were conducted on each measure of dieting motivation. These analyses found significant differences between groups on all three measures: the DFT subscale,  $F(2, 99) = 44.5, p < .001$ ; the GFFS,  $F(2, 99) = 86.7, p < .001$ ; and the DFOT Scale,  $F(2, 99) = 14.8, p < .001$ . Table 1 illustrates group comparisons within each measure of motivation to diet, using Tukey's test. Post hoc tests revealed that restrained eaters scored significantly higher on the DFT subscale and the GFFS compared to unrestrained eaters, but the two groups did not differ on the DFOT Scale. The BNS group scored significantly higher than restrained eaters on the GFFS and the DFOT Scale.

### Discussion

The hypothesis that the DFT subscale, a measure frequently used to assess an ostensible source of eating-disordered psycho-

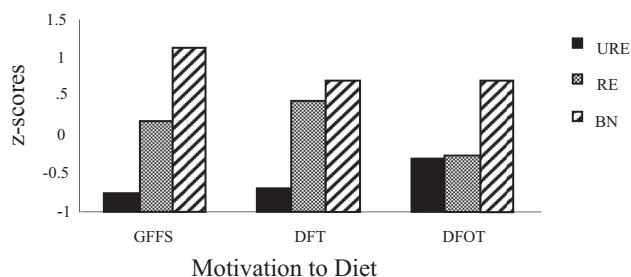


Figure 1. Interaction between weight-related dieting motivation and group. Estimated marginal means are graphed. BN = group with bulimia nervosa; DFOT = Drive for Objective Thinness Scale; DFT = Drive for Thinness subscale; GFFS = Goldfarb's Fear of Fat Scale; RE = restrained eaters; URE = unrestrained eaters.

pathology, is distinct from the newly developed DFOT Scale was supported by the present results. With regard to comparisons of nonclinical unrestrained and restrained eaters, our findings are consistent with past studies that found that restrained eaters score substantially higher than unrestrained eaters on the DFT and GFFS measures. However, restrained eaters did not differ significantly from unrestrained eaters on the DFOT Scale. Our results are consistent with a recent study by Dalley and Buunk (2009) that found that frequent weight-loss dieting in nonclinical samples was motivated mainly by a "desire to avoid an unfavorable over-fat identity, rather than by a desire to acquire the favorable thin identity" (p. 217). The traditional assumption that normal-weight restrained eaters' drive for thinness reflects an unhealthy need to be thin (e.g., Polivy & Herman, 1987), therefore, may be inaccurate. The present results suggest that dieting behaviors practiced by restrained eaters are much more strongly motivated by a desire to lose a small amount of weight or to avoid weight gain than by a desire to reach a pathologically low body weight. Furthermore, because restrained eaters have higher relative weights than unrestrained eaters, even when both are in the normal weight range (Lowe, 1984), a desire on their part to lose a small amount of weight might be viewed as relatively benign. This conclusion is consistent with research showing that restrained eaters—and those with a history of weight-loss dieting in particular—are susceptible to future weight gain rather than to weight loss (Lowe & Thomas, 2009). It is also consistent with the previously proposed (Lowe & Levine, 2005) notion that restrained eating and dieting in normal-weight populations is much more likely to represent a proxy risk factor for weight gain rather than a risk factor for the development of eating disorders.

Our second comparison of relevance revealed that individuals with bulimia nervosa scored significantly higher on the GFFS and the DFOT Scale compared to restrained eaters. As noted in the introduction, the body weight of most individuals with bulimia nervosa included in research and clinical studies lies roughly midway between their previous highest and lowest body weights. These observations might explain why they are highly motivated both to return to their lowest previous weight and to avoid returning to their highest previous weight. Many investigators have pointed out that although a large percentage of young women diet, only a small fraction of them develop serious eating-disorder symptoms (Wilson, 2002). It is possible that the strong desire to become objectively thin might be a major factor that differentiates the small fraction of dieters who develop an eating disorder from the much larger percentage who do not. Given evidence from taxometric studies that bulimia nervosa differs from normality qualitatively, not just quantitatively (Wonderlich, Joiner, Keel, Williamson, & Crosby, 2007), it is also possible that a strong desire to be objectively thin is a characteristic that qualitatively differentiates individuals with bulimia nervosa from those with lesser forms of eating and weight concerns.

Across the whole sample, the very high correlation between the DFT subscale and the GFFS indicates that the two measures were almost indistinguishable. The same is true of the combined group of unrestrained and restrained eaters. This is noteworthy because many researchers have assumed that drive for thinness reflects a desire to reach an emaciated body weight (e.g., Polivy & Herman, 1987). Instead it appears that the drive for thinness mostly reflects a fear of weight gain and becoming fat. To the extent that drive for

thinness does reflect a desire to lose weight, it appears that what most normal-weight restrained eaters desire is modest weight loss, not to achieve a state of “ruddy-cheeked emaciation” (Polivy & Herman, 1987, p. 635). This indicates that scores of past studies that have measured drive for thinness and related constructs should be interpreted not in terms of a desire to become thin but in terms of a desire to be somewhat thinner (e.g., in a woman of average height, to weigh 130 rather than 135 lbs) or to avoid weight gain (neither of which appear to be pathological goals).

These results may help resolve a contradiction that exists in current models of restrained and disordered eating. Female restrained eaters in the normal weight range have traditionally been assumed to be seeking an unhealthy level of thinness to meet sociocultural norms for ideal body shape in young women. The present results are consistent with a reformulated view of the motivational source of chronic dieting in normal-weight women, which suggests that their dieting is motivated much more by a desire to reverse or prevent weight gain than to reach a socioculturally prescribed thin body weight (Lowe & Levine, 2005; Lowe & Thomas, 2009).

For individuals with BNS, the high correlation between the DFOT and DFT measures indicates that elevated scores on the DFT subscale among such individuals do in fact reflect a motivation to diet to reach an unhealthy level of thinness. In the clinical group only, the DFT subscale appears to measure its intended construct of drive for true thinness. These findings are consistent with research indicating that most individuals with bulimia nervosa once weighed both significantly more and significantly less than their current body weight and are, therefore, extremely fearful of weight gain and highly motivated to reach an objectively low body weight.

Although it is not known if a desire to be objectively thin, as measured by the DFOT Scale, contributes to the etiology of the disorder, the DFOT Scale could be utilized in nonclinical samples to help identify individuals at the highest risk for embarking on potentially dangerous diets. That is, normal-weight women who score high on the DFOT Scale might be particularly appropriate for eating-disorder prevention programs because their high scores may indicate that they do not simply have moderate concerns about their weight—as many young women do—but that they may be at risk of engaging in the kind of radical weight-loss dieting that heightens risk for bulimia nervosa. Clinically, the DFOT Scale could alert therapists to situations where the elimination of dieting and the normalization of eating patterns (major goals of cognitive behavioral therapy for bulimia nervosa) might be difficult or impossible to achieve.

Limitations of this study include the inclusion of some individuals who received a diagnosis of EDNOS-BN. However, the inclusion of this group with those who received a diagnosis of bulimia nervosa did not appear to bias the results. The DFOT measure is also new, so its validity and test-retest reliability have not been firmly established. Finally, the participants with bulimia were enrolled in an intensive outpatient program (and many had stepped down from a higher level of treatment), so the present results may not generalize to outpatients with bulimia nervosa or to those not in treatment. That is, because all of the current participants were entering an intensive outpatient program and many had stepped down from a higher level of care (day and/or residential treatment), the present sample may have had more complex or

severe forms of disordered eating. The generalizability of the present results to bulimic individuals with less severe eating disorders and to those not in treatment remains to be established.

In sum, the present results suggest that dieting to achieve an objectively low body weight is rarely the motive behind chronic dieting among nonclinical restrained eaters but may in fact be an important motive behind the development and/or maintenance of bulimia nervosa. It appears that dieting among restrained eaters may at worst be ineffective in reversing past weight gain and preventing future weight gain (Lowe & Kral, 2006) and at best may slow or prevent unhealthy weight gain. Hundreds of existing studies on restrained eating may need to be reinterpreted because chronic dieting does not appear to have the pernicious effects long attributed to it (Polivy & Herman, 1987). Dieting among those with or at risk for developing bulimia nervosa, on the other hand, may in fact be problematic. These conclusions could go a long way toward resolving the perennial debate about the wisdom of dieting (cf. Lowe & Levine, 2005). In the future, the newly developed DFOT Scale might profitably be used to investigate a number of potentially important topics, such as the relationship of the DFOT Scale and weight suppression (Butryn et al., 2006) and weight rebound (i.e., the difference between lowest weight since developing bulimia nervosa and current weight; Garner & Fairburn, 1988) in those with disordered eating and the role of a strong desire to be objectively thin in risk for developing an eating disorder.

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