

Health Outcomes, Personality Traits, and Eating Disorders

John C. Ham, Daniela Iorio, and Michelle Sovinsky*

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Abstract

Abstract: Bulimia Nervosa (BN) is a detrimental persistent eating disorder that impacts millions of women, and imposes serious costs on the economy in terms of physical health, treatment costs, absence from work, and reduced human capital accumulation. One important issue in treating BN is that it is often undiagnosed, especially among disadvantaged girls. The failures to diagnose BN occur, in part, because many cases of BN are unobservable to others, and asking girls about their bingeing and purging behavior can be considered invasive. Using data on eating disorder behaviors from the National Heart, Lung, and Blood Institute Growth and Health Study, we show that information on a girl's personality traits, along with information on her family's socioeconomic status, can be used to impute the unobservable BN behavior. In particular, we find that personality traits are significant determinants of bulimic behavior, even after controlling for socioeconomic status. These results suggest a way to target those who are likely to suffer from BN based on identifiable personality traits. Given the costs involved in BN, and the number of individuals affected, our research suggests a practical direction for public health policy in order to reduce the number of undiagnosed cases.

Keywords: Bulimia Nervosa, Personality Traits, Social Class, Economic Costs

JEL Codes: C23, J58, I1

⁰*Ham is at the NYU Abu Dhabi, NYU Wagner School, IFAU, IRP, and IZA. Sovinsky is at the University of Mannheim and CEPR. Iorio is at the University of Bologna. Sovinsky acknowledges support from the European Research Council Grant #725081 FORENSICS and from the CRC Transregio Grant 224.

1 Introduction

Health disparities by education, race, and income are widespread. There has been an outpouring of research in health economics focusing on disparities by socioeconomic status (SES) in a number of behaviors and measures, such as the adoption of contraceptive methods, smoking, drinking, body size, eating habits, use of illicit drugs, compliance in following treatments, and medication adherence. There are also important differences across SES in terms of who receives treatment for a disease, in part because diagnosing a disease is difficult if the patient does not report his/her condition to a doctor.

This is certainly true for the eating disorder Bulimia Nervosa (BN), which is defined by recurrent episodes of binge-eating followed by compensatory behavior.¹ The binge-purge cycle usually occurs several times a week, and as a result, BN can cause serious health problems. The negative impact is even more detrimental for the young due to the irreversible effects on development.² The costs of BN to society are magnified by the fact that eating disorders affect a significant number of individuals. More than 20 million women will suffer from a clinically significant eating disorder at some point. Over the past decades 6% to 8.4% of female adolescents reported trying to lose weight by purging, which is one of the characteristics of BN (National Youth Risk Behavior Survey, 2005). Moreover, the seriousness of the disease is accentuated by the fact that only about half of those diagnosed manage to recover (Keel et al., 2005).

Of course, the situation is even more serious for undiagnosed individuals, who by definition receive no treatment. Further, certain socioeconomic groups are more likely to be underdiagnosed. For example, Ham, Iorio and Sovinsky (2015) show that black girls, low-

¹Binge-eating is the consumption of an unusually large amount of food (by social comparison) in a two-hour period accompanied by a loss of control over the eating process. Compensatory behavior includes self-induced vomiting, misuse of laxatives, diuretics, or other medications, fasting, or excessive exercise.

²For example, the cycle of bingeing and purging can lead to electrolyte and chemical imbalances that affect the heart (i.e., irregular heartbeats and possibly heart failure). Other health concerns include the inflammation of the esophagus, gastric rupture, tooth decay, muscle weakness, and anemia (American Psychiatric Association, 1993). The harmful side effects consist of pubertal delay or arrest and impaired acquisition of peak bone mass resulting in growth retardation and increased risk of osteoporosis (Society for Adolescent Medicine, 2003).

income girls and especially low-income-black girls who suffer from BN were much less likely to be diagnosed. Further, it is difficult to simply observe which girls have BN, as they are characterized by average weight, and hide their behaviors. Moreover, Ham, Iorio and Sovinsky (2013) find that bulimia is a progressive disease in that the intensity of BN behavior in next period will be 50% higher than the intensity in the current period. Hence it is important to determine who is suffering from BN and to identify them. However, identifying who has BN is difficult, and asking young girls about their BN behavior is regarded to be too intrusive.³ Furthermore, given the stigma associated with an eating disorder, girls may be unlikely to directly reveal their behavior.

Our goal in this paper is to show how to use a set of (relatively easy to observe) variables to predict bulimic behavior. Specifically, we show how personality traits of the girls, in addition to SES can provide valuable information regarding current bulimic behavior.⁴⁵ Our results are supported by a growing number of papers in psychology, sociology and economics that have found that personality traits are associated with health behaviors, or the lack of thereof.⁶ Similar conclusions have been reached by a large set of small-scale studies underlining the link between bulimic behavior and perfectionism, sense of ineffectiveness, obsessive compulsive disorder, neuroticism, low self-directedness, and low cooperativeness.⁷

³For example, the study would need to ask young girls sensitive questions on whether they eat excessively, if they make themselves vomit after eating, or whether they engage in other purging behavior such as excessive use of laxatives.

⁴A number of papers have investigated the relationship between SES and eating disorders. Hudson et al. (2007) document various types of eating disorder behaviors among women and men (in a univariate framework) using data from the National Comorbidity Replication Survey. Reagan and Hersch (2005) investigate the frequency of bingeing behavior (but not purging) using cross-sectional data from the Detroit metropolitan area. They find that there are no race effects on bingeing behavior, and that marital status, neighborhood, and income play a role among women. A related epidemiological study using the NHLBIS is Strigel-Moore et al. (2000), who examine correlations between BN and race and between BN and parental education. Their univariate results show that BN is more prevalent among African American girls. Ham, Iorio, and Sovinsky (2015) use the same data, NHLBIS, together with the AddHealth dataset, to show that the distribution of bulimic behavior across socioeconomic groups may crucially differ depending on if the focus group is all individuals potentially at risk or only on diagnosed individuals.

⁵Roberts (2009) defines personality traits as “the relatively enduring patterns of thoughts, feelings, and behaviors that reflect the tendency to respond in certain ways under certain circumstances.”

⁶Regarding the education-health gradient, see Rosenzweig and Schultz, 1989; Goldman and Smith, 2002; Lillard et al., 2007; Cutler and Lleras-Muney, 2010. Regarding the association between personality traits and health behaviors and outcomes, Pulkki et al., 2003; Smith, 2007; Turian et al., 2012, and Turian et al., 2015.

⁷See Cassin and von Ranson (2005) for a comprehensive review of the literature.

We cannot investigate the possibility of using the personality traits to choose a treatment strategy conditional on a diagnosis of clinical BN, but we believe that such an investigation in the future would be quite interesting.

We use a unique longitudinal dataset from the National Heart, Lung, and Blood Institute Growth and Health Study (NHLBIS) to examine the association between personality traits, SES (such as race, parental education, and family income), and bulimic behaviors. Information on personality traits are based on indices that measure a respondent’s potential for personality traits/disorders, such as tendencies toward perfectionism, feelings of ineffectiveness, body dissatisfaction, and interpersonal distrust (Garner et. al., 1983). Information on bulimic behaviors are based on an Eating Disorders Inventory index that was developed by a panel of medical experts to assess the psychological characteristics that may be relevant to eating disorders (Garner et. al., 1983). We focus on the level of the Eating Disorders Inventory index, which allows us to obtain more efficient estimates of our parameters, as opposed to using a binary variable determined by higher levels of this index (that are consistent with fully-developed BN).⁸

The NHLBIS surveyed a relatively large number of female adolescents who were first interviewed when they were between the ages of 11 and 12—ages that typically signify the onset of eating disorders. They used a stratified sampling scheme to survey an equal number of blacks and whites, which enables us to estimate precise relationships for both groups.⁹

Our goal is to impute current bulimic behavior using personality traits and SES variables rather than to establish causal relationships between BN and these variables. To see the difference, assume that there is a single genetic factor that determines BN and the personality traits. To address this issue when undertaking causal analysis we would use a Fixed Effects model. However, this approach is not useful for imputing current BN behavior since the fixed effects are unknown variables to those implementing our results for other children. Of

⁸Garner et al, (1983) combine a sample of girls suffering from anorexia with a control sample of girls and look at the univariate correlations between anorexic behavior and several variables including the personality traits. However, their sampling scheme induces choice-based sampling, which they do not correct for.

⁹Since ethnicity is treated as exogenous, this stratifying will not create any bias.

course, another option is to rely only on the SES variables to impute BN because collecting data on personality traits, while not considered invasive, will still be time-consuming. The problem with this strategy is that the SES variables explain only 3% of the variance in our measure of bulimic behavior.

Given the number of people suffering from BN, BN imposes significant costs on individuals and the economy. First, engaging in BN behavior reduces the health of the individual. Addressing these health issues will require considerable resources. Second, BN is likely to negatively affect human capital accumulation as BN has negative effects on cognitive development, and adolescents suffering from BN are more likely to miss class and to be less attentive in class. Third, BN has a negative impact on work productivity. BN may reduce the return to on-the-job training, which is often aimed at single mothers. Individuals suffering from BN may be more likely to miss work, which affects their likelihood of having a stable job. Thus BN can impose serious costs to the economy in terms of physical health, treatment costs, reduced human capital accumulation, increased absence from work and decreased productivity.

As a result of the costs to society, BN is considered a primary health concern. However, it has received relatively little attention from the government (as opposed to, say, obesity). Public campaigns targeting BN remain scarce, as noted by the U.S. Senate Committee of Appropriations, who expressed concern about the “growing incidence and health consequences of eating disorders among the population” (Department of Health and Human Services, 2006).¹⁰ This lack of targeting is especially unfortunate because of the number of BN cases that go undiagnosed.

This study on BN yields the following: First, we find that including current personality traits (conditional on the SES variables) substantially and significantly increases our ability to explain BN. Second, this relationship holds for every wave of our cohort, i.e. at each age

¹⁰According to the 2004 School Health Profiles study, only 25 states had at least one school that taught students about eating disorders. In these states, between 78 and 99% of schools provided education on eating disorders. The majority of these programs were in high schools.

level of the cohort, including the wave when the girls are only 11-12 years old. Third, race and family income continue to be significant when we control for the personality traits. Hence, our results strongly suggest that outreach should be based on both SES characteristics and personality traits.

The outline of the paper is as follows. In section 2 we describe the data and present basic statistics on BN. In section 3 we discuss the econometric methodology. In section 4 we present the results regarding the predictive role of the SES and personality traits in the incidence and intensity of bulimic behaviors. We discuss the policy implications of our results in section 5, and conclude in section 6.

2 Data

We use data from the National Heart, Lung, and Blood Institute Growth and Health Study (NHLBIS). The data include a cohort of black and white girls from schools in Richmond, California and Cincinnati, Ohio, as well as from families enrolled in a health maintenance organization in Washington, DC.¹¹ The sampling scheme used exogenous stratification on race and initial family income. Specifically, it was constructed to have equal numbers of African Americans and Whites, and to have approximately equal representation across three income groups (defined below) by race (Kimm et. al., 2002). The survey collected data on the (same) girls in this cohort for ten years, starting in the academic year 1989/1990, when the girls were between the ages of 11 and 12.¹² The survey contains questions on BN behavior; these questions were asked approximately every other year. Demographic and socioeconomic information include age, race, parental education, and initial family income (in categories). The data also contain a number of time-varying psychological or personality indices (reflecting the potential for personality disorders) that were sampled every year except 1993.

¹¹Due to confidentiality concerns, the data do not indicate where an individual lives.

¹²The dataset is unbalanced. The attrition rate after ten years was 11%.

Our outcome variable is an index of bulimic behavior (d_{it}), which is constructed based on questions on BN behavior asked in every other year of the survey (i.e., in five waves starting when the girls were between the ages of 11 and 12). The questions were formulated to be consistent with diagnostic criteria for BN and were adjusted to be easy to understand for young respondents. For each girl in every other year, the survey contains an Eating Disorders Inventory-BN scale, which measures degrees of BN symptoms. The ED-BN index is constructed from ordered responses ((1) always; (2) usually; (3) often; (4) sometimes; (5) rarely; (6) never) to seven items: (i) I eat when I am upset; (ii) I stuff myself with food; (iii) I have gone on eating binges where I felt that I could not stop; (iv) I think about bingeing (overeating); (v) I eat moderately in front of others and stuff myself when they are gone; (vi) I have the thought of trying to vomit in order to lose weight; and (vii) I eat or drink in secrecy. A response of 4–6 on a question contributes zero points to the ED-BN index; a response of 3 contributes 1 point; a response of 2 contributes 2 points; and a response of 1 contributes 3 points. The ED-BN index is the sum of the points, and ranges from 0 to 21 in our data. For instance, if a respondent answers “sometimes” to all questions, her ED-BN index will be zero; if she answers “always” to each question, her index will be 21. Therefore, a higher ED-BN score is indicative of more intense BN behavior. The survey does not provide the researcher with the answers to individual questions, only the overall index.

According to the panel of medical experts who designed the index (Garner et. al., 1983), a score higher than 10 indicates that the girl is very likely to have a clinical case of BN.¹³ Approximately 2.2% of the NHLBIS respondents scored higher than 10, which is close to the national average of clinical BN reported from other sources.¹⁴ We refer to a respondent with an ED-BN index greater than 10 as one exhibiting clinical BN. However, we focus our attention on the index rather than the discrete variable (which is equal to one when the

¹³In order to externally validate the ED-BN index, a sample of women diagnosed with BN (according to the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV) criteria) was interviewed using the NHLBIS questionnaire: the average ED-BN index among this sample was 10.8. See Garner et al. (1983) for more details of the development and validation of the ED-BN index.

¹⁴See for instance, Hudson et al. (2007) and National Eating Disorders Association (2012), which notes between 1.1% and 4.6% of females will develop bulimia.

index is greater than 10) to exploit the intensity of bulimic tendencies available in the data.

<Insert Table 1>

Table 1 shows the descriptive statistics of the variables. For all demographic variables except age we have one observation per person. The mean of the ED-BN index is 1.4, and has substantial variation among the girls. The average age of the girls is approximately 15 years. Recall that the sample was chosen to have (approximately) an equal number of girls for whites and blacks in the three income groups, so by design there will be a lot of variation in the demographic variables. Recall that this design is one of exogenous sampling and hence does not create a sample selection problem. Moreover, following the literature in economics we do not reweight the data to mimic a nationally representative sample. Given that parent's education and race are very unlikely to change (except perhaps by remarriage) the only SES variable for which it would be useful to have multiple observations is family income. The data also contain indices that measure a potential for personality characteristics (henceforth, "personality indices"), and are available in all years of the survey except for 1993. The first index assesses the degree to which the respondent is dissatisfied with the size and shape of specific parts of her body (henceforth "the body dissatisfaction index"). The remaining personality indices assess tendencies toward: perfectionism (henceforth "the perfectionism index"), feelings of ineffectiveness (henceforth "the ineffectiveness index"), and interpersonal distrust (henceforth "the distrust index"). For all the personality indices, a higher score indicates a higher intensity of the personality trait. For ease of exposition, we provide details on the questions used to form the personality indices in Appendix A.

<Insert Table 2>

The top panel of Table 2, illustrates the distribution of the ED-BN index by year. Specifically, in panel A, each row shows the percentage of young women with an ED-BN index of zero, between 1 and 5, between 6 and 10, and greater than 10 in each interview year. We

see that in 1989, the first wave of the sample when the subjects were between the ages of 11 and 12, has the lowest fraction of the sample with ED-BN of zero, and the highest fraction with ED-BN greater than 10. In fact, it appears that the proportion of girls with high BN scores shrinks as the waves proceed and they get older. This may be due to the fact that some children are getting treatment in the later waves (at older ages), but unfortunately we cannot observe whether a girl received treatment. The bottom panel presents the sample size for all relevant variables in each wave.

<Insert Figure 1>

Consider the distribution of ED-BN scores by the demographic variables. The common perception that BN is a disorder that only affects upper-income girls, or White girls, is discredited by Figure 1. For example, an ED-BN index equal to zero is more prevalent among Whites than African-Americans, an ED-BN index that is greater than zero is more prevalent among African-Americans than Whites.¹⁵ Further, as parental education increases, and as initial family income increases, the seriousness of ED-BN is decreasing. Combined with the results for African Americans, Figure 1 suggests that untreated BN is more problematic among African American girls, girls from low-income families, and girls from families with low parental education, motivating our goal of identifying girls at risk of BN in our sample, and subsequently in the population. One possibility is that the results for race or class will disappear once we also condition on the personality traits. But our multivariate analysis below shows that the race and class factors continue to be significant when we do this.

<Insert Table 3>

¹⁵One could be concerned that the ED-BN index might capture obesity instead of bulimic behavior. However, if the index was actually measuring obesity, we would expect a strong positive correlation between ED-BN scores and body mass index (BMI), while the correlation in the data for all girls is only 0.05, and is actually negative for African Americans. In addition, one might be concerned that correlation is driven by the highest ED-BN scores, and that the index represents obesity among those scoring 0-10. However, average BMI for girls with an ED-BN index above 5 (i.e., the midpoint of the 0 – 10 interval) is lower than average BMI for girls with an index of 5 or lower for both African Americans (22.48 versus 24.72) and Whites (20.55 versus 22.14). These statistics strongly suggest that the ED-BN index is not an obesity index.

To get a first look at the relationship between the personality traits and ED-BN, in Table 3, columns (1) and (2), each row shows the correlation between ED-BN and each personality trait for the full sample and the first wave data when the girls are 11-12 years old. In columns (3) and (4), each row shows the correlation between clinical bulimia (ED-BN Index >10) and each personality trait, again for the full sample and the first wave data when the girls are 11-12 years old. These correlations are sizeable and statistically significant at the 1% level. For our purposes, it is helpful to note that these correlations are always stronger in the first wave than in all of the data. Below we see that our regression results are stronger in the first wave, suggesting that personality traits are a good signal of BN even for the youngest girls.

3 Empirical Strategy

We begin our analysis by including SES and personality traits measures in separate regressions. We estimate the following regressions,

$$d_{it} = \beta_0 + \mathbf{X}_{it}\beta_1 + v_{it}, \quad (1)$$

$$d_{it} = \beta_2 + \mathbf{p}_{it}\beta_3 + e_{it}, \quad (2)$$

where d_{it} is the ED-BN index for child i in year t , \mathbf{X}_{it} is her set of SES variables, \mathbf{p}_{it} denotes the vector of personality indices, and v_{it} and e_{it} represent contemporaneous shocks for person i at time t . In some specifications we add wave dummies and drop age from \mathbf{X}_{it} since we cannot distinguish time effects from age effects within a single cohort.

We then control both for socioeconomic characteristic and personality traits:

$$d_{it} = \alpha_0 + \mathbf{X}_{it}\alpha_1 + \mathbf{p}_{it}\alpha_2 + u_{it}, \quad (3)$$

We do not interpret the coefficients in (1)-(3) as causal, since individuals may have unobservables that affect both d_{it} and p_{it} . The inability to determine causality is not a concern as

our goal is to ascertain whether these variables allow us to impute who has BN, or is likely to experience BN in the future. We cluster the standard errors by individuals to control for correlation across time as well as any heteroskedasticity in u_{it} (following Abadie et al, 2017).

One drawback of the regression model is that it ignores the large number of observations with an ED-BN index of zero. To address this drawback we consider a Tobit model where the latent variable underlying the ED-BN index is

$$d_{it}^{Tobit*} = \mu_0 + \mathbf{X}_{it}\mu_1 + \mathbf{p}_{it}\mu_2 + \theta_i + \varepsilon_{it}, \quad (4)$$

where θ_i is an individual specific random effect that is assumed to be independent of \mathbf{X}_{it} and \mathbf{p}_{it} , and ε_{it} are iid idiosyncratic shocks. The observed value, d_{it}^{Tobit} , is

$$d_{it}^{Tobit} = \begin{cases} 0 & \text{if } d_{it}^{Tobit*} \leq 0 \\ d_{it}^{Tobit*} & \text{otherwise.} \end{cases}$$

Note that the Tobit parameter estimates will be inconsistent if we have heteroskedasticity so we do not allow for heteroskedasticity. However, we can allow for correlation over time in an individual's error terms by including the random effect θ_i and assuming that θ_i and ε_{it} are independent of each other and distributed as i.i.d. normal random variables.¹⁶ Following the custom in applied economics, we report the partial effects, e.g.

$$\frac{\partial d_{it}^{Tobit}}{\partial X_k} = \mu_{1k} \overline{\Pr}(d_{it}^* > 0),$$

where $\overline{\Pr}(d_{it}^* > 0)$ is the average of $\Pr(d_{it}^* > 0)$ over individuals and time periods. Note that these partial effects are analogous to estimated coefficients in the regression approach.

We also estimate a Probit model for clinical bulimia. The latent index function is:

$$d_{it}^{Probit*} = \delta_0 + \mathbf{X}_{it}\delta_1 + \mathbf{p}_{it}\delta_2 + \eta_i + w_{it}, \quad (5)$$

where the observed value of clinical bulimia is

¹⁶We do not need the random effect in the regression equations since we allow for unrestricted correlations across the errors for the same girl.

$$d_{it}^{\text{Probit}} = \begin{cases} 1 & \text{if } d_{it}^{\text{Probit}^*} > 10 \\ d_{it}^{\text{Probit}^*} & \text{otherwise.} \end{cases}$$

We also report the partial effects which are formed analogously. Again, we do not allow for heteroskedasticity. We do allow for correlation over time in an individual’s error terms by including the random effect η_i , and assuming that η_i and w_{it} are independent of each other and distributed as i.i.d. normal random variables.¹⁷

4 Empirical Results

Table 4 contains the results for the OLS model. We include only the SES characteristics in Column (1). The benchmark group is African-American families, from the lowest income bracket and comprising parents who are (at most) high school graduates. In column (1), all of the SES coefficients are jointly significant. Column (2) presents the regression results with the personality characteristics as explanatory variables; all of the personality traits coefficients are jointly significant. Column (3) includes both sets of explanatory variables.

<Insert Table 4>

Column (3) includes both the SES and personality traits as explanatory variables.¹⁸ Now the coefficients for race, age, and income remain jointly statistically significant, even when we condition on personality traits, but fall in size compared to those in Column (1). Specifically, the coefficient for White is about 25% smaller while the coefficient for income falls by about 47% for the middle group, and by 50% for the high-income group.

In column (3) we also see that all but one of the personality indices (interpersonal distrust) continue to be individually and jointly significantly associated with the ED-BN index in

¹⁷We use the common normalization that the variance of $(\eta_i + w_{it})$ equals 1.

¹⁸Some readers may be more familiar with results when the BN-ED and the personality traits are measured as Z-scores, i.e. with mean 0 and standard deviation 1. To get the Z-score (aside from the intercept) multiply the respective coefficient by the ratio of (i) the BN-ED standard deviation and (ii) the respective personality trait standard deviation. The values of the standard deviations are in Table 1.

the direction expected from Column (2). Note that each of these estimated coefficients is substantial when compared to the mean ED-BN index of 1.4. The estimates of ineffectiveness, perfectionism, and body dissatisfaction are individually and jointly significant, and quite stable when we control for SES. Some may be concerned about the fit of our model given R-Squared values around 0.23, which suggest that we can explain 23% of the variance in the ED-BN variable. But we feel it is informative to put our findings within the context of the larger literature, where equations with R-Squared values of 0.23 are considered to perform very well in prediction.¹⁹ Hence we believe that our results are quite compelling.

<Insert Table 5>

We argued that early identification of BN behavior will enable early intervention. Hence the ability to impute BN behavior at young ages could have substantial benefits. In Table 5 we have replicated Table 4 using only the first wave of data, when the girls are between the ages of 11 and 12. Importantly, the results in Table 5 are similar to those in Table 4. Both SES and personality traits are predictive of BN behavior.

<Insert Table 6>

Table 6 shows the estimated partial effects from the Tobit model in columns (1)-(3). These partial effects are quite similar to the regression results in Table 4. In Columns (4)-(6) we show the partial effect from the Probit model. These estimates use only the information provided by the dummy variable for clinical bulimia, and are considerably weaker in terms of significance than the estimates for the Tobit Model. The loss of significance when we move from the Tobit to the Probit models is to be expected, since the Tobit and Probit model use the same index function structure, but the Tobit model uses much more data by considering the actual values of the BN-ED index.

¹⁹The commonly used regression of log-wages on schooling and IQ has an R-squared around 0.18.

In Table 7 we replace the current values of the personality variables with those in the previous wave, and find similar results to Table 4. For ease of comparison, Column (1) in Table 8 is a replicate of Column (1) in Table 4. Note that as soon as the personality traits are collected, they can be used to impute BN next year.

<Insert Table 7>

We also considered robustness checks where we replaced our age variable with wave/year fixed effects but this had no effect on the other coefficients. Perhaps not surprisingly, we cannot separately estimate with any precision age effects and wave effects. We present these results in Appendix B.

5 Policy Prescriptions

Our results strongly indicate that we can impute who is demonstrating symptoms of BN using relatively noninvasive questions on personality traits, as opposed to using invasive questions on BN behavior. This finding is crucial since diagnosis of BN is very different across racial groups and income groups; specifically, minorities and low-income groups are especially likely to experience untreated bulimia. Moreover, our results suggest that we can successfully impute BN behavior for girls as young as 11–12 years. Since we know that BN is a progressive disease and hence should be treated as early as possible, these latter results are important.

But our results are based on a relatively small data set that covers only three cities, so we would recommend that much larger data sets be collected for at least the four general regions of the country. With such a larger data set we could allow for region-specific coefficients, as well as interactions among the SES variables, interactions among the personality traits, and interactions between the SES variables and the personality traits. Here it will be crucial to also collect data on who is receiving treatment for BN.

6 Conclusions

We examine the role of personality traits in eating disorder behavior, and find that personality traits explain a significant amount of the variation in ED-BN behavior, while SES variables explain much less of this variation. Further, we present results showing that personality traits continue to be significant determinants of BN behavior, even after controlling for the SES. With a much bigger data set, along the lines of that suggested in Section 5, we would be able to substantially improve imputations for BN. A better data set would also avoid a possible disadvantage of our data: since we cannot observe who has been treated for BN in the NHLBIS, we do not know which girls have already received treatment.²⁰

Finally we recommend that programs or publicity campaigns aimed at overeating be sensitive to possible unintended consequences, e.g., inducing eating disorders. In preliminary regressions using data from the National Longitudinal Study of Adolescent Health, we find that women who have been exposed to preventative educational programs on the dangers of being overweight report more severe bulimic behavior.²¹

²⁰Furthermore, certain individual characteristics might identify those at a high risk of bulimia, but not necessarily those who are more likely to respond to treatment. Also, treatment itself might affect an individual's personality traits over time. We thank an anonymous referee for this point.

²¹These concerns have also been raised in a number of publications in the eating disorders literature. More recently the Academy for Eating Disorders commented on the risk of unintended negative consequences from obesity education (see Danielsdottir et al., 2009).

Table 1: Descriptive Statistics

	Mean	Clustered Standard Error of Mean	Standard Deviation			Number of Waves
			Overall	Between	Within	
Age	14.992	0.014	2.755	1.240	2.542	All
White	0.480	0.010	0.499			1
Parents High School or Less	0.255	0.009	0.436			1
Parents Some College	0.393	0.010	0.488			1
Parents Bachelor Degree or More	0.352	0.010	0.477			1
Family Income less than \$20,000	0.318	0.010	0.466			1
Family Income in [\$20000, \$40000]	0.315	0.010	0.465			1
Family Income more than \$40,000	0.367	0.010	0.482			1
ED-BN Index	1.4	0.039	2.852	2.287	1.869	3,5,7,9,10
Clinical Bulimia (ED-BN>10)	0.022	0.002	0.159	0.118	0.116	3,5,7,9,10
Body Dissatisfaction Index*	8.039	0.131	7.432	6.384	4.075	3,5,7,9,10
Distrust Index**	3.589	0.056	3.466	2.768	2.218	3,5,9,10
Ineffectiveness Index***	2.752	0.063	3.903	3.144	2.479	3,5,9,10
Perfectionism Index****	6.468	0.052	3.290	2.541	2.168	3,5,9,10

Notes: Income is in 1988\$; * ranges from 0 to 27 (maximal dissatisfaction); ** ranges from 0 to 21 (maximal distrust); *** ranges from 0 to 29 (maximal ineffectiveness); **** ranges from 0 to 18 (maximal perfectionism). See Appendix A for more detailed description of the variables. Clustering is at the individual level.

Table 2: Distributions of the ED-BN Index and Sample Sizes

	Waves	1989	1991	1993	1995	1996
		ED-BN Index Range % = 0	all years	60.37	62.16	67.86
ED-BN Index Range % = [1,5]	all years	27.84	27.8	26.98	24.11	24.24
ED-BN Index Range % = [6,10]	all years	8.01	6.76	3.78	3.21	3.24
ED-BN Index Range % > 10	all years	3.78	3.28	1.38	0.85	1.3
Sample Size:						
ED-BN index	all years	2198	2011	1879	1995	2071
Perfection	all except 1993	2194	2012	0	1995	555
Ineffectiveness	all except 1993	2185	1993	0	1990	555
Distrust	all except 1993	2193	2005	0	1995	555
Body Dissatisfaction	all years	2198	2005	1874	1992	2071
Parental Education	baseline only	2196	2010	1878	1993	2066
Family Income	baseline only	2077	1899	1778	1887	1957
White	baseline only	2198	2011	18789	1995	2071
Age	all years	2198	2011	1879	1995	2071

Table 3: Correlations of ED-BN Index and Clinical Bulimia with Personality Traits

	ED-BN Index		Clinical Bulimia (BN)	
	Full sample	Aged 11 or 12	Full sample	Aged 11 or 12
<u>Personality Trait Index:</u>				
Body Dissatisfaction Index	0.221	0.252	0.114	0.157
Distrust Index	0.213	0.238	0.107	0.122
Ineffectiveness Index	0.439	0.462	0.274	0.298
Perfectionism Index	0.229	0.322	0.145	0.206

Note: Correlations are significant at the 1% level using clustered standard errors.

Table 4: SES, Personality Indices and the ED-BN Index (OLS)

	(1)	(2)	(3)
White	-0.318*** (0.099)		-0.238*** (0.088)
Age	-0.130*** (0.013)	-0.087*** (0.012)	-0.087*** (0.013)
Parents Some College	-0.160 (0.129)		-0.083 (0.110)
Parents Bachelor Degree or More	-0.327** (0.135)		-0.143 (0.119)
Income in [\$20000, \$40000]	-0.440*** (0.130)		-0.232** (0.112)
Income more than \$40,000	-0.504*** (0.127)		-0.253** (0.109)
Distrust Index		0.026** (0.012)	0.008 (0.013)
Ineffectiveness Index		0.261*** (0.017)	0.260*** (0.018)
Perfectionism Index		0.142*** (0.013)	0.134*** (0.014)
Body Dissatisfaction Index		0.037*** (0.006)	0.040*** (0.006)
Constant	4.033*** (0.246)	0.699*** (0.201)	1.179*** (0.241)
Sample Size	6308	6291	6291
F statistics	30.84	112.45	56.84
R-squared	0.034	0.236	0.239

Notes: Standard errors are robust to intra-individual correlation and robust to heteroskedasticity are in parentheses. * indicates significant at the 10% level; ** at 5%; *** at 1%.

Table 5: SES, Personality Indices and the ED-BN Index (OLS) - First wave

	(1)	(2)	(3)
White	-0.647*** (0.159)		-0.267** (0.141)
Age	-0.012 (0.119)	0.109 (0.107)	0.073 (0.109)
Parents Some College	-0.256 (0.207)		-0.199 (0.181)
Parents Bachelor Degree or More	-0.716*** (0.216)		-0.352* (0.194)
Income in [\$20000, \$40000]	-0.406** (0.202)		0.057 (0.181)
Income more than \$40,000	-0.439** (0.204)		0.022 (0.181)
Distrust Index		0.041* (0.021)	0.028 (0.028)
Ineffectiveness Index		0.289*** (0.028)	0.285*** (0.028)
Perfectionism Index		0.202*** (0.024)	0.194*** (0.024)
Body Dissatisfaction Index		0.037*** (0.011)	0.038*** (0.011)
Constant	2.905** (1.461)	-0.927*** (0.166)	-1.392 (1.342)
Sample Size	2029	2022	2022
F statistics	12.11	142.35	72.35
R squared	0.035	0.261	0.265

Notes: Standard errors robust to heteroskedasticity are in parenthesis.

* indicates significant at the 10% level; ** at 5%; *** at 1%.

Table 6: SES, Personality Indices and the ED-BN Index Tobit and Probit Partial Effects

	ED-BN index - Tobits			Clinical Bulimia - Probits		
	(1)	(2)	(3)	(4)	(5)	(6)
White	-0.288*** (0.090)		-0.248*** (0.073)	-0.008 (0.005)		-0.011*** (0.004)
Age	-0.106*** (0.012)	-0.076*** (0.010)	-0.075*** (0.010)	-0.005*** (0.001)	-0.003*** (0.001)	-0.003*** (0.001)
Parents Some College			-0.019 (0.085)	-0.005 (0.005)		-0.005 (0.005)
Parents Bachelor Degree or More			-0.105 (0.098)	-0.005 (0.006)		-0.002 (0.006)
Income in [\$20000, \$40000]			-0.242*** (0.083)	-0.006 (0.005)		-0.001 (0.005)
Income more than \$40,000			-0.441*** (0.106)	-0.015*** (0.005)		-0.008 (0.005)
Distrust Index		0.037*** (0.009)	0.020** (0.009)		0.000 (0.000)	0.000 (0.000)
Ineffectiveness Index		0.150*** (0.010)	0.150*** (0.009)		0.004*** (0.000)	0.004*** (0.000)
Perfectionism Index		0.101*** (0.010)	0.093*** (0.009)		0.003*** (0.000)	0.003*** (0.000)
Body Dissatisfaction Index		0.041*** (0.004)	0.044*** (0.004)		0.001*** (0.000)	0.001*** (0.000)
Sample Size	6308	6291	6291	6308	6291	6291

Notes: Standard errors robust intra-individual correlation are in parenthesis.

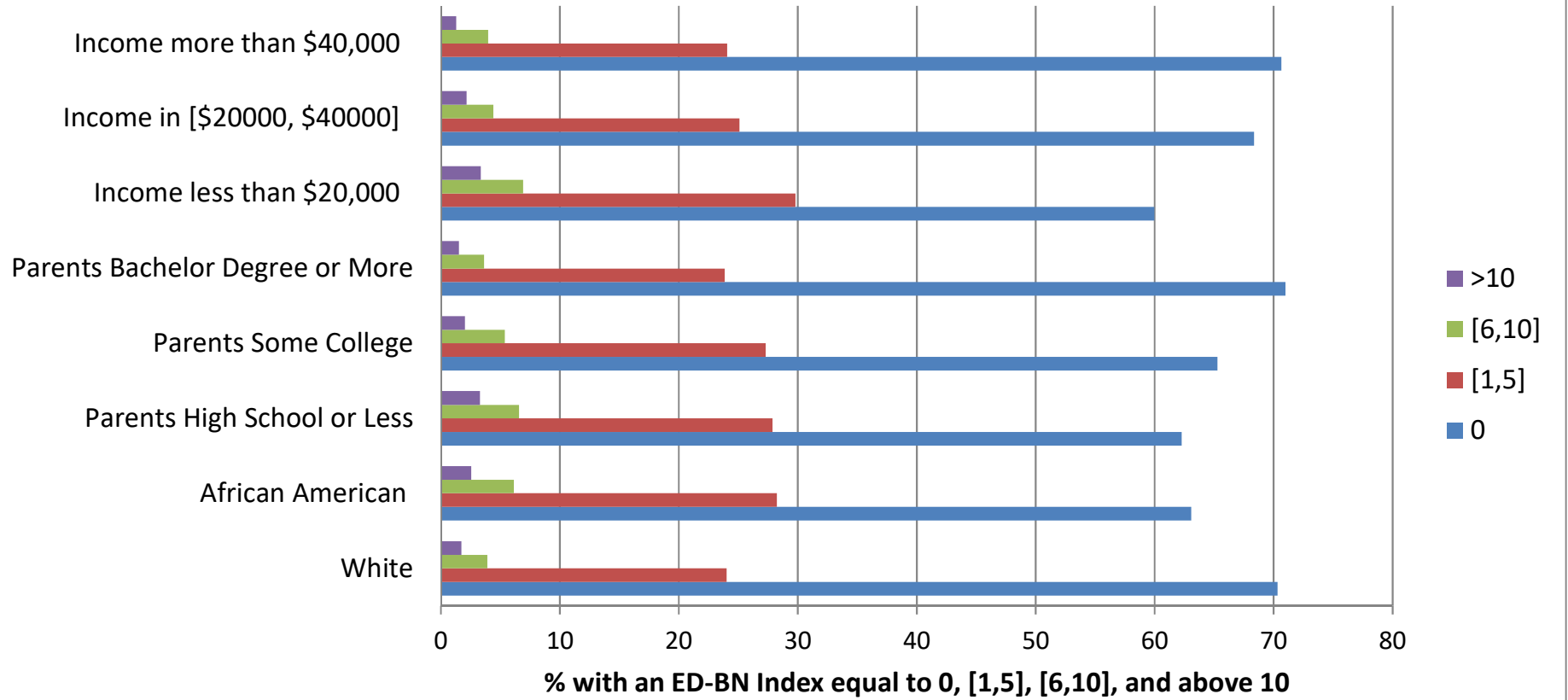
* indicates significant at the 10% level; ** at 5%; *** at 1%.

Table 7: SES, Lagged Personality Indices, and the ED-BN Index (OLS)

	(1)	(2)	(3)
White	-0.318*** (0.099)		-0.038 (0.089)
Age	-0.130*** (0.013)	-0.090*** (0.015)	-0.092*** (0.015)
Parents Some College	-0.160 (0.129)		-0.132 (0.110)
Parents Bachelor Degree or More	-0.327** (0.135)		-0.053 (0.117)
Income in [\$20000, \$40000]	-0.440*** (0.130)		-0.294*** (0.109)
Income more than \$40,000	-0.504*** (0.127)		-0.382*** (0.105)
Lagged Distrust Index		0.057*** (0.013)	0.046*** (0.014)
Lagged Ineffectiveness Index		0.131*** (0.015)	0.128*** (0.015)
Lagged Perfectionism Index		0.078*** (0.013)	0.075*** (0.013)
Lagged Body Dissatisfaction Index		0.034*** (0.006)	0.035*** (0.006)
Constant	4.033*** (0.246)	1.353*** (0.262)	1.179*** (0.296)
Sample Size	6308	5520	5520

Notes: Standard errors robust intra-individual correlation and robust to heteroskedasticity are in parenthesis. * indicates significant at the 10% level; ** at 5%; *** at 1%.

Figure 1: The relationship between SES and ED-BN index



Appendix

A Data Variable Definitions

We describe the construction of the ED-BN index in the main text of the paper. The body dissatisfaction index is based on subject responses to nine items: (i) I think that my stomach is too big; (ii) I think that my thighs are too large (iii) I think that my stomach is just the right size; (iv) I feel satisfied with the shape of my body; (v) I like the shape of my buttocks; (vi) I think my hips are too big; (vii) I think that my thighs are just the right size; (viii) I think that my buttocks are too large; (ix) I think my hips are just the right size. This index ranges from 0 to 27, and responses are scored such that a higher score indicates more dissatisfaction²²

The perfectionism index is based on subject responses to six items: (i) In my family everyone has to do things like a superstar; (ii) I try very hard to do what my parents and teachers want; (iii) I hate being less than best at things; (iv) My parents expect me to be the best; (v) I have to do things perfectly or not to do them at all; (vi) I want to do very well. The responses are scored in the same way as the ED-BN index.

The distrust index is based on subject responses to seven items: (i) I tell people about my feelings; (ii) I trust people; (iii) I can talk to other people easily; (iv) I have close friends; (v) I have trouble telling other people how I feel; (vi) I don't want people to get to know me very well; and (vii) I can talk about my private thoughts or feelings. The scoring rule is as follows: "Always" = 1; "Usually" = 2; "Often" = 3; "Sometimes" = 4; "Rarely" = 5; and "Never" = 6 in questions 5 and 6; and "Always" = 6, "Usually" = 5; "Often" = 4; "Sometimes" = 3; "Rarely" = 2; and "Never" = 1 in questions 1, 2, 3, 4, and 7. A response

²²The scoring rule is as follows: "Always" = 6; "Usually" = 5; "Often" = 4; "Sometimes" = 3; "Rarely" = 2; and "Never" = 1 in questions 3, 4, 5, 7, and 9; and "Always" = 1; "Usually" = 2; "Often" = 3; "Sometimes" = 4; "Rarely" = 5; and "Never" = 6 in questions 1, 2, 6, and 8. Again a response of 4-6 on a given question contributes zero points to the body image index; a response of 3 contributes 1 point; a response of 2 contributes 2 points; and a response of 1 contributes 3 points. The body image index is the sum of the contributing points.

of 4–6 on a given question contributes zero points to the distrust index; a response of 3 contributes 1 point; a response of 2 contributes 2 points; and a response of 1 contributes 3 points. The distrust index is the sum of all contributing points.

The ineffectiveness index is based on subject responses to ten items: (i) I feel I can't do things very well; (ii) I feel very alone; (iii) I feel I can't handle things in my life; (iv) I wish I were someone else; (v) I don't think I am as good as other kids; (vi) I feel good about myself; (vii) I don't like myself very much; (viii) I feel I can do whatever I try to do; (ix) I feel I am a good person; (x) I feel empty inside. The scoring rule is as follows: "Always" = 1; "Usually" = 2; "Often" = 3; "Sometimes" = 4; "Rarely" = 5; and "Never" = 6 in questions 1, 2, 3, 4, 5, 7, and 10; and "Always" = 6; "Usually" = 5; "Often" = 4; "Sometimes" = 3; "Rarely" = 2; and "Never" = 1 in questions 6, 8, and 9. A response of 4–6 on a given question contributes zero points to the ineffectiveness index; a response of 3 contributes 1 point; a response of 2 contributes 2 points; and a response of 1 contributes 3 points. The ineffectiveness index is the sum of all contributing points.

B Additional Specifications

SES, Personality Indices and the ED-BN Index (OLS) - Year FE						
	(1)	(2)	(3)	(4)	(5)	(6)
White	-0.287*** (0.1000)		-0.238*** (0.088)	-0.287*** (0.1000)		-0.213*** (0.087)
Age				-0.010 (0.073)	-0.020 (0.064)	0.002 (0.063)
Parents Some College	-0.162 (0.129)		-0.083 (0.110)	-0.162 (0.129)		-0.084 (0.110)
Parents Bachelor Degree or More	-0.331** (0.136)		-0.143 (0.119)	-0.331** (0.136)		-0.146 (0.119)
Income in [\$20000, \$40000]	-0.470*** (0.130)		-0.232** (0.112)	-0.470*** (0.130)		-0.255*** (0.112)
Income more than \$40,000	-0.555*** (0.128)		-0.253** (0.109)	-0.554*** (0.127)		-0.292*** (0.109)
Distrust Index		0.0267** (0.0122)	0.00880 (0.0130)		0.0268** (0.0122)	0.009 (0.013)
Ineffectiveness Index		0.259*** (0.0178)	0.258*** (0.0178)		0.259*** (0.0178)	0.258*** (0.018)
Perfectionism Index		0.143*** (0.0133)	0.135*** (0.0136)		0.143*** (0.0133)	0.135*** (0.0136)
Body Dissatisfaction Index		0.0378*** (0.00589)	0.0403*** (0.00584)		0.0378*** (0.006)	0.040*** (0.006)
Constant	1.891*** (0.167)	-0.428*** (0.103)	0.0455 (0.156)	2.589*** (0.902)	-0.622 (0.763)	0.080 (0.776)
Sample Size	6308	6291	6291	6308	6291	6291
R-squared	0.039	0.235	0.241	0.039	0.235	0.241

Notes: Standard errors robust intra-individual correlation and robust to heteroskedasticity are in parenthesis. * indicates significant at the 10% level; ** at 5%; *** at 1%.

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