Published in final edited form as:

Eur Eat Disord Rev. 2013 September ; 21(5): 405–410. doi:10.1002/erv.2241.

Psychological Factors Predict Eating Disorder Onset and Maintenance at 10-year Follow-up

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Abstract

The present study sought to identify psychological factors that predict onset and maintenance of eating disorders. Secondary analyses were conducted using data from an epidemiological study of health and eating behaviors in men and women (N=1320; 72% female) to examine the prospective and independent influence of the Eating Disorder Inventory (EDI) Perfectionism, Interpersonal Distrust, and Maturity Fears subscales in predicting the onset and maintenance of eating disorders at 10-year follow-up. Multivariate models indicated higher Perfectionism ($p=.025$), lower Interpersonal Distrust ($p<.001$), and higher Maturity Fears ($p=.037$) predicted increased risk for eating disorder onset at 10-year follow-up, but only Perfectionism ($p=.004$) predicted eating disorder maintenance. Differential prediction of eating disorder onset versus maintenance highlights potentially different psychological foci for prevention versus treatment efforts.

Keywords

longitudinal; eating disorders; onset; maintenance

Both clinical observations (Bruch, 1978; Debois, 1949; Nilsson, Abrahamsson, Torbiornsson, & Hagglof, 2007) and empirical research (Bardone-Cone, Sturm, Lawson, Robinson, & Smith, 2010; Cassin & von Ranson, 2005; Lilenfeld, Wonderlich, Riso, Crosby, & Mitchell, 2006; Wagner et al., 2006) suggest psychological factors play a crucial role in the etiology and maintenance of eating pathology. Reflecting this, Garner and colleagues developed subscales of the Eating Disorders Inventory (EDI; Garner, Olmsted, & Polivy, 1983) to assess personality factors (e.g., perfectionism), interpersonal factors (e.g., interpersonal distrust), and developmental factors (e.g., maturity fears) to identify potential risk and maintenance factors in addition to developing scales that directly measure eating disorder symptoms. Cross-sectional studies support significant and consistent elevations in perfectionism, interpersonal distrust, and maturity fears among individuals with eating disorders (Espelage et al., 2003; Nevenon, Clinton, & Norring, 2006). Across eating disorder diagnoses, high levels of perfectionism, interpersonal distrust, and maturity fears have been implicated in poorer outcomes, supporting the predictive significance of these psychological factors for AN (Bizeul, Sadowsky, & Rigaud, 2001; Rigaud, Pennacchio,

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Portions of this work were presented at the 2012 International Conference on Eating Disorders in Austin, TX.

Bizeul, Reveillard, & Verges, 2011; Shafran, Cooper, & Fairburn, 2002; van der Ham, van Strien, & van Engelend, 1998), BN (Bardone-Cone et al., 2010; Blouin et al., 1995; Shafran et al., 2002; Olmsted, Kaplan, & Rockert, 1994; Lilenfeld et al., 2000; Maddocks & Kaplan, 1991), and EDNOS (Bardone-Cone et al., 2010; Tasca et al., 2011; Fassino, Piero, Tomba, & Abbate-Daga, 2009). As such, targeting these psychological features in treatment may be crucial to averting the chronic nature of these disorders. However, additional longitudinal studies are needed to establish temporal precedence of the influence of these psychological factors on both the onset and maintenance of eating disorders. The current study uses data from an epidemiological longitudinal study to examine perfectionism, interpersonal distrust, and maturity fears for predicting the onset and maintenance of eating disorders over a 10 year follow-up period.

Individuals with eating disorders often display high levels of maladaptive perfectionism, including idealistic personal expectations (Bardone-Cone et al., 2007; Brown et al., 2012) that may contribute to the development and maintenance of the disorder. Indeed, perfectionistic traits may lead an individual to adhere rigidly to strict rules regarding what or when they should eat, place an over-emphasis on the attainment of the thin ideal, and be overly critical when expectations are not met. Several longitudinal studies have found higher perfectionism to predict onset of anorexic syndromes (Tyrka, Waldron, Graber, & Brooks-Gunn, 2002), bulimic symptoms (Killen et al., 1994; Vohs, Bardone, Joiner, Abramson, & Heatherton, 1999), and binge eating (Bardone-Cone et al., 2006). In addition, longitudinal follow-up studies of clinical samples provide evidence that perfectionism is a negative predictor of treatment outcome across eating disorder diagnoses at one- (Ro, Martinsen, Hoffart, & Rosenvinge, 2003) and five to ten- (Bizeul et al., 2001) year follow-up, which suggests perfectionism may maintain eating pathology in addition to predicting its onset (Bardone-Cone et al., 2007).

Interpersonal distrust encompasses not only a reluctance to form close relationships, but also the reluctance to express feelings to others, which may contribute to difficulty in the self-regulation of negative emotional states (Dodge & Garber, 1991). There is some support for interpersonal distrust as a predictor of onset of eating pathology in adolescent boys (Leon, Fulkerson, Perry, & Early-Zald, 1995). In addition, previous studies have reported that higher interpersonal distrust scores predict relapse among individuals with AN (Bizeul et al., 2001) and BN (Olmsted et al., 1994; Toner, Garfinkel, & Garner, 1988). There is also evidence that interpersonal distrust may increase in importance over time. For instance, Sohlberg and colleagues (1992) reported that interpersonal distrust was not a significant predictor of outcome at one-year follow-up among inpatients with AN or BN; however, higher interpersonal distrust at intake predicted outcome at three-year follow-up of the same sample. Thus, the ability of interpersonal distrust to predict eating disorder maintenance increased in importance over time.

Maturity fears reflect a resistance to assuming adult responsibilities and a desire to return to the security of childhood, which is a developmental struggle that has been posited to be characteristic of the onset of eating pathology (Bruch, 1978; Nakai, 1997). One study found higher maturity fears scores predicted onset of disordered eating symptoms at trend level among adolescent girls (Killen et al., 1994). However, other prospective studies have not

supported a prospective association between maturity fears and onset of disordered eating symptoms (see Lilenfeld et al., 2006 for a review). There is some evidence that high maturity fears may predict poor outcome among adolescent inpatients with AN (van der Ham et al., 1998). Sohlberg and colleagues (1992) reported that higher maturity fears scores at intake predicted poorer outcome at one-year follow-up among inpatients with AN or BN; however, at three-year follow-up of the same sample, *lower* maturity fears scores at intake predicted poorer outcome. The finding that the impact of maturity fears was reversed between one and three-year follow-up may reflect changes over development. Specifically, younger patients tended to have a higher chance of recovery (Sohlberg et al., 1992) but may experience more maturity fears (Heebink, Sunday, & Halmi, 1995). Thus, the wide age range of the patient sample (18–45) may explain results and highlights the need for prospective studies to be contextualized within specific developmental periods. This finding is important because it suggests that duration between baseline assessment and follow-up and stage of life (i.e., late adolescence vs. early to middle adulthood) may be important variables to consider when examining the influence of these psychological factors over time.

Importantly, studies of onset necessarily occur in nonclinical samples whereas most studies of maintenance factors have been conducted in clinical populations to ensure access to large numbers of affected individuals. Relying on clinical samples to evaluate predictors of maintenance makes it difficult to determine whether treatment status influences results. Although several prospective follow-up studies have examined perfectionism as a maintenance factor using community-based samples (Santonastaso, Friederici, & Favaro, 1999; Shafran et al., 2002; Stice, 2002), to our knowledge, no studies have examined the influence of interpersonal distrust or maturity fears as maintenance factors outside of clinical samples. As such, it is unclear if limited evidence for the influence of interpersonal distrust and maturity fears on eating disorder maintenance reflects relatively less attention to these domains in community-based samples.

In summary, perfectionism appears to be a significant risk and maintenance factor for eating pathology in both clinical and nonclinical samples. However, the roles of interpersonal distrust and maturity fears are less clear given the limited number of longitudinal studies focusing on these constructs and reliance on clinical samples to identify maintenance factors. With consideration to the limitations of prior studies, the purpose of the present study was to examine whether perfectionism, interpersonal distrust, and maturity fears were differentially predictive of onset versus maintenance of an eating disorder at 10-year follow-up. Differentiating between predictors of onset versus maintenance is important as these have distinct clinical implications. Predictors of onset would identify targets for prevention whereas predictors of maintenance would identify targets for treatment. An advantage over previous longitudinal studies is the long duration of follow-up in a nonclinical sample of late adolescent/young adult women and men, followed from the age of 20 (± 2) to 30 (± 2) years. In addition, this study focused on diagnosed eating disorders rather than levels of disordered eating (Lilenfeld et al., 2006).

Methods

Participants

The sample included students from a northeastern university during the spring of 1982 or 1992 who were randomly selected in a 2:1 ratio of women:men to complete self-report surveys of health and eating patterns. Participants were contacted to complete 10-year follow-up surveys in 1992 and 2002, respectively. Of those randomly selected to complete surveys (N=2,400), 75% participated at baseline, and 78% were retained for follow-up assessment. No differences were found on baseline measures between participants who completed follow-up and those who did not (all $ps>.05$). Participants (N=1,320; 72% female) had a mean $\pm$ SD age of 20 ± 2 years at baseline and 30 ± 2 years at 10-year follow-up and identified as Caucasian (75.1%), African American (6.1%), Asian (11.6%), Hispanic (5.6%), and Biracial/other (1.6%). Further details on the selection and participant procedures have been reported elsewhere (Keel & Heatherton, 2010; Keel, Heatherton, Dorer, Joiner, & Zalta, 2006). The Institutional Review Board approved this study, and participants completed informed consent documents prior to completing surveys.

Measures

Eating Disorder Diagnoses—Eating disorder diagnoses were determined through algorithms applied to the self-report survey data (see Keel et al., 2006 for eating disorder diagnostic criteria). Diagnoses were made for participants who reported either (1) full or partial AN; (2) full or partial BN; (3) purging disorder (PD); or (4) full or partial binge-eating disorder (BED) within the 3-month period prior to baseline and/or 10-year follow-up assessment. Participants who did not meet criteria for any eating disorder and provided adequate information to determine the absence of an eating disorder were classified as non-eating disorder controls. Eating disorders were collapsed across diagnoses and thus measured as a dichotomous variable (absent versus present) in the current study to increase sample size and statistical power, as is commonly done in community-based studies (e.g., Cervera et al., 2003; Ghaderi & Scott, 2003; Patton, Selzer, Coffey, Carlin, & Wolfe, 1999). Of note, structured clinical interviews (First, Spitzer, Gibbon, & Williams, 1995) were conducted in a subset of participants in the second stage of this two-stage epidemiological and longitudinal study (Keel et al., 2006). Specificity and sensitivity of the survey-based diagnoses were .89 and .91, respectively, and overall agreement between survey and interview-based diagnoses was high ($\kappa = .80$), with no significant differences between cohorts. Because survey data were available for the full sample and in consideration of the high level of agreement between survey-based and interview-based diagnoses, survey-based diagnoses were used in the current study. This allowed diagnostic status of a larger sample to be determined, which was crucial for examining predictors of onset and maintenance separately.

Eating Disorders Inventory (EDI)—The EDI (Garner et al., 1983) is a self-report questionnaire that measures eating related attitudes and behaviors as well as psychological factors commonly associated with eating disorders. The current study uses data from an epidemiological and longitudinal study initiated in 1982, prior to the publication of the EDI. As such, original surveys distributed in 1982 included only 5 of the 8 original EDI

subscales, and only 3 of these focus on posited etiological factors rather than measures of actual eating pathology: Perfectionism, Interpersonal Distrust, and Maturity Fears. The other two subscales included in the survey (Bulimia and Drive for Thinness) measure eating related attitudes and behaviors. Because this paper examined psychological factors as predictors of onset and maintenance of eating pathology, we included the three scales measuring psychological factors that were included in the original and subsequent surveys in our analyses as we did not have data on other psychological scales (e.g., Interoceptive Awareness, Ineffectiveness). The EDI has shown excellent reliability and validity in previous samples of both individuals with and without eating disorders (Thiel & Paul, 2006) as well as factor invariance in men and women and across age groups (Keel, Baxter, Heatherton, & Joiner, 2007). Cronbach's alpha was good for the current study, ranging from .72-.80 for the subscales.

Data Analyses

Logistic regression analyses were conducted to examine the influence of psychological factors on eating disorder onset and maintenance at 10-year follow-up in multivariate models. Due to the potential influence of sex and cohort on outcome variables, both were entered as covariates in analyses. First, a logistic regression was conducted in individuals without an eating disorder diagnosis at baseline ($n=1,162$) to predict eating disorder onset at 10-year follow-up. Next, a regression analysis was conducted among individuals with an eating disorder diagnosis at baseline ($n=150$) to predict eating disorder maintenance at 10-year follow-up.

Results

Descriptive statistics on changes in eating disorder diagnostic status in men and women from baseline to 10-year follow-up appear in Table 1. Overall, 11.5% of the sample ($n=150$; $n=7$ AN, $n=29$ BN, $n=115$ EDNOS) met criteria for an eating disorder diagnosis at baseline. At 10-year follow-up, 4.5% of the sample ($n=59$; $n=1$ AN, $n=6$ BN, $n=52$ EDNOS) met criteria for an eating disorder, with 45.8% ($n=27$) of these cases representing individuals who had maintained an eating disorder from baseline to 10-year follow-up and 54.2% ($n=32$) of these cases representing new onset eating disorders. Approximately 18% ($n=27$) of individuals with an eating disorder at baseline had an eating disorder at 10-year follow-up, consistent with findings from other long-term follow-up studies of eating disorder outcome (for review, see Keel & Brown, 2010). Thus, the overall pattern reflected that as participants aged, the number of individuals meeting criteria for an eating disorder decreased; however, approximately 18% of the individuals who met criteria for an ED in college retained a diagnosis 10 years later. In addition, new onset eating disorders were still observed as participants transitioned from their 20s to their 30s. Means and standard deviations for EDI subscale scores at baseline are presented in Table 2, with a division by eating disorder diagnostic status at baseline and 10-year follow-up.

Table 3 presents results from analyses of eating disorder onset. For onset, all three EDI subscales were associated with a significantly higher likelihood for onset of an eating disorder at 10-year follow-up. Among individuals who did not have an eating disorder at

baseline, higher levels of perfectionism ($OR = 1.07$, $df=1$, $p<.05$) and higher maturity fears ($OR = 1.24$, $df=1$, $p<.05$) and lower levels of interpersonal distrust ($OR = 0.71$, $df=1$, $p<.001$) predicted the presence of an eating disorder at 10-year follow-up. Higher perfectionism and higher maturity fears scores were associated with significantly a higher likelihood of meeting criteria for an eating disorder at follow-up, whereas lower interpersonal distrust scores were associated with a significantly higher likelihood of meeting criteria for an eating disorder at follow-up.

Table 4 presents results from analyses of eating disorder maintenance. In contrast to results for predicting onset, only perfectionism emerged as a significant predictor of eating disorder maintenance at 10-year follow-up (Wald $\chi^2=8.20$, $df=1$, $p<.01$). Specifically, among individuals who met criteria for an eating disorder diagnosis at baseline assessment, higher perfectionism scores ($OR = 1.12$) were significantly associated with maintenance of an eating disorder diagnosis at 10-year follow-up.

Discussion

The current study utilized a longitudinal design with a long duration of follow-up (10 years) to evaluate posited psychological etiological factors as predictors of both onset and maintenance of diagnosable eating disorders in a community-based sample of young men and women. This study is important because theories regarding the relevance of these psychological factors to eating disorder development require empirical tests in longitudinal designs. Overall, results from the current study provide further evidence that psychological factors are important in the risk of eating pathology, such that all three EDI subscales were predictive of onset of an eating disorder diagnosis at 10-year follow-up in multivariate models. Importantly, maturity fears emerged as a significant predictor of onset of eating pathology, highlighting its potential significance as a predictor of eating pathology in not only adolescents, but also adulthood. However, in contrast to theories that interpersonal distrust increases risk for eating pathology, current findings suggest that lower rather than higher levels contributed to eating disorder onset at 10-year follow-up in this sample. Additionally, only perfectionism predicted maintenance of eating disorders. Findings are consistent with results from previous studies that found perfectionism is a robust maintenance factor for eating pathology among inpatient samples at one- (Bizeul et al., 2001; Olmsted et al., 1994) and five to ten- (Ro et al., 2003) year follow-up.

Findings have several implications for eating disorder interventions. Given that perfectionism predicted both eating disorder onset and maintenance, targeting high perfectionism in both eating disorder prevention and treatment may be crucial to averting the occurrence and chronic nature of these disorders. While an expanded form of cognitive behavioral therapy for eating disorders targets clinical perfectionism as a maintaining factor of eating pathology (Fairburn, Cooper, & Shafran, 2008), there has been a relative lack of attention given to perfectionism as a risk factor for the onset of eating pathology in current preventions. Importantly, perfectionism has been implicated as playing an important role in the etiology and maintenance of various psychological disorders (e.g., depression, obsessive-compulsive disorder, eating disorders) as well as suicidality (Flett & Hewitt, 2002), suggesting that interventions targeting clinical perfectionism may have benefits for

eating and comorbid disorders. Glover and colleagues (2007) developed an intervention based on Shafran et al.'s (2002) cognitive-behavioral model for clinical perfectionism. Results from a preliminary case studies series indicated that the intervention resulted in clinically significant decreases in self-oriented perfectionism among participants and a range of axis I diagnoses, suggesting that larger trials of this transdiagnostic intervention are warranted.

In addition to perfectionism, higher maturity fears emerged as a potential risk factor for the onset of an eating disorder as individuals transitioned from their 20s to their 30s. Although fear of adulthood has long been conceptualized as an important pre-illness feature of eating disorders, this is the first study to provide evidence for a predictive association between maturity fears and eating disorder onset. Failure to find this association in previous studies (Lilenfeld et al., 2006) may reflect differences in study samples, such that the desire to return to the security of childhood when the demands of adulthood are too great may be a particularly sensitive indicator among college-aged individuals. As individuals transition from their 20s to their 30s, they are faced with many new challenges not faced by younger adolescents, such as leaving home, obtaining employment, getting married, or becoming a parent. Individuals high on maturity fears may turn to disordered eating during developmental transitions as a misdirected attempt to feel control or to regulate emotions in the face of such changes. Results support that maturity fears may be used to identify individuals at risk for developing eating pathology and that prevention efforts might seek to address these fears in college-aged samples. Supporting this conclusion, one psychoeducational eating disorder prevention program that emphasized developmental transitions throughout the program led to a significant reduction in maturity fears and bulimic attitudes among teenage women compared to control women (Rocco, Ciano, & Balestrieri, 2001).

The direction of the association of interpersonal distrust scores in predicting eating disorder onset was unexpected because it contradicts theories regarding the etiology of eating disorders (Blouin et al., 1995; Olmsted et al., 1994; Sohlberg et al., 1992). It is possible that the result may reflect the current study's distinctive focus on a non-clinical sample followed for 10 years during the transition from late adolescence to adulthood. For example, participants in prior studies come from inpatient, female adolescent samples and thus looked at predictors of maintenance whereas participants from the current study represent a college-aged community-based sample and only found support for prediction of onset. It is possible that the age of the participants and characteristics of the inpatient setting (e.g., lack of control over food or activities, being surrounded by unfamiliar people) from prior studies may have increased the association between feelings of mistrust and poor outcome. In contrast, lower scores on the interpersonal distrust scale in our college-based sample may reflect a different phenomenon that increased risk for onset as individuals moved from their 20s to their 30s. However, these results may also reflect a chance finding and thus should be interpreted with caution. Independent replication is crucial for interpreting or forming recommendations based on this finding.

The present study had several strengths, including a prospective longitudinal design with high retention, which made it possible to determine temporal associations between

personality factors and eating pathology. In contrast to previous studies that have largely relied on clinical samples recruited from treatment settings, the current study examined associations between psychological features and eating disorder outcome without the confound of treatment setting. This allowed for a unique opportunity to examine the same set of psychological features as risk versus maintenance factors for eating disorders. Further, the time-frame over which assessments were conducted captured participants during a period in which individuals are still developing eating disorders but also recovering from these disorders, and this further enhanced our ability to distinguish predictors of onset from predictors of maintenance. Finally, duration between baseline and follow-up assessment was 10 years, advancing prior studies of changes over adolescence (Killen et al., 1996; Leon, Fulkerson, Perry, Keel, & Klump, 1999; van der Ham et al., 1998; Vohs et al., 1999) to examine the predictive utility of personality variables into adulthood.

While the present study had several strengths, there are limitations worth noting. Given that the study sample was college-based, the prevalence of specific eating disorder diagnoses was too low to allow examination of associations with specific diagnoses or subtypes. Fortunately, prior studies support the transdiagnostic relevance of the psychological features examined in the current report. Furthermore, diagnoses were based on self-report data, which may introduce assessment error. Importantly, survey-based diagnoses demonstrated concurrent validity with interview-based diagnoses in the sample, increasing confidence in results. Participants in the current study came from a selective northeastern university, thus findings may not generalize to populations of dissimilar demographics. However, previous studies that have examined stability of eating disorder diagnoses in both inpatient and community-based samples have reported similar rates of remission (Keel & Brown, 2010), supporting the representativeness of longitudinal patterns in this sample. Additionally, although longer duration between baseline assessment and follow-up assessment (10 years) was a strength of the study, we are not able to examine course of illness over the 10-year follow-up period. Psychological factors may have demonstrated important associations with remission and relapse that we were unable to evaluate. Finally, the study survey did not include all of the EDI subscales, so we were unable to examine other psychological factors theorized to contribute to eating pathology (e.g., interoceptive awareness, ineffectiveness); thus, it will be important for future studies to examine how all psychological scales of the EDI predict onset and maintenance of eating pathology.

In summary, findings from the current study provide further evidence that psychological factors differentially contribute to the onset and maintenance of eating pathology. Results indicate that perfectionism, interpersonal distrust, and maturity fears predict onset of eating disorders but only perfectionism predicted maintenance. Given the evidence that non-treatment seeking samples may differ significantly from treatment-seeking samples in several respects including psychological factors (Perkins, Klump, Iacono, & McGue, 2005), replications of the influence of interpersonal distrust and maturity fears across diverse samples are needed. Exploration of additional psychological variables associated with eating disorders as well as different dimensions of these variables (e.g., self-oriented perfectionism vs. socially-prescribed perfectionism) across several methods of assessment would strengthen the understanding of the relationships between psychological factors and eating

disorders. In addition, identifying protective psychological factors may inform future prevention and treatment efforts.

Acknowledgments

This work was supported by the Milton Fund and the National Institute of Mental Health (R01MH63758; PI: Pamela K. Keel). We thank the Henry Murray Center of the Radcliffe Institute for access to baseline data from Anne Colby's "Prevalence of Bulimia Among College Students" and access to 10-year follow up data from Todd Heatherton's "Follow-up and Replication of Prevalence Among College Students" as well as Harvard University's Alumni Office for participant addresses for follow-up assessments.

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Table 1

Changes in Eating Disorder Status from Baseline to 10-year Follow-up in Women and Men

<u>ED Status at 10-year Follow-up (n=1312)</u>			
	<u>Baseline ED Status</u> n (%)	<u>No Eating Disorder</u> n (%)	<u>Eating Disorder</u> n (%)
Women (n=949)			
No Eating Disorder	813 (85.7%)	787 (83.0%)	26 (2.7%)
Eating Disorder	136 (14.3%)	114 (12.0%)	22 (2.3%)
AN	6 (0.6%)	6 (0.6%)	0 (0.0%)
BN	26 (2.7%)	18 (1.9%)	8 (0.8%)
EDNOS	104 (11.0%)	90 (9.5%)	14 (1.5%)
Men (n=363)			
No Eating Disorder	349 (96.1%)	343 (94.4%)	6 (1.7%)
Eating Disorder	14 (3.9%)	9 (2.5%)	5 (1.4%)
AN	1 (0.3%)	1 (0.3%)	0 (0.0%)
BN	2 (0.6%)	0 (0.0%)	2 (0.6%)
EDNOS	11 (3.0%)	8 (1.9%)	3 (0.8%)

Table 2

Baseline Mean (SD) EDI Subscale Scores by Eating Disorder Diagnostic Status at Baseline and 10-year Follow-up

Baseline ED Status	ED Status at 10-Year Follow-up (n=1312)	
	<u>No Eating Disorder (n=1253)</u> M(SD)	<u>Eating Disorder (n=59)</u> M(SD)
<u>No Eating Disorder (n=1162)</u>		
EDI Perfectionism	22.9 (5.3)	24.9 (4.1)
EDI Interpersonal Distrust	18.5 (2.0)	17.5 (2.3)
EDI Maturity Fears	12.6 (2.2)	13.5 (1.5)
<u>Eating Disorder (n=150)</u>		
EDI Perfectionism	24.4 (5.3)	26.4 (5.6)
EDI Interpersonal Distrust	18.8 (2.0)	19.2 (1.7)
EDI Maturity Fears	13.0 (2.1)	13.2 (2.0)

Table 3

Logistic Regression Analysis Predicting Onset of Eating Disorder at 10-year Follow-up (n= 1,162)

	B	S.E.	Wald	df	p	Odds Ratio (95% CI)
Cohort	−0.53	0.39	2.27	1	.132	0.56 (0.26–1.19)
Sex	0.82	0.47	3.05	1	.081	2.27 (0.91–5.69)
EDI Perfectionism	0.08	0.04	5.00	1	.025	1.07 (1.01–1.16)
EDI Interpersonal Distrust	−0.33	0.09	13.03	1	<.001	0.71 (0.61–0.86)
EDI Maturity Fears	0.21	0.10	4.35	1	.037	1.24 (1.02–1.50)

Table 4

Logistic Regression Analysis Predicting Maintenance of Eating Disorder Diagnosis at 10-year Follow-up (n=150)

	B	S.E.	Wald	df	p	Odds Ratio (95% CI)
Cohort	−0.74	0.43	2.96	1	.086	0.48 (0.21–1.11)
Sex	0.53	0.51	0.69	1	.408	1.52 (0.56–4.11)
EDI Perfectionism	0.11	0.04	8.20	1	.004	1.12 (1.04–1.21)
EDI Interpersonal Distrust	0.11	0.10	1.09	1	.298	1.11 (0.91–1.36)
EDI Maturity Fears	0.03	0.10	0.10	1	.758	1.03 (0.85–1.25)