Chapter #6

DEFENSIVE STYLES OF COPING AND ATTITUDES TOWARD EATING IN WOMEN WITH ANOREXIA NERVOSA, BULIMIA NERVOSA, BINGE EATING, AND IN WOMEN WITHOUT EATING DISORDERS DIAGNOSIS

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ABSTRACT
Eating disorders are tied with disturbed emotion regulation. Anorexia nervosa is connected with a tendency for emotion suppression, there is no homogeneous pattern of emotion regulation specific for bulimia nervosa, and no data on binge eating disorders. It is interesting to check whether patients suffering with various eating disorders differ in their tendency toward repression or sensitization. In the study 127 women, aged 18-69 participated. There were 61 persons without clinical diagnosis, 21 women with anorexia nervosa, 23 with bulimia nervosa, and 22 with binge eating disorder (all diagnosed by psychiatrists). Respondents filled in the Eating Disorder Inventory and Eating Attitudes Test. Results showed that for women without diagnosis low anxiety and repression were most popular, for anorexia nervosa repression was most frequent, for bulimia nervosa the most popular was high anxiety, for binge eating disorder low anxiety was the most frequent. The relations between type of disorder and defensive coping style were statistically significant. It was also proved that there were statistically significant differences between groups identified according to the coping style in their mean attitudes towards eating. It might be stated that repressors, high anxious, and sensitizers are more prone to having eating problems than low anxious persons.

Keywords: repression, sensitization, anorexia nervosa, bulimia nervosa, binge eating disorder.

1. INTRODUCTION

Eating disorders (EDs) are defined as mental disorders accompanied by abnormal eating behaviors resulting in weight changes and highly influencing quality of life and social functioning of an individual (Hay et al., 2017; Pohjolainen et al., 2016). It was proved that suicidal risks, and mortality rates are higher for people suffering eating disorders in comparison to non-clinical populations (Keski-Rahkonen & Mustelin, 2016; Smink, van Hoeken, & Hoek, 2012), with rates as high as 5%-20% (Qian et al., 2022).

Data published up to date proves that eating disorders and their related behaviors are prevalent amongst people from different groups (Calzo, Blashill, Brown, & Argenal, 2017; Hazzard, Loth, Hooper, & Becker, 2020; Murray et al., 2017; Pike & Dunne, 2015). They are chronic in their nature, with relatively early age of onset and high likelihood for relapses during a lifetime with the highest prevalence in children and adolescents but present in other age groups as well (Hay et al., 2023; Qian et al., 2022).

Among people suffering eating disorders there were discovered indicators of low parental care, insecure attachment style, and high parental control (Waller, Kennerley, & Ohanian, 2007; Ward, Ramsay, & Treasure, 2000), mediated by low self-efficacy, avoidant coping and early maladaptive schemas of defectiveness, abandonment, and

vulnerability to harm (Waller et al., 2007). According to the data published so far physical and emotional abuse were proved as predictors of eating disorders (Racine & Wildes, 2015), while emotional abuse and invalidation were perceived as predictors of severity of eating disorders (Kent, Waller, & Dagnan, 1999). Eating disorders co-occur with high levels of shame, rigid thinking patterns, perfectionism, and compulsive behaviors (Waller et al., 2007). People suffering EDs also experience high levels of negative emotions and negative affect (Blasczyk-Schiep, Adamczewska, & Funez Sokoła, 2019; Espeset, Gulliksen, Nordbø, Skårderud, & Holte, 2012; Sierra, Senín-Calderón, Roncero, & Perpiñá, 2021; Wonderlich et al., 2022).

1.1. Emotion Regulation in Eating Disorders

Emotion regulation is defined as a set of strategies used by an individual in order to recognize, initiate or modify emotions. The strategies of emotion regulation are divided into uncontrolled, automated or subjectively controlled sets of actions aimed at coping or modifying any external or internal aspect of unwanted emotional experience (Gross, 2002). Those strategies are perceived either as adaptive or maladaptive ways of coping with emotions (Gross, 2015). Adaptive emotion regulation strategies include effective and helpful techniques aimed at facing the problem and solving it, whereas maladaptive strategies usually concentrate on various avoidance-related methods (Aldao, Nolen-Hoeksema, & Schweizer, 2010). It has been proved that maladaptive emotion regulation strategies have long lasting negative effects on somatic and mental health of an individual (Leppanen, Brown, McLinden, Williams, & Tchanturia, 2022). It was also found they are connected with eating disorders (Dingemans, Danner, & Parks, 2017; Mason et al., 2021; Oldershaw, Lavender, Sallis, Stahl, & Schmidt, 2015; Patel & Schlundt, 2001).

It was proved that the tendency to overeating is correlated with experiencing high levels of negative emotions (Ogden, 2011), while restrictive eating is connected with high levels of cognitive control accompanied by low intensity of experienced emotions (Boon, Stroebe, Schut, & Jansen, 1998). Michael Macht (2008) underlined that when a person is experiencing intense emotions, they are able to either control food they'll eat, decide not to intake any food at all, experience problems with cognitive control over eaten food, decide to use food as a regulative mechanism for experienced emotions or eat because they're influenced by emotions. Affective processes can create needs of food intake or inhibit those desires. They could also be understood as an element of bilateral regulative relationship, where emotions regulate food intake, and food intake regulates emotions (e.g. Evers, Marijn Stok, & de Ridder, 2010).

Results of studies published so far emphasize that the maladaptive emotion regulation observed in people suffering from eating disorders is connected with socio-emotional factors (Prefit, Cândea, & Szentagotai-Tătar, 2019). It was discovered that patients with anorexia nervosa, in comparison to people with bulimia nervosa, had an increased tendency toward emotional suppression and cognitive reappraisal (Gross, & John, 2003). Persons diagnosed with anorexia nervosa also reported problems with acceptance of negative situations (Wolfsdorf Kamholz, Hayes, Carver, Bird Gulliver, & Perlman, 2006). Individuals with bulimia nervosa reported difficulties recognizing their emotional states. It was also proved that both anorexia nervosa and bulimia nervosa patients use very limited, inflexible strategies of emotion regulation (Gratz & Roemer, 2004). They also present low levels of emotional awareness, and acceptance of emotional responses. Interestingly, it was discovered that among patients suffering eating disorders the most effective emotional regulation, understood as general ability to exert control over unpleasant emotional states an individual experiences, was observed in patients with binge eating disorder (Brockmeyer et al., 2014).

1.2. The Concept of Defensive Styles of Coping

The term defensive styles of coping as presented in the article relates to the processes an individual employs in order to protect themselves from situations and stimuli perceived as subjectively demanding and/or threatening. This approach was proposed by Weinberger, Schwartz, & Davidson (1979), who believed that there are two different methods of defensive coping: repression and sensitization. Repression is defined as a coping strategy that aims to shield the organism from distressing stimuli by avoiding any unpleasant and/or threatening characteristics. Sensitization on the other hand includes coping strategies that aim to reduce uncertainty through approaching unpleasant and/or threatening stimuli (Myers, 2010; Myers & Derakshan, 2004). According to the presented approach repression-sensitization is often described and understood as a two-dimensional concept of dispositional coping observed in stressful, especially ego-related, situations (Krohne, 2001).

The relatively stable individual tendency to use repression or sensitization (Weinberger et al., 1979) is recognized based on subjectively assessed individual levels of anxiety (measured for example with MAS Scale or State Trait Anxiety Inventory) and social desirability (assessed for instance with Marlowe-Crowne Social Desirability Scale). In order to identify repressors and sensitizers (i.e. persons with a tendency for repression or sensitization) the median split of the results of the abovementioned scales are calculated and then combined, resulting in formation of four independent groups: repressors, truly low-anxious, truly high-anxious, and sensitizers.

It was proved that the median splits serves as an adequate method for identification of independent groups of people with varied tendencies toward defensive style of coping (see Kleszczewska-Albińska, 2011; Myers, 2010). It should be emphasized that the presented classification does not include clinical criteria of high or low anxiety levels. This categorization helps only to differentiate persons who describe themselves as individuals with certain levels of trait anxiety and social desirability that can be used for identification of a tendency for defensive coping style. According to Weinberger and colleagues (1979) repressors report experiencing low levels of anxiety with accompanying high levels of social desirability. Truly low-anxious individuals present low indexes of both anxiety and social desirability, truly high-anxious individuals experience high levels of anxiety and low levels of social desirability, whereas sensitizers describe themselves as high on both anxiety and social desirability (Weinberger et al., 1979).

According to the studies (e.g. Krohne et al., 2000; Rauch et al., 2007; Rohrmann, Hennig, & Netter, 2002) it was proved that repressors have a tendency to avoid, deny or minimize the existence of internal pressure. They underestimate the physiological signs of arousal, try to control their behavioral arousal (i.e. muscle activity), and at the same time use cognitive reinterpretations in favor of creating an unthreatening explanation of their own feelings (Myers, 2010). In result, they fail to verbalize feelings of distress and avoid concentrating on possible negative outcomes of situations (Krohne, 2001). Truly low-anxious individuals present adequate to the situation, internally coherent low levels of physiological, behavioral, and cognitive arousal, whereas truly high-anxious persons present internally coherent high levels of physiological, behavioral, and cognitive arousal. Sensitizers overestimate the physiological signs of arousal, present high levels of behavioral arousal, use cognitive processes in search for signs of real or anticipated threats, ruminate, and worry obsessively (Krohne, 2001). The general description of the four defensive styles of coping is presented in table 1. below.

Table 1.
General characteristics of defensive styles of coping identified according to the Weinberger's and colleagues (1979) typology.

Group	General characteristics
repressors (↓anxiety ↑social desirability)	High levels of physiological arousal Low levels of behavioral arousal Low levels of cognitive arousal Underestimation of threat-related stimuli Avoidance tendencies
truly low-anxious (↓anxiety ↓social desirability)	Low levels of physiological arousal Low levels of behavioral arousal Low levels of cognitive arousal Adequate interpretation of stimuli Tendencies for reactions adequate to the situations
truly high-anxious (↑anxiety ↓social desirability)	High levels of physiological arousal High levels of behavioral arousal High levels of cognitive arousal Interpretation of a stimuli in threatening manner Avoidance tendencies
sensitizers (↑anxiety ↑social desirability)	Moderate levels of physiological arousal High levels of behavioral arousal High levels of cognitive arousal Overestimation of threat-related stimuli Approach tendencies

1.3. A Foundation for Current Research

Previous research has documented that there is a connection between problems with employment of adaptive emotion regulation strategies and eating disorders (e.g. Harrison, Sullivan, Tchanturia & Treasure, 2010; Leppanen et al., 2022). There were also discovered the relationships between eating disorders and mood disorders, anxiety, personality disorders, impulse control disorders, self-injurious behaviors and substance abuse (Keski-Rahkonen & Mustelin, 2016). In some studies it was underlined that problems with emotional control may cause or uphold eating disorders, including anorexia nervosa (Harrison, Tchanturia & Treasure, 2010) and binge eating (Dingemans et al., 2017; Leehr et al., 2015).

It was discovered that the connection between eating disorders, ruminations and problems with accepting one's own emotions is stronger for people with higher BMI than it is for lower BMI levels (Leppanen et al., 2022). In other studies, it was proved that persons suffering eating disorders report problems with identifying emotions and using adaptive regulatory strategies (Trompeter, Bussey, Forbes, & Mitchison, 2021). Also, high correlations between emotional dysregulation and intensity of disordered eating behaviors (e.g. dietary restraint, binge eating) were found in both clinical and non-clinical samples (Burton & Abbott, 2019; Goodwin, Haycraft, & Meyer, 2014). It is therefore possible that problems with emotional dysregulation observed in eating disorders are also connected with defensive styles of coping as they were described by Weinberger and colleagues (1979).

According to the authors defensive styles of coping should be defined as a relatively stable (i.e. observed in various situations) individual tendency to cope with difficult, stressful or threatening situations with repression or sensitization (Weinberger et al., 1979). In other words, it was believed that people identified as repressors or sensitizers present relatively stable patterns of defensive reactions across different situations (Kleszczewska-Albińska, 2008; Myers, 2010).

Many studies proved the existence of relationship between eating disorder attitudes and/or EDs and avoidant coping, emotional detachment, and denial (e.g. Ghaderi & Scott, 2000; Macneil, Esposito-Smythers, Mehlenbeck, & Weismoore 2012; Sulkowski, Dempsey, & Dempsey, 2011; Waller et al., 2007). It was hypothesized that poor coping self-efficacy (i.e. ineffective management of life stressors) is strongly connected with eating disorders (Jáuregui Lobera, Estébanez, Santiago Fernández, Alvarez Bautista, & Garrido, 2009; Macneil et al., 2012). It was also discovered that the risk for eating pathology increases with the decrease of the belief in the ability to cope with difficult and stressful situations (Macneil et al., 2012). It is therefore interesting whether defensive coping styles as defined by Weinberger and colleagues (1979) are also related to EDs. According to the knowledge of the author of the presented article up to now no studies on relationships between eating disorders and defensive styles of coping (i.e. repression and sensitization as defined by Weinberger et al., 1979) were published in the literature.

2. METHOD

2.1. Participants

In the study participated 127 women, aged 18-69 (M=28.73; SD=7.74). Among all the respondents there were 61 persons without diagnosis (age 18-69; M=28.54; SD=8.61), 21 women with anorexia nervosa (age 18-42; M=28.19; SD=7.39), 23 respondents with bulimia nervosa (age 18-39; M=27.7; SD=6.19), and 22 persons with binge eating disorder (age 22-48; M=30.86; SD=7.05). All diagnoses were given by psychiatrists. The number of women without a clinical diagnosis who completed the study was significantly greater than the number of respondents with each type of eating disorder accounted separately $\chi^2_{(2)}$=35,99; p<.001. The respondents were similar according to the sociodemographic characteristics, so the main difference between the groups concerned the presence or absence of eating disorders.

2.2. Procedure

All the respondents suffering eating disorders were approached individually during their ambulatory visits to the mental health professionals in several different clinics. Respondents not diagnosed with eating disorders were also individually asked for participation in the study while they visited primary care physicians in different clinics. Women from the group without eating disorders diagnosis were chosen according to the sociodemographic characteristics, so they resemble respondents suffering eating disorders in terms of age, education, place of residence etc.

The respondents were approached by trained data collection psychology student who informed females waiting for their appointments with professionals about the possibility of participation in the psychological study concerning the eating attitudes and coping. Next, women who expressed their interest in learning more about the project were given details about the aim and procedure of the research. After giving an informed consent, respondents who volunteered to participate in the study were given questionnaire sets and were asked to

fill them in, and to return them to the person collecting the data. It was decided to invite females only to participate in the study, since the statistics prove that the three eating disorders analyzed in the study (i.e. anorexia nervosa, bulimia nervosa, binge eating) are more common for women than men (Statistics & Research on Eating Disorders, n.d.). The study was conducted in compliance with ethical principles.

2.3. Materials

Four standardized tests were used in the study, two for measuring different aspects of eating disorders, and two others to identify the type of defensive coping according to the approach proposed by Weinberger and colleagues (1979) that was described above. Problems concerning eating disorders were assessed with Eating Disorder Inventory (Pawłowska & Potembska, 2014) and Eating Attitudes Test (Garner, Olmsted, Bohr, & Garfinkel, 1982) in Polish adaptation authored by Rogoza, Brytek-Matera, and Garner (2016). Defensive style of coping was identified with application of two questionnaires: Polish adaptation of State Trait Anxiety Inventory (Wrześniewski, Sosnowski, Jaworowska, & Fecenec, 2011) that is used for assessing the levels of trait anxiety, and questionnaire assessing the levels of social desirability, i.e. Social Desirability Questionnaire (Drwal & Wilczyńska, 1980).

Eating Disorder Inventory (EDI) consists of 37 items with 5-point Likert scale, and it is used to identify four different attitudes towards eating: (1) negative perception of one's body; (2) overeating; (3) restrictive diet; and (4) laxativation. The questionnaire is reliable, reaching Cronbach's alpha α=.96 for negative perception of one's body; α=.97 for overeating, α=.89 for restrictive diet, and α=.94 for laxativation.

Eating Attitude Test (EAT) is used in order to describe eating habits that could be connected to anorexia nervosa, bulimia nervosa or binge eating disorder. The test includes 26 items with a 6-point Likert answer scale. It can be divided into three independent scales: (1) dieting; (2) bulimia and food preoccupation; and (3) oral control, that reach satisfactory reliability of Cronbach alphas of α=.93 for dieting, α=.84 for bulimia and food preoccupation, and α=.89 for oral control. The test results can be also analyzed without the division into certain subscales. Reaching the level of at least 20 points is considered an indicator of possible tendency for eating disorders. This latter method of interpretation of gathered results was used in the presented study.

Polish adaptation of State Trait Anxiety Inventory (STAI) was used as an instrument indicating the level of anxiety. The questionnaire includes 20 questions assessing anxiety understood as a temporary state, and 20 other questions for estimation of a relatively stable trait. Each scale includes a 4-point Likert scale. In the described study the scale measuring anxiety understood as a trait was used, and it reached a satisfactory reliability level of Cronbach's alpha α=.88.

The last questionnaire used in the presented study was the Social Desirability Questionnaire (KAS). It was used for assessment of the level of social desirability understood as an indicator of defensiveness level. The instrument includes 29 questions with a true/false response sequence. It includes items that are socially desirable but rather uncommon in society (e.g. "I am never late for my work"), and other features that are quite frequent in the society, but socially undesirable at the same time (e.g. "I remember I was pretending to be sick in order to avoid something"). The reliability of the test in the conducted study equals α=.84.

3. RESULTS

3.1. Preliminary Data Organization

Before the actual analyses were conducted four independent groups that will later be described as types varied in their tendency for defensive coping were formed. For that reason, medians for the STAI (Me=52) and KAS (*Me*=14) questionnaires were calculated, and based on the median split groups that differ in the levels of anxiety and social desirability were identified. Adequate information concerning classification of respondents in the presented study is given in table 2. below.

Table 2.
Groups identified according to their tendency for defensive style of coping.

Group	Number of people
low-anxious (↓STAI ↓KAS)	27
high-anxious (↑STAI ↓KAS)	41
repressors (↓STAI ↑KAS)	39
sensitizers (↑STAI ↑KAS)	20

As can be seen in the table above there are significant $\chi2(3)=9.41$; $p<.05$ differences in the number of people identified as representatives of each group.

Next, the normality of the distribution of the EDI and EAT tests was verified with the Shapiro-Wilk test combined with an analysis of indexes for skewness and kurtosis. Gathered results met the criteria for normal distribution (e.g. Field, 2018; George & Mallery, 2019; Hasiloglu & Hasiloglu-Ciftciler, 2023) therefore in order to analyze the differences in the mean level of eating attitudes and eating habits it was decided to use parametric tests. While analyzing the categorical data non-parametric tests were applied (Field, 2018).

3.2. Eating Disorders and Defensive Styles of Coping

The main analyses started with verification whether there are any connections between defensive styles of coping and types of eating disorders. The crosstab with chi^2 test proved that there is a significant connection between those two variables $\chi2(9)=53.25$; $p<.001$. Detailed information is given in table 3.

Table 3.
Number of people from low-anxious, high-anxious, repressors, and sensitizers types according to diagnosed eating disorder.

	without a diagnosis	anorexia nervosa	bulimia nervosa	binge eating
low-anxious	16	1	0	10
high-anxious	16	2	16	7
repressors	23	14	0	2
sensitizers	6	4	7	3

Next, based on the ANOVA analyses, the mean differences between the attitudes toward eating in groups identified based on defensive styles of coping were assessed. There were three significant differences that are given in detail in table 4. below.

Table 4.
Results of ANOVA analyses for mean level of attitudes toward eating, overeating and laxativation in groups identified according to defensive style of coping.

	low-anxious N=27		high-anxious N=41		repressors N=39		sensitizers N=20		F	p	η^2
	M	SD	M	SD	M	SD	M	SD			
attitudes toward eating	12.04	7.56	24.22	11.68	24.74	18.09	23.10	14.76	5.54	.001	.12
overeating	15.74	10.45	22.61	9.19	6.82	9.13	16.95	11.44	17.46	.001	.30
laxativation	1.33	2.35	7.98	7.70	3.08	3.86	7.15	7.24	9.68	.001	.19

Based on the Bonferroni post-hoc comparisons it was discovered that there were significant differences ($p<.05$) between low-anxious and high-anxious, repressors and sensitizers in their general attitudes toward eating. High-anxious had a significantly higher tendency toward overeating in comparison to repressors, low-anxious and sensitizers. High-anxious and sensitizers presented a significantly higher tendency toward laxativation in comparison to low-anxious and repressors.

Additionally it was also verified whether there is a connection between the coping style and the subjectively assessed weight perception of a respondent classified to one of three categories: underweight, normal weight, overweight or obesity. The obtained results are presented in table 5.

Table 5.
Number of people from low-anxious, high-anxious, repressors, and sensitizers types according to weight category.

	low-anxious	high-anxious	repressors	sensitizers
underweight	1	9	17	6
normal weight	14	17	19	7
overweight/ obesity	12	13	3	7

As presented in the table above there is a significant relationship between analyzed variables $\chi2(6)=19.84$; $p<.01$.

4. DISCUSSION

The main aim of the study presented in the article was to check whether female patients suffering anorexia nervosa, bulimia nervosa or binge eating and women without eating disorders differ in their tendency toward repression or sensitization. First of all four independent groups of respondents varied in their anxiety and social desirability levels were identified. The most numerous was the group of truly high-anxious individuals, while the

least numerous was the group of sensitizers. Among the respondents there were relatively many repressors, and truly low-anxious individuals. Those results are comparable to data obtained in other studies where four types according to Weinberger and colleagues typology (1979) are identified (e.g. Asendorpf & Scherer, 1983; Kleszczewska-Albińska, 2011; Myers, 2010; Rauch et al., 2007).

A significant relationship between defensive style of coping and type of eating disorder was observed. It was noticed that among respondents, who declared not having any eating problems as well as in the group diagnosed with anorexia nervosa there were many repressors. In the group with bulimia nervosa there were many high-anxious respondents, whilst in the group diagnosed with binge eating there were many low-anxious persons. Therefore, it could be stated that the most characteristic for non clinical group and respondents diagnosed with anorexia nervosa is a tendency to avoid directing attention toward experienced feelings. People with bulimia nervosa present a propensity towards high levels of anxiety, while individuals suffering binge eating disorder present limited tendency for defensive styles of coping.

It was observed that low-anxious persons differ from other groups according to the attitudes toward eating, while high-anxious individuals have the tendency to engage in overeating. When respondents were asked to subjectively assess their weight perception the majority of low-anxious and high-anxious individuals identified themselves as having normal weight or being overweight. Interestingly, in the group of repressors most respondents identified themselves as underweight or having normal weight.

Based on the gathered results it can be therefore stated that there are differences between groups identified according to their level of defensive coping in their mean level of attitudes toward eating, overeating, and laxativation. Low-anxious individuals believed that one should listen to their body signals and eat when they're hungry. They stated it is important to taste the food they're consuming and to pay close attention to the variety of food. Beside the importance of nurturing function of the food intake low-anxious respondents suggested also interpersonal functions food should play in the life of an individual. High-anxious persons and both defensive groups, i.e. repressors and sensitizers presented disturbed attitudes toward eating. They misinterpreted body signals corresponding to hunger and satiety. The data obtained in the study leads therefore to the hypothesis that according to the general attitudes toward eating, repressors are similar to high-anxious and sensitizers.

The tendency for overeating was the most frequent for high-anxious persons, and lowest for repressors. It is possible that people experiencing high levels of anxiety use excessive engagement in eating as a strategy for regulating their unpleasant emotions. Repressors on the other hand probably underestimate the level of overeating they truly experience. The results obtained for the tendency for laxativation are the hardest to explain, especially looking at the standard deviation scores that in all cases are higher than means. Since the results in all of the groups are very discrepant, other studies in that area are needed. Another result that needs additional empirical verification concerns high tendency for keeping either extremely low or normal weight that was observed in repressors.

The results obtained in the described above study stay in agreement with the data already published in the literature. It was proved that in comparison to the general population women with eating disorders less frequently use cognitive reinterpretation strategy, and are more prone to engage in suppression of emotions (Danner, Sternheim, & Evers, 2014). Persons with bulimia nervosa have problems using any coping strategies (Dixon-Gordon, Aldao, & De Los Reyes, 2015), while for females with anorexia nervosa quite common is use of repression strategies (Ruscitti, Rufino, Goodwin, & Wagner, 2016),

and withdrawal of positive emotions (Józefik & Pilecki, 1999). It was hypothesized that disturbed relations with eating could be differentiated based on the individual strategies of coping with stress (Villa et al., 2009). Ineffective styles of coping could result in sustaining unhealthy eating habits that could lead to interpersonal conflicts (Holt & Espelage, 2002; Wiatrowska, 2009).

The results obtained in the presented above study are ambiguous and hard to interpret. There are no consistent relationships between disturbed eating habits and defensive styles of coping, so further studies in that area are needed. It is possible that better understanding of relations between eating disorders and defensive styles of coping will help professionals to plan adequate psychological interventions, that most probably should be differentiated for each of the groups identified based on their levels of anxiety and defensiveness.

5. FUTURE RESEARCH DIRECTIONS

Eating disorders are very complex phenomena strictly connected with difficulties within emotion regulation (Leppanen et al., 2022). Data from previous research shows that there is a connection between disturbed eating habits and other mental problems, such as depressive disorders or heightened anxiety levels (Spindler & Milos, 2007). It is therefore important to pay close attention to the way people with eating disorders are coping with everyday difficult and demanding situations. According to the results obtained in the study described in the article it seems important to further analyze the relationships between eating disorders and a tendency for repression or sensitization.

Such research might help to complete sets of guidelines for diagnostic procedures applied for patients with different types of disturbed relations with eating. It could also be helpful during the identification of crucial points necessary in the psychoeducation process of different patients. Based on the data gathered up to date it is believed that repressors have a tendency to avoid any threatening information concerning their health, and prefer situations in which they feel responsible for their own health. Contrary, sensitizers present a tendency to learn as much as possible about their condition, and they are willing to give away control over their health to professionals (e.g. Myers, 2010). Therefore, it seems that different information should be emphasized for repressors and sensitizers suffering from eating disorders.

The next step of analyses should concern the development and empirical verification of psychotherapeutic methods of work aimed at treatment of different eating disorders, with special attention given to binge eating. According to the results presented in the study described above this group of patients presented the most ambiguous attitudes toward eating. The conclusive data gathered in all of the above proposed studies should help mental health professionals to plan and conduct as specific and effective treatment programs for each patient suffering eating disorders as possible.

6. CONCLUSIONS

In the presented article there was conducted the analysis of relationships between a tendency for repression or sensitization and eating disorders in groups of females suffering anorexia nervosa, bulimia nervosa, binge eating, and in women from non-clinical sample. It was discovered that women recruited from the general population quite often presented a tendency toward repression. This result should draw more attention since proneness to avoidant behaviors observed in repression may be related to underestimation of disturbed

eating behaviors. Patients suffering anorexia nervosa presented high inclination for repression, while for persons diagnosed with bulimia nervosa a shift toward high anxiety was observed. Results for individuals with binge eating disorders were the most ambiguous, and cannot be easily explained given the data obtained during the study. It was proved that there are differences in the attitudes toward eating in groups of low-anxious, high-anxious, repressors, and sensitizers. These results captured similarity between a group of high-anxious individuals and two highly defensive groups, i.e. repressors and sensitizers. Based on the conducted study it is possible to presume that defensive styles of coping influence the functioning of people with eating disorders, but this hypothesis needs further empirical investigation.

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