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Experiences of University Women At Risk for Developing Eating Disorders

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THESIS

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ABSTRACT

Studies within the field of eating disorders often address pathology, prevalence/risk factors, body image, beliefs/perceptions (not specific to body image), treatment programs and psychometry. The main theoretical frameworks may be classified as developmental, sociocultural and perceptual. Most research, however, has been conducted using quantitative methodologies with clinical populations. Of the few qualitative studies (Blok, 2002; Budd, 2002; Pearson, 1998), none of them investigate the experience of being *at risk* for developing eating disorders. This was the aim of this study, which used a mixed methodology and a health perspective. In phase one, Quantitative questionnaires were administered to university women in order to identify four who were at risk for developing an eating disorder. In the second phase, qualitative interviews, using a phenomenological approach, were then conducted with the four consenting participants in order to appreciate their daily experiences of being at-risk. Gathered data was then analysed using two strategies. The first entailed regrouping data according to Integrator Themes. Results reveal a deeper, richer understanding of the experiences, as they were revealed phenomenologically. The second analysis strategy used the Wellness Model (Donatelle, Davis, Munroe, & Munroe, 2001), which describes health as having six dimensions: physical/physiological, psychological, social, environmental, intellectual and spiritual. Results of this analysis reveal that all six dimensions are impacted when a woman is at-risk of developing an eating disorder. While her specific experiences may be unique, one from the other, all aspects of her life are affected. Discussion emphasises the importance of qualitative methodologies and the use of a health perspective in this domain of study.

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CHAPTER I

INTRODUCTION

Society is constantly bombarded with images of culturally determined "beauty", body shape and size. Unfortunately, these ideals are becoming thinner and thinner (Nemeroff, Stein, Diehl & Smilack, 1994). As a result, young women often torture themselves in the hopes of attaining the unattainable, the unreasonable, and thus can suffer both physically and mentally (Tomori & Rus-Makovec, 2000). The presence of eating disorders in our society is growing in prevalence (Wakeling, 1996). As such, all members of our society are affected, whether directly or indirectly. Furthermore, the prevalence of eating disorders is spreading to younger and younger populations (Fombonne, 1998). Consequently, it is important that further research be conducted in order to attain a better understanding of this societal problem, as well as, possible resolutions and treatments. There is no doubt that a vast amount of research has been produced in this area, but given the increasing prominence of these disorders, it is clear that more information and research is needed to overcome this sickness.

The most effective way to overcome such maladies is to stop women from developing an eating disorder, before it happens. As such, focusing on risk factors is of prime importance. The present study will investigate the experience of women at risk for developing an eating disorder. Such an investigation serves to attain a deeper, more profound appreciation of the life experiences had by these women. Specifically, "What are the experiences of women at risk for developing an eating disorder?" Attaining a better knowledge of the experiences of at-risk women will give a better understanding of

possible forces that drive these women to, or impede the development of an eating disorder.

The investigation of such experiences will be conducted using a phenomenological approach. Such an approach will allow the participants to retell "their story, their way". Such an approach focuses on the notion that each experience a person lives is directly influenced by their previous experiences (Van Manen, 1990). This notion, which focuses on the impact of previous experiences on the present experience, consequently renders each experience completely and utterly unique (Van Manen, 1990). Phenomenology is a perspective which will contribute to the richness and depth of information revealed. Given its comprehensive nature, it is interesting that such an approach has not been used, at present knowledge, in this field of study. This feature of the present study is thus unique, compared to other studies investigating eating disorders.

At first glance, the term "experiences" seems quite broad and non-descript. This is, in fact, the intention of the formulation of the question. The non-descript nature of the question allows many aspects to be investigated in a free and open manner. Without restraints, this approach is consistent with the phenomenological theory. Allowing the participant to interpret the term "experiences" will induce them into discussing what is most important to them and what is most prominent in their life at the time. The advantage of the phenomenological approach is getting the "real story".

Although the phenomenological approach is one that leaves a lot of liberty to the participant in discussing experiences of importance, a certain structure will be used in order to classify and organize this study. Part of the operationalisation of this study will entail using the six dimensions of the Wellness Model presented in Donatelle, Davis,

Munroe and Munroe (2001). This model has its origins in the World Health Organization (WHO, 1947) definition of health and has been developed and expanded over the years by various researchers. Today, this model of wellness proposes that there are six dimensions of wellness that interact with one another. The premise of the model is that wellness should be defined in accordance with each of these dimensions, both individually and with respect to their interactions. To be noted is that these dimensions are not mutually exclusive. Donatelle, et al. (2001) renders a suitable account for the distinctions between the models following six dimensions: physical/physiological, psychological, social, environmental, intellectual and spiritual. It is these six spheres that will operationalize the concepts of the present study. As such, information collected from the participants will be collected with respect to these six dimensions of their lives.

The data to be collected in this study will be both of quantitative and qualitative nature. The first phase of this study will be quantitative in that the use of quantitative questionnaires will permit the identification of women who are at risk for developing an eating disorder. The series of quantitative questionnaires to be used will assess various measures that are indicative of at-risk women. Examples of risk factor measures include body image, eating attitudes and "Social Physique Anxiety". A sample of four at-risk women will be identified. Those consenting will be asked to participate in the second phase, which entails conducting semi-structured interviews. These interviews will be conducted using the phenomenological approach. These interviews will be performed at various times over a four month period, in order to appreciate the experiences of these women at various times during one of their scholastic terms.

The information attained during these qualitative interviews will then be analysed. The results will be beneficial in attaining a better understanding of the experiences that undergo women who are at risk for developing an eating disorder. This increased understanding is crucial to the appreciation of how an eating disorder develops. This appreciation may then contribute to the long-term development of strategies aimed at preventing the development of eating disorders among those not already afflicted.

CHAPTER II

RESEARCH CONTEXT

Literature Review

Many studies have been conducted in the field of eating disorders. Despite the uniqueness of each study, when one peruses the literature as a whole, distinct categories of research become evident. The eating disorder literature commonly addresses issues such as pathology, prevalence/risk factors, body image, beliefs/perceptions (not specific to body image), treatment programs and psychometry. Closer examination of these various issues indicates that there are common theoretical frameworks that drive various issues being explored. It may be said that the theoretical frameworks may be classified as developmental, sociocultural and perceptual. The following literature review will discuss each of these theoretical frameworks and the common areas of research that are addressed within the various theories. Such a review will be beneficial in explaining the theoretical framework that structures the present study. Furthermore, a review of the literature will illustrate the importance and necessity of the present study, specifically the fact that there is a void in the literature pertaining to the experiences of women at risk for developing eating disorders.

The following literature review will begin by providing an overview of the pathology of eating disorders. This will be followed by a brief description of the prevalence of the disorders, with respect to gender, ethnicity and other demographic characteristics. With this groundwork laid, a detailed discussion of the various theoretical frameworks and the research issues investigated within each will ensue. This

literature will conclude by discussing various theories and approaches that will structure the present study.

Pathology of eating disorders

The Diagnostic and Statistical Manual for Mental Disorders (DSM-IV-TR; American Psychiatric Association, 2000) is the reference manual used to diagnose mental disorders, of which eating disorders is a subcategory. Providing full listings of diagnostic criteria and details of symptomatology for all mental disorders, the DSM-IV-TR (American Psychiatric Association, 2000) is complete and precise in detailing eating disorders. The most recognized eating disorders are bulimia nervosa and anorexia nervosa.

Bulimia Nervosa

Bulimia nervosa is a disorder in which the sufferer attempts to restrict food, but in doing so engages in episodes of binge eating. Purging, either by use of laxatives or self-induced vomiting, commonly follows these episodes. The American Psychiatric Association (APA; 2000), however, also indicates that people with bulimia nervosa may also engage in non-purging compensatory behaviour, such as excessive exercise or fasting. The DSM-IV-TR criteria indicate that binge eating and compensatory activities, on average, occur for at least three months. During these months, these activities occur at least twice a week. Another criterion is that sufferers engage in self-evaluation that is greatly affected by weight and body shape (American Psychiatric Association, 2000).

Anorexia Nervosa

According to the APA (2000), anorexia nervosa is characterized by a person who refuses to eat anything, except in minimal amounts. The result is a person with such a

low body weight that various health risks ensue. For example, many women have amenorrhoea, an absence of their period for at least three consecutive months (APA, 2000). Diagnostic criteria state that people with anorexia nervosa, have an intense fear of becoming fat or gaining. Like people with bulimia, the self-evaluation of people with anorexia is greatly affected by weight and body shape.

It is evident that the above brief descriptions of eating disorders do not do justice to the complexity of the disorders and the knowledge that is present within the field. APA (2000) describes in greater detail the various subtypes and differences which exist within the larger classifications of anorexia nervosa and bulimia. Furthermore, there are a variety of articles and chapters providing meta-analytical reviews of the literature regarding bulimia and anorexia (e.g. Ressler, 1998). Other researchers, however, have conducted studies examining possible traits that coincide with eating disorders. For example, Vohs, Bardone, Joiner, Abramson and Heatherton (1999) investigated the relationship between perfectionism, self-esteem, and perceived weight status and how these three traits predict bulimic symptoms. Perfectionism is a personality trait that can be measured using various psychiatric and psychological instruments. In the case of Vohs et al. (1999), results indicated that self-esteem moderated the interaction between perfectionism and perceived weight status in predicting bulimic symptoms. Studies of this nature are important in that they give a more complete understanding of the pathological issues contributing to eating disorders.

Another such article is Suldo and Sandberg (2000), which identified the attachment styles that were related to eating disorder symptomatology. Attachment styles have typically been discussed in relation to the parent-child relationship, but have since

been expanded to include consideration of adult-adult relationships (Suldo & Sandberg, 2000). Understanding attachment styles gives a more complete perspective of the person and thus the possible eating disorders aetiology. In the Suldo and Sandberg research, it was found that only "preoccupied" attachment styles are positively correlated with eating disorder symptomatology. A "preoccupied" attachment style, as defined by Bartholomew (1990), describes a person's having a negative view of themselves, and a positive view of others.

Other examples of studies investigating other traits and behaviours contributing to the pathology of eating disorders are food rumination (Hart & Chiovari, 1998) and impulsivity (Steiger, Lehoux, & Gauvin, 1999). Furthermore, coping strategies and internalization of feelings have also been found to be linked to eating disorders, as is evidenced by various treatment programs which incorporate such interpersonal skills (e.g. Melrose, 2000).

Prevalence and Risk Factors

Part of understanding the pathology of eating disorders comes from understanding the prevalence and characteristics of at-risk populations. As such, investigating the prevalence and risk factors of eating disorders is another common area of study within this field of study. The available literature indicates that while eating disorders can happen to anyone at anytime in their life, there are certain populations that are more at risk for developing them. Differences among such populations include differences in gender, ethnicity, socio-economic status, and age.

Ethnicity

Unfortunately, there seems to be some discordance between these studies regarding race. For example, Rucker and Cash (1992) indicated that eating disorders are more prevalent among Caucasians versus other ethnicities. Thompson (1996) also stated that Caucasian females are at relatively greater risk than any other ethnicity. This report is followed up, however, by another statement indicating that other studies (e.g. Pumariega, Gustavson, Gustavson, Motes, & Ayers, 1994) have found African American women to be at equal risk as Caucasian women. This is consistent with Serdula et al. (1993), which indicated that women's trying to lose weight is comparable across "Hispanic", "Black", "Caucasian" and "other" races.

Gender

Thompson (1996) provided a thorough review of studies and indicated that eating disorders were more prevalent among women, as compared to men. Many studies indicated a greater prevalence of eating disorders among women than men (e.g. Serdula et al., 1993). Cook, Reiley, Stallsmith, and Bray Garretson (1991) also studied the frequency of eating concerns among men and women. This study took place at two Christian colleges and two non-sectarian colleges. Results indicated that women had significantly greater eating concerns compared to men, who had a degree of concern much higher than that indicated in the literature. Men's concerns, however, were more so in regards to the desire to gain weight. This study is a good example of a study that explores the prevalence of eating disorders in various settings.

Socio-economic status

As for socio-economic status, Slater, Guthrie, & Boyd (2001) indicated that most adolescent girls that are affected by this are of middle or upper-middle class families. This is not, however, to imply that girls of other socio-economic classes are not affected, given that other studies would contradict such findings. Wakeling (1996) provides a suitable review of literature discussing various findings regarding socio-economic status and its relationship with eating disorders. Interestingly, it is in this review that Wakeling states that the association between anorexia nervosa and middle and upper classes is, in fact, not robust.

Age

Age is another demographic factor that seems to produce results indicating that women of various ages are at risk for developing an eating disorder. This is seen by the fact that available studies discussing the presence of eating disorders in young girls (Fabian & Thompson,1989), adolescents (Wardle & Marsland, 1990; Button, Loan, Davies, & Sonuga-Barke, 1997) and adults (Fairburn, Cooper, Doll, Norman, & O'Connor, 2000). When one looks at the literature on eating disorders, it is seen that the research pertaining to adolescents investigates developmental issues, such as puberty and maturation. Studies focusing on adult populations, however, focus more on issues of perception and socialization.

Having reviewed the pathology and prevalence of eating disorders, a discussion of the different theoretical frameworks will now ensue.

Perceptual Theoretical Framework

Of the theories driving research conducted in the field of eating disorders, theories relating to perception place emphasis on the accuracy of one's perceptions regarding one's size (Thompson, 1996). Within this theoretical framework, three primary theories arise. The first relates to the possibility that people's perceptions of their own size may be inaccurate due to visuospatial deficits that may actually be tested neuropsychologically (Thompson & Spana, 1991). A second perceptual theory discusses the hypothesis that one's perceptions of their body do not change at the same rate as their actual physical size (Thompson, 1996). A third perceptual theory proposes that the extent to which one overestimates their size is indirectly proportional to their actual size (Thompson, 1996). From these three types of perceptual theories, it is evident that there is a role of perception in eating disorders. Further proof of its importance lies in the fact that perception is a diagnostic feature of anorexia nervosa (APA, 2000). The perceptual theoretical framework has propelled the following areas of research.

Body Image

A common line of research which follows the perceptual theoretical framework is that of body image research. One of the most fundamental concepts in the understanding of eating disorders is that of body image. Kay (1996) defined body image as including, "... perceptual, cognitive, and affective elements of how we internally represent our own bodies and the bodies of others." (p. 236). Such aspects of body image build on the definition set out by Cash and Pruzinsky (1990), which states that body image is a multidimensional construct which includes internal, subjective representations of physical appearance and bodily experience.

Body image has been studied in a wide variety of contexts with a great variety of populations. Cash and Henry (1995), for example, conducted a national U.S. representative survey, evaluating the body images of women. Using the Multidimensional Body-Self Relations Questionnaire, their results indicated that 48% of these women negatively evaluated their body image. Although this study investigated body image concerns among a non-clinical population, other studies have studied this concern among eating disorder patients. Gupta and Johnson (2000) surveyed the prevalence of nonweight-related body image concerns among eating-disordered patients and nonclinical controls. Their results indicated a greater prevalence of body image dissatisfaction among eating disordered patients, as compared to a non-clinical population.

The majority of body image studies are performed using questionnaires that display drawings of various female bodies of differencing shapes and sizes. Raudenbush and Zellner (1997), Fallon and Rozin (1985), Lamb, Jackson, Cassiday, and Priest (1993) and Singh (1994) are all examples of such studies. Admittedly, while results may vary slightly, in general, results have indicated that the figure women choose to represent their "current" body size is larger than their actual body size. The figure women chose to represent their "preferred" body size is smaller than the figure they have identified as representing "current" body size. Interestingly, these women also indicated that men would prefer a figure that is in between the figures they have identified as their "current" and "preferred" body sizes (Lamb et al., 1993; Fallon & Rozin, 1985).

Unfortunately, although these studies are fascinating and yield interesting results, they do not reveal any information regarding the experiences lived by women at risk for

developing eating disorders. This thus supports the value of and need for investigating such experiences.

Core Beliefs and Perceptions (not pertaining to body image)

Non-body image related perceptions constitute another area of research in which the influence of the perceptual framework is evident. Although body image is a person's perception of their body shape, appearance or figure, other perceptions and core beliefs have also been investigated to understand the impact of these on eating disorders. For example, Leung, Waller, and Thomas (1999) investigated the impact of unhealthy non-food related beliefs on eating disorders. These researchers used a questionnaire to assess 16 core beliefs regarding: functional dependence/incompetence, abandonment, emotional deprivation, emotional inhibition, social isolation, social undesirability, vulnerability to harm and illness, defectiveness/shame, enmeshment, entitlement, failure to achieve, insufficient self-control, mistrust/abuse, subjugation, self-sacrifice and unrelenting standards. It was found that, compared to controls, anorexic and bulimic women have significantly higher levels of all above-mentioned unhealthy core beliefs. The only difference between restrictive anorexics and bulimics was that bulimics showed greater levels of entitlement beliefs.

Another study (Furnham & Atkins, 1997) investigated the locus of control concerning control of personal weight. The loci of control were identified among women in two different groups: female-eating-disordered patients and non-clinical female undergraduate students. It was found that the former group exhibited significantly more internal control beliefs regarding weight loss control as compared to the control group. This information indicates that female eating disordered patients believe that their weight

is controlled by behaviours they carry out, such as exercise, food restriction. Appreciating the locus of control that such patients exhibit is important in coming to an understanding of the aetiology of eating disorders.

A variety of other articles report studies that address issues such as, " ... whether women who focus on their own bodies place a similar focus on body shape when evaluating others and expect others to have a strong body focus in their self-evaluations" (Beebe, Holmbeck, Schober, Lane, & Rosa, 1996, p. 415). Evaluating one's own shape or that of others is basic to the assessment of social physique anxiety. Literature investigating the relationship between social physique anxiety, social behaviour and eating disordered behaviours includes Frederick and Morrison (1998). Using a path analysis, they found that eating disordered behaviour mediated eating disordered traits, the latter of which were significantly moderately related to social physique anxiety scores. Such results indicate support for the belief that milder symptoms, such as social physique anxiety, may be the beginning for eating-disordered behaviour.

Unfortunately, as is seen with the studies investigating body image and core beliefs, the present studies never address the issue of the experiences of at-risk women.

Treatment Programs

The above-mentioned areas of study contribute to the knowledge regarding eating disorders, which in turn assists others to develop effective prevention and treatment programs to stop the occurrence of eating disorders. Various treatment programs are in place, however, eating disorders is still occurring among young women. The greatest development would be effective prevention programs, so the occurrence of eating

disorders would be prevented before it starts. Given the role perception plays in eating disorders, it is understandable why some treatment programs address this issue.

An example of a prevention program that has provided some interesting and encouraging results is a dissonance-based preventive intervention program for high-risk populations (Stice, Chase, Stormer, & Appel, 2001; Stice, Mazotti, Weibel, & Agras, 2000). According to these studies, the cognitive dissonance is stimulated by inducing the participants to act in a manner contrary to a previously held attitude. Usually the created dissonance then leads people to either change their behaviour or their attitude. Specifically, authors asked women who were trying to adopt an anti-thin-ideal stance, to create a program to help other women how to avoid the thin-ideal. In promoting attitudes that contradicts the ones they manifest through thin-idealization, the inconsistent cognitions would lead them to change their behaviour. Stice et al. (2001) tested the efficacy of this dissonance-based prevention program and results indicated, "...decreased thin-ideal internalization, body dissatisfaction, dieting, negative affect and bulimic symptomatology at termination and at 4-week follow-up." (p. 247). The decrease is definitely encouraging, the first step to a program that causes cessation of the above behaviours and attitude. Some might question, however, if treatments would be more effective if they focused less on perceptions, but rather on the development of these women.

Developmental Theoretical Framework

Studies that are driven by a developmental theory focus on the development of young women. As such, the importance is placed on childhood experiences as well as pubertal development stages (Thompson, 1996). This theoretical framework produces

studies that focus on the experiences of teasing during pubertal years, while others focus on the actual maturation process. As will be seen from the following studies, the time of pubertal development has a large impact on the possible development of eating disorders.

Maturation.

Slater, Guthrie and Boyd (2001) presented a theoretical framework to explain health concerns that adolescent women face. Such health issues include depression, violence/ sexual abuse, eating disorders and substance abuse. The conceptual framework presented was based on a feminist perspective. More specifically, they highlighted the importance of socialization and the period of adolescent development in the occurrence of eating disorders. According to Slater et al., the processes of self-definition and identity formation are major psychosocial determinants of the adult woman. The authors also discuss gender socialization as a moderator within these developmental processes. Consequently the authors highlight the intense impact social influences have on the development of young women.

A variety of studies have investigated the relationship between the pubertal stage of development and body image. For example, Duncan, Ritter, Dornbusch, Gross and Carlsmith (1985) found that, of early, mid and late maturing girls, the early maturing girls demonstrated the greatest dissatisfaction with their weight. According to the researchers, their findings indicated that early-maturing girls became dissatisfied with their weight as they developed.

Teasing.

Studies investigating the impact of teasing also fall within the developmental theoretical framework, as opposed to the sociocultural framework, given that they are

conducted with adolescent populations. For example, Fabian and Thompson (1989) conducted a study where results indicated that body dissatisfaction, self esteem and eating disturbance were all significantly related to teasing during adolescence, which can be known as a developmentally sensitive time. From this, the authors concluded that teasing during these years might have lasting effects (Fabian & Thompson, 1989).

The impact of teasing is also seen from the Thompson, Fabian, Moulton, Dunn, and Altabe (1991) study, which developed the Physical Appearance Related Teasing Scale. This tool was constructed in such a way so as to assess comments that may be seen as being teasing in nature and related to issues of physical appearance, size and weight. The creation of such a measurement tool is supported by the numerous studies, as referred to in Thompson et al. (1991), which have made the link between teasing and body image disturbance.

Sociocultural Theoretical Framework

A third visible framework that is present in the eating disorder literature is that which discusses the role of society and culture. In discussing eating disorders, the notion of a "social" and "cultural" influence is often mentioned. Such an influence, or impact, can come from a young woman's family, friends, or from the media images that are conveyed to her. As such, there are many external factors that contribute to the possible initiation and development of an eating disorder. Various studies have investigated such factors. These studies are truly representative of the sociocultural theoretical framework that structures such research.

Impact of Cultural Influences

Garner, Garfinkel, Schwartz and Thompson (1980), for example, performed a study in order to document and quantify the shift that was occurring, in the previous 20 years, towards a thinner ideal. This study examined magazines and Miss America contestants in order to identify this trend. Fallon (1990) also documents the change over time, within Western culture as well as non-Western cultures. Fallon (1990) discusses the concept of "beauty" and "attractiveness" among various times and cultures. This chapter is particularly interesting in that it highlights the movements various societies have made towards glorifying thinness (Fallon, 1990).

Magazines are a common vehicle for communication. Cusumano and Thompson (1997) assessed the impact of magazines on women's measures of body image, eating dysfunction and overall self-esteem. These authors indicated that, according to regression analyses, awareness of societal pressures was a significant predictor of such measures. Furthermore, it was found that, beyond awareness, internalization of social standards of appearance accounted for significant levels of variance within these measures. Pinhas, Toner, Ali, Garfinkel and Stuckless (1999) also conducted a study investigating the impact of magazine exposure. Specifically, Pinhas et al. (1999) examined the changes in women's mood states as a result of viewing various images from fashion magazines. These images depicted models representing a "thin ideal". According to Pinhas et al. (1999), exposed women rated higher on measures of depression and anger post-exposure as compared to pre-exposure.

Impact of Social Influences.

Although all of the above-mentioned studies have evaluated the impact of cultural influences (e.g. magazines and media exposure), social influences also contribute to the possible development of eating disorders – e.g. family, friends, peers, colleagues, coaches, etc. Haworth-Hoeppner (2000) discusses how cultural ideas, regarding thinness, are mediated and conveyed by the family. Unlike many other studies in the field, Haworth-Hoeppner (2000) performed open-ended interviews with Caucasian middle class women. Following qualitative comparative analysis, results indicated a few identifiable salient conditions. These included a dominating discourse on weight in the household, a critical family environment and coercive parental control (Haworth-Hoeppner, 2000). Such a study clearly indicates that media is not the only influencing factor in the development of eating disorders.

Acknowledging the impact that various settings may have on eating concerns is of great importance in the detection and prevention of eating disorders. Wade et al. (1999), investigated the impact of setting by carrying out three waves of data collection. The first wave entailed having female twins fill out questionnaires regarding their attitudes towards eating, weight and shape. Although the authors of the study provided a sample of the questionnaire that was administered, they do not provide any psychometric information regarding this measure. The second wave consisted of conducting a general psychiatric interview and the third wave entailed the Eating Disorder Examination. The three waves of data collection permitted these researchers to determine that both environmental and genetic factors contribute to the development of the attitudes and behaviours that are common to eating disorders.

In reviewing the published works that discuss the impact culture and social surroundings has on women, with respect to the ideal "beauty", questions remain unclear. What experiences do these cultural and societal influences lead women to have? Stated otherwise, what is it like for these women to be exposed to these cultural and societal impacts and gender role implications? How do they overcome the messages their culture and social surroundings conveys to them? These questions identify a few aspects that remain to be investigated.

The Role of Exercise

Some might believe that women can overcome the thin-idealized images that society emphasizes by engaging in exercise. As such, various studies have investigated the impact exercise has on the development or impediment of eating disorders. These studies discuss the multiplicity of consequences exercise has with regards to eating disorders and body-esteem among men and women.

McDonald and Thompson (1992) performed a study in which men and women were questioned regarding their motivation for exercise and their body dissatisfaction. These participants were also assessed with regards to their eating disturbances. This study found that women's motivation for exercise, compared to men, was more often related to weight and tone (McDonald & Thompson, 1992). It was also found that lower levels of eating disturbances and higher self-esteem were related to exercising for fitness; this finding, however, was only among men participants (McDonald & Thompson, 1992). Another study, Smith, Handley, and Eldredge (1998) also investigated the differences in exercise motivation among men and women. According to Smith et al. (1998), women reported exercising for appearance-related reasons more than men. Women, compared to

men, also reported higher situational body dissatisfaction (Smith et al., 1998). Interestingly, however, their study found that women's reasons for exercising were not significantly related to their dissatisfaction with specific bodily attributes. Women who experienced more situational body dissatisfaction, however, exercised for weight control and appearance (Smith et al., 1998).

The above studies exemplify ones that have examined gender differences with regards to exercise and exercise motivation. Other studies, however, have been performed to investigate the possible impact different levels of physical activities can have on body-esteem. Finkenberg, DiNucci, McCune, and McCune (1993), for example, distributed the Body Esteem Scale to men and women engaged in physical education classes requiring different intensities. It was found that the women's mean overall body-esteem scores were higher for those engaged in the more intense physical activity courses, as compared to those in the less intense physical activity course.

The above-mentioned studies suggest that exercise and physical activity is related to body-esteem, body dissatisfaction and motivation for exercising. Another study, however, investigated the association of exercise with eating disorder psychopathology (Davis, Woodside, Olmsted & Kaptien, 1999). Female eating disorder patients completed a variety of scales and measurements, and interviews. During one of these interviews, patients were asked to discuss their involvement in physical activity prior to admission. From this, patients were categorized as either moderate/nonexercisers or high-level exercisers. The latter was defined as being one who engaged in "...leisure-time activity, for a minimum of 6 hrs a week averaged over the 12 months prior to assessment." (Davis et al., 1999, p. 143). These researchers found that a greater

psychopathology was present among the females who were considered to be high-level exercisers, compared to moderate/nonexercisers (Davis et al., 1999). Such a study highlights the possible contributing influence exercising may have on the development of eating disorders, or vice-versa.

As with many other areas of research within this field, none of the above studies discuss the experiences of these young women. Interestingly, one study, Hill and Brackenridge (1989) did perform a qualitative study to investigate the experiences of girls and women with respect to physical activity, school physical education and body image. When discussing the issue of appearance, although a few of the six women indicated a few positive comments, there were many who expressed embarrassment with regards to their shape and their menstrual periods (Hill & Brackenridge, 1989). Many of these women also expressed a dislike for the exercise clothing and negative attitudes towards their physical abilities (Hill & Brackenridge, 1989). Hill and Brackenridge (1989) went on to indicate that the development and maintenance of positive body image and self concept were important in ensuring that children remain involved in physical activity.

Psychometrics: Quantitative Measures and Qualitative Investigations

Given the vast array of research that is conducted in the field of eating disorder research, the need for varied and specific assessment tools is inherent. Researchers are continually developing, testing and evaluating measures that assess various variables. The accurate assessment of these variables is important given the implications for diagnoses. The list of assessment tools is quite long and detailed, each one designed for specific purposes and populations. Examples of these tools are the Eating Attitudes Test-

26 (EAT-26; Garner & Garfinkel, 1979), which evaluates the participants' attitudes toward eating; the Social Physique Anxiety Scale (SPAS; Hart, Leary, & Rejeski, 1989), a tool which measures the degree to which participants become anxious when their physique is observed or evaluated by others; and the Questionnaire Eating Disorders Diagnostic (Q-EDD; Mintz, O'Halloran, Mulholland, & Schneider, 1997), which is used in order to make a diagnostic differentiation in the participant's physical activity and dietary attitudes and behaviours.

Qualitative Investigations

In reviewing the available published psychometric literature in the field of eating disorders, it is evident that psychometric studies predominantly investigate quantitative methods of assessment and assessment tools. This is understandable given the value and importance of correctly identifying women with, or at risk for developing, eating disorders. As a result, however, a gap is present in the available literature. Very few studies within the field of eating disorders use qualitative methodology.

Hill and Brackenridge (1989) investigated the experiences of girls and women with respect to physical education, physical activity, body image and school. A more recent study (Beaudoin, Ste-Marie, & Bottamini, 2000) used a qualitative approach to investigate girls' perceptions of physical education teachers with regards to their role in the education of girls on issues such as the adoption of healthy and active lifestyles. These two studies, both of which conducted group discussions, gained information focusing on the women's perceptions of exercise and/or physical education.

Both Pipher (2001) and Brown and Gilligan (1992) are very well recognized pieces of qualitative literature within the field of eating disorders. Both tell the stories of

adolescent girls as a means to highlight and discuss sociocultural and developmental aspects implicated in eating disorders. The value of qualitative aspects is also demonstrated in Piran (1998), which discuss the participatory approach to preventing eating disorders. Such an approach is based on participant dialogue to determine the course of the intervention.

Despite the fact that studies have been conducted on the experience of having an eating disorder, at present, none seem to explore the experience of being *at-risk* of developing an eating disorder with a non-athletic female university population. Most studies investigating experience focus on women who have (or have had) an eating disorder. Exploring the experiences had by those at risk is an important line of questioning still needing to be addressed and is thus the focus of the present study.

Pilot Study

The above literature review clearly indicates the need for studies investigating the experience of women at risk for developing eating disorders. Prior to conducting this study, however, it was considered important to conduct a preliminary study in order to assess the feasibility of the methodology. This assessment provided an opportunity to discover the strengths and weaknesses of the proposed methodology.

Pilot Methodology

The principal researcher for this study attended the first five minutes of a first year undergraduate human kinetics course at the University of Ottawa. It was during the first five minutes that she made a brief announcement regarding her thesis study and need for participants. It was at this time that the study was briefly explained as a study that investigated women's thoughts, perceptions and opinions regarding their eating habits,

appearance and body. Participants were told that, while their time was not remunerated monetarily, there were many advantages to participating in research, including the opportunity to express one's opinions. It was also explained that participation in the study was completely voluntary and independent of their involvement in the course. At this point, a sign-up sheet was passed around the class. Those interested in participating wrote their name and contact information.

Using the names and contact information attained on the sign-up sheet, the principal researcher called participants individually. It was at this point that the procedure of the study was explained in a little more detail. The participants were also asked various questions, which indirectly gave the researcher an idea as to whether or not the participant might feasibly have some concerns regarding eating, her appearance or her body. From this, the researcher selected one willing participant to take part in the study. This participant was 18 years old, was 5'5"tall and weighed 120lbs.

The selected participant was told, over the phone, that the study consisted of three meetings. It was explained that during the first meeting, if willing, she would be asked to sign a consent form and fill out some questionnaires. The second and third meeting would entail an interview in which the researcher would ask her opinion and thoughts regarding various issues. The participant seemed willing and interested.

The first meeting took place and the participant was explained the consent form, which she then signed. With an understanding that there were no right or wrong answers, she then filled out the questionnaires, taking approximately 30 minutes to do so. During the time lapse between the first and second meeting, the principal researcher scored and analysed each questionnaire according to the direction put forth by each of the authors of

the questionnaires. The results of these questionnaires, as well as some of the individual responses given by the participant, served as initiators for various questions during the interview. The interview followed the river-and-channel method described in Rubin and Rubin (1995), in that questions were asked regarding one issue and follow-up questions were used to probe that issue until it was completely discussed. At that point, another issue was then addressed, and probed similarly, and so on and so forth. The results were then analysed. A description of the results attained from both the questionnaires (quantitative) and the interview (qualitative) follow.

Results of Pilot Study

Phase 1 - Quantitative

The participant completed four questionnaires: SPAS, Q-EDD, EAT-26, EDI-2. The results of each of these will be discussed individually.

In completing the SPAS: Social Physique Anxiety Scale (Hart, Leary, & Rejeski, 1989), a tool which measures the degree to which participants become anxious when their physique is observed or evaluated by others, it was found that the participant did not have any major social physique anxiety concerns. Out of 12 items, only two indicated slightly above-normal concerns regarding social physique anxiety.

The Questionnaire Eating Disorders (Q-EDD; Mintz, O'Halloran, Mulholland, & Schneider, 1997), which is used in order to make a diagnostic differentiation in the participants' physical activity and dietary attitudes and behaviours, revealed that the participant was classified, according to the Q-EDD, as non-eating disordered. Results from this questionnaire also indicated that the participant had specific concerns regarding certain parts of her body and the possibility of gaining weight.

These last concerns were also evident in the results of the EAT-26: Eating Attitudes Test (Garner & Garfinkel, 1979), which assesses participants' attitudes and behaviours characteristic of eating disorders. It was notable, however, that these concerns were not enough to warrant one considering the participant as having pathological eating attitudes or behaviours.

Finally, the Eating Disorders Inventory-2 (EDI-2; Garner, 1991) was administered. Assessing symptoms commonly associated with bulimia and anorexia, this self-report questionnaire revealed that the participant had concerns regarding her body. This was seen in her high rating on the Body Dissatisfaction scale. Noteworthy, however, is the fact that the participant's resulting profile placed her in the zone represented by a "normal female college" population. None of her results fell within the eating disordered profile.

As such, it may be said that the participant of this study did not have eating disorder symptomatology. It is noteworthy, however, that she did have some concerns regarding certain parts of her body, as well as a concern for the possibility of gaining weight. The presentation of these concerns may be seen as criteria for being at risk for developing an eating disorder, given that these are issues that are commonly assessed in various eating disorder assessment questionnaires. It is the presence of these concerns that rendered this participant suitable for participating in the qualitative interviews. The above-mentioned concerns will evidently be considered as possible indicators should participants in the main study demonstrate them. Admittedly, however, the main study will aim to recruit participants who have a greater number of risk factor criteria than the pilot participant.

Phase 2 – Qualitative

The two qualitative interviews that were conducted with the participant were audio-recorded and revealed results that allowed the researcher to better understand her daily experiences. As was previously mentioned, in reviewing her answers to the various questionnaires, numerous situations were discussed. The following will discuss these and illustrate the different dimensions of the Wellness Model (Donatelle, Davis, Munro, & Munroe, 2001) that are revealed in this dialogue, as well as the factors within each dimension.

The participant indicated having thoughts regarding her body when she looks in the mirror. For example, "... but when I look at myself in the mirror, there are always things where I am like 'uh' (negative reaction)." As a result, the participant demonstrated that the physical and emotional dimensions of her life are involved in her thoughts regarding her body. Specifically there are the visual factors of her physical dimension, and there are some emotions of dislike or disappointment in relation to what she sees.

Similar results were produced, according to the participant, when she puts on her clothes. "...or when I try on clothes and I look down and I am like, 'Aw, this doesn't look good.'" When asked about whether there are certain parts of her body that she is not happy with the participant indicated her thighs, hips and stomach. Such results indicate, again, that the dimensions of her life that are affected are the physical and the emotional dimensions. More specifically, it is her visual evaluation of her body parts and her unhappiness regarding these parts.

The participant also indicated that her friends influence her eating habits. When discussing what might have triggered her to stop eating sweets and soft drinks she replied, "Well all of my friends were really thin. So maybe that is what it was. Because we used to go out to clubs and stuff and I would just feel... I don't know... I guess... fat." Such a statement seemed to suggest that the social dimension of her life, specifically the factor of her friends, had an impact on the physical dimension of her life. The physical feeling of "fat" is a factor that may be considered within the physical dimension of her life.

The participant also expressed concerns regarding her own body when she considered her father's body. Given her father's overweight status, she had concerns about gaining weight. Specifically, she was concerned about the health impacts that result from obesity. As such, it may be said that these concerns appeared to affect the physical dimensions of her life given that she had concerns about her health status. Such concerns also highlighted the implication of the emotional and psychological dimensions of her life. Apparent within these dimensions were factors of worry and thinking about the future, respectively.

From the qualitative interviews, it may be said that issues related to her eating habits and her body affect this participant's physical, emotional and psychological dimensions of her life. Such results help to explain some of the experiences that this participant has, relative to eating and her body.

Conclusions and Lessons Learned

Conducting a pilot study proved to be a very useful and important component of this research. Not only did it allow the principal researcher to become familiar with the

various stages involved in recruitment, the various questionnaires used, the interviewing process and data analysis, but it also served to identify the strengths and weakness of the protocol. These advantages and limitations have been beneficial in improving upon the methodology to be conducted in the formal part of the study. They will now be discussed in conjunction with suggested alterations of the proposed methodology.

First of all, it is believed that the chosen undergraduate class had some limitations. Given the class was a human kinetics course, it is believed that many of the students were aware of healthy and unhealthy behaviours, thus creating a population in which eating disorders was less present. As such, it is foreseen that in the actual study, participants will be recruited from courses and faculties other than human kinetics.

Secondly, conducting the brief conversations over the phone did not prove to be the most useful strategy of participant selection. The results of the quantitative questionnaires indicated that the participant was not necessarily at risk for developing an eating disorder. Thus, it is evident that a slight modification will be carried out in the method of recruitment. Specifically, participants will be selected based on the results of the questionnaires, as opposed to a brief telephone conversation. The literature available on these questionnaires will be used to determine the specific criteria participants must meet, in order to be considered at-risk. As such, interested students of first year undergraduate courses will be asked to fill out questionnaires. It is the results of these that will determine the selected participants.

It must be said that the interviewing procedure did provide some advantages and limitations. In using the results from the questionnaires to incite conversation in all of the interviews, it was found that the conversations raised many issues that could be

discussed. As such, it may be said that the use of the questionnaire results was a useful guide in highlighting issues to be discussed. In doing so, however, there are admittedly a few limitations to this method. Specifically, it must be said that following the questionnaire results may have limited the expanse of the content of the interviews. Consequently, there may have been some issues, concerns and situations that were not discussed. Furthermore, there may have been some detail that was omitted. These aspects may have been important to the participant, and she was not given the chance to discuss or reveal them. In fact, it may be said that this methodology was not overly consistent with the phenomenological approach in that it placed a few restraints on the selection of topics discussed.

The greatest concern in using questionnaire results to guide all of the interviews, however, is the possibility of having a participant who has never been faced with the notion that she may be at risk for developing an eating disorder. In presenting the questionnaire results that indicate that she may be at risk, an adverse reaction of shock or disbelief or disagreement may ensue. This may, as a result, lead such a participant to not be as open, honest or forthcoming in her communication of thoughts, concerns and perceptions. Given the above-mentioned limitations of using the questionnaire results to guide all of the interviews, it is believed that this will not be the optimal interviewing strategy. As such, in the main study, the questionnaire results will not be used. Instead, only the issues raised by questionnaires will be discussed. It must also be said that the participants will not be told that they are at risk, given the fact that the researcher is not clinically certified to do so. Instead, at one point during the interviews, the researcher will ask the participants if they view themselves as being at-risk.

Member-checking, a process in which participants will be asked to review the transcripts of the interviews, will be conducted in order to ensure that information has been properly collected. It must also be said that there is a concern with regards to the analysis of the qualitative results. This concern lies specifically in the interpretation of the vast amount of the qualitative information given by the participant. Much work will need to be conducted to ensure that there is no occurrence of false interpretation and that the information is properly categorized and organized. As such, this pilot study has highlighted the need to ensure that the data analysis strategies are refined with the help of the supervising professor.

It is evident from the above description that there are a few limitations to the methodology used in this present study. As such, it may be said that the suggested changes will be conducted. It is believed that such modifications will solidify the effectiveness of the methodology in understanding the experiences that women at risk for developing an eating disorder undergo.

Research Question

The gap in the literature that drove the present study is the realization that there is a limited exploration of the experiences of women at risk for developing an eating disorder. As such, the present study investigated the question "What are the experiences of women at risk for developing an eating disorder?"

At first glance, the term "experiences" seems quite broad and non-descript. This was, in fact, the intention of the formulation of the question. The non-descript nature of the question allowed many aspects to be investigated in a free and open manner. Without restraints, the participants were able to interpret the term "experiences", thus inducing

each one into discussing what was most important to them and what was most prominent in their life at the time. Consequently, the interviews asked one simple question, "Have you recently either experienced an event or been particularly concerned about your eating habits, your weight or your body shape?" This question was considered the instigating question. From this point, it was anticipated that the participant would begin to reveal the types of experiences she had recently had. During her discourse, further questions were asked in order to assist the participant in elaboration. To be noted is the fact that the exact wording of these questions was not specified prior to the interview. The interviewer, however, was aware of possible questions that could incite additional information pertaining to the six dimensions of the Wellness Model (Donatelle, et al., 2001). Examples of possible questions are found in Appendix A.

CHAPTER III

METHODOLOGY

Research Paradigm: Phenomenology

The present study used a phenomenological approach given that it focuses on the notion that each experience a person lives is directly influenced by their previous experiences. This notion, which focuses on the impact of previous experiences on the present experience, consequently renders each experience completely and utterly unique. The advantage of having used the phenomenological approach during the interviews was getting the "real story". The use of this approach was therefore ideal in the investigation of experiences, given that it allowed the participants to retell "their story, their way".

The phenomenological approach is one that is commonly used in psychology, consulting, pedagogy, and research. It is useful in that it permits the expression of experience in a very open, unconfined way. According to Van Manen (1990), phenomenology asks the question, "What is this or that kind of experience like?" (p. 9). Van Manen goes on to explain, "... phenomenology is the systematic attempt to uncover and describe the structures, internal meaning structures, of lived experience." (p. 10). As such, phenomenology focuses on meaning and the explanation of the meaning that is lived in our everyday existence. This renders this approach unique from other social or human sciences, according to Van Manen (1990), which may focus on the occurrence or frequency of certain behaviours, the statistical relationships between variables. Other approaches also focus on social opinions (Van Manen, 1990). Deschamps (1993) further details the use of the phenomenological approach within the field of research.

According to Bachelor and Joshi (1986), there are four specific methods that may be used to collect data using a phenomenological approach. One may ask, in writing, that a participant describe, in writing, how (s)he felt with respect to a certain situation or happening. A second method is to observe a participant in a social setting and to perform a qualitative analysis of the observations. The third method is to perform an interview with the participant. This method shall be used in the present study, and thus discussed in further detail in later parts of this paper. The fourth method is a combination of the three above-mentioned methods.

Van Manen (1990) is also clear to point out that this approach, unlike other sciences, attempts to gain descriptions of how one experiences the world, without classifying, categorizing, taxonomizing. The absence of categorization is most appropriate for the present study given that the aim is to understand the individual experiences of the individual women. Although the participating women will have some commonalities among them, they will all be unique.

Population and Sample

The present study examined the experiences of women at risk for developing an eating disorder. While women are at risk for developing eating disorders at any age, most studies indicate that the ages of 16 and 17 are the most at-risk (Wakeling, 1996). The present study wished to examine women who are between the ages of 18-24, however, given that for women entering university, this time of life is filled with a vast number of changes. As is indicated in the literature, a factor that contributes to being at risk is being in a life stage that encompasses a lot of change and instability (Sharpe, Ryst, Hinshaw, & Steiner, 1997). The present study investigated socialization, perceptual and

developmental issues faced by the women of this age group. Given the two-phase structure of this study, to be discussed in the data collection section, two different samples were needed. The first phase of the study, the quantitative phase, used a "convenience" sampling of women, aged 18-24, who were enrolled in first year courses at the University of Ottawa. Women willing to volunteer their time were recruited from a variety of domains, such as math, psychology, sociology, etc. This fairly homogenous sample of Canadian women was English-speaking given that the questionnaires used were validated in English.

Women of this university sample who were available and willing to participate completed a consent form and a variety of questionnaires. These were used to identify the at-risk women to be examined in the second phase of this study, the qualitative phase. The non-random sample of this latter phase was a purposive sample in that the women possessed certain characteristics that, according to the literature, put them at risk for developing an eating disorder. It is these women with whom qualitative interviews were conducted in order to better understand their experiences. Four women participated in this second, qualitative, phase of the study. This was thought to be appropriate given the vast amount of detail that would be collected for each.

Research Design

The design of this study, as illustrated in Table 1 (Appendix B), had two phases. As previously mentioned, the first phase was quantitative due to the use of quantitative questionnaires. The second phase entailed the qualitative interviews.

Insert Table 1 About Here

Quantitative Phase

The first phase of the study was conducted using quantitative questionnaires. The purpose of the first phase was to identify women at risk for developing eating disorders. This was accomplished using a variety of questionnaires that assessed characteristics that describe women at risk for developing eating disorders. Such characteristics included social physique anxiety, physical activity and dietary attitudes and behaviours. Social physique anxiety was defined as the degree to which a participant becomes anxious when her physique is observed or evaluated by others (Hart, Leary, & Rejeski, 1989). Physical activity and dietary attitudes and behaviours were defined as the behaviours and attitudes, held by the participants, related to eating and physical activity or exercise. The psychometric information of each questionnaire shall be discussed in the "Assessment Tools" section of this paper.

The issuing of a package of questionnaires was the best way to examine the characteristics of interest given that the questionnaires could be distributed, in a concise and complete fashion. Also, handing out one package with a variety of questionnaires is more efficient than handing out individual questionnaires.

Prior to the completion of the questionnaires, participating women were made aware, through the use of consent forms, that 1) the study aimed to better understand women's eating and dietary thoughts and concerns, and 2) a possible interview might ensue. Once the questionnaires were completed, the traits assessed by the questionnaires were examined and scored in order to identify women who were at risk for developing an eating disorder. This data was primary data in that it was collected specifically for this study and was not taken from another study's archived data.

Assessment Tools

The psychometric properties of the following questionnaires have all been assessed in various published works. This psychometric information is the greatest justification for the use of the selected questionnaires. Specific explanations of each questionnaire and their target variable(s) follow. (The reader may, at this point, find it useful to consult Table 1, Appendix B.)

Social physique anxiety (SPA) was evaluated using the SPAS: Social Physique Anxiety Scale (Hart, Leary, & Rejeski, 1989). The SPAS (Appendix E) is the most appropriate tool to measure the degree to which participants become anxious when their physique is observed or evaluated by others. This questionnaire is an interval measurement in that it has 12-items which are assessed using a 5-point Likert scale. It has been found that the SPAS demonstrates concurrent validity and discriminant validity and criterion-related validity (Ostrow, 1996). Ostrow (1996) goes on to state that the SPAS has an alpha reliability coefficient of 0.90 and 0.82 for an 8-week test-retest reliability coefficient.

In order to make a diagnostic differentiation in the participants' physical activity and dietary attitudes and behaviours, the Q-EDD: Questionnaire Eating Disorders (Mintz, O'Halloran, Mulholland, & Schneider, 1997) was administered. This questionnaire served to differentiate between "non-eating-disordered" and "eating disordered". The former category can be subdivided into asymptomatic and symptomatic. The Q-EDD (Appendix F) is a self-report questionnaire that contains 50 questions. The questionnaire asks questions on nominal, ordinal, interval and ratio type of scales. The data yielded is frequency data and categorical labels for each participant. Published psychometric

information indicates that the tool has very good test-retest reliability and interscorer agreement (Mintz, O'Halloran, Mulholland, & Schneider, 1997). Specifically, the instrument has been found to have 1 to 3 month test-retest reliability kappa values ranging from 0.54 to 0.64. The same study indicate that the 2-week test-retest reliability was more stable, however, with a kappa values ranging from 0.85 to 0.94. Mintz, et al. (1997) also found the questionnaire to demonstrate convergent validity, criterion validity and incremental validity.

The EAT-26: Eating Attitudes Test (Garner & Garfinkel, 1979), was also administered. It is a shortened version of the common EAT-40 (Garner & Garfinkel, 1979; Appendix G), having 26 items, all of which are answered using a Likert Scale. The EAT-26 is one of the most common measurements in the field of eating disorders, in that it assesses participants' attitudes and behaviours characteristic of eating disorders. Garner, Olmsted, Bohr and Garfinkel (1982) indicate that the tool is valid and has a reliability of .90. Admittedly, one shortcoming of this use of this measure with this non-clinical population is attributable to the fact that the scoring method that is described by Garner and Garfinkel (1979) does not account for non-clinical differentiation. As such, the scoring method outlined by Wells, Coope, Gabb & Pears (1985) was used given that it does not collapse the non-anorexic response distribution.

In order for a participant to be considered eligible for the qualitative phase of the study, she had to be categorized as "non-eating disordered (symptomatic or asymptomatic)" according to the Q-EDD and have a total score greater than 37 and 60 on the SPAS and EAT-26 measures, respectively. Such cut-off scores put the participants in a range that was above the non-clinical mean score of the measure. These questionnaires

were specifically chosen given that they are known to assess characteristics known to characterize women at risk for developing eating disorders (Ostrow, 1996; Kay, 1996).

Qualitative Phase

Women identified as being "at-risk" in the first phase of the study were contacted. Contact information was obtained from the participants in the questionnaire package. The four women selected from the first phase were then contacted and asked if they were interested in participating in the qualitative phase of the project. Women consenting to participate in the qualitative phase were asked to sign a consent form that detailed the pertinent information. For this study, the intended number of participants was four. Four interviews were conducted with each participant in order to more fully appreciate the experiences of these at-risk women at different times and over a period of two months. Different issues were raised and questions asked during each of the four interviews in order to cover the various aspects that were pertinent to the participant at each interview time. As such, it was not intended that the same questions be asked during each interview. Four interviews was appropriate and allowed the information gathered to reach a point of saturation.

Method

The interviewer performed an "open-structured" interview with each participant. The term "open-structured" is used because some would argue that the extremely flexible nature of this method does not even qualify to be termed "semi-structured". The questions were asked in interview format in order to attain the personal nature of the questions to be asked. This "open-structured" approach was also appropriate given the qualitative nature of the study. Furthermore, it may be said that this adaptable structure

was a befitting design of this study, a multiple single case study, and its strategy, a phenomenological approach.

The interviews started in a very casual manner in order to break the ice. Questions such as, "So, how are things? How is school? What is new?" were asked. Once a rapport had been established the participant was asked, "Have you recently, or ever, either experienced an event or been particularly preoccupied by your eating habits, your weight or your body shape?" It is this instigating question that initiated a deeper interaction, at which time a series of questions might have been asked. This variety of possible questions rendered the interaction unique and un-predetermined. This permitted a fair amount of guided latitude within the procedure. An interview guide, however, was used to outline a variety of possible questions that could be asked. It is also important to note that the qualitative and phenomenological nature of the interviews also reduced the possible seeming repetitiveness of the interviews for each participant. In other words, interviews were guided by possible questions, yet the participant was able to interpret them according to her experiences, her phenomenology. Given the multiple interviews and the phenomenological approach that allowed the participants to share their experiences as they liked, a rapport was fostered between interviewer and interviewee. This rapport was, in fact, hoped for in order to ensure accurate revealing of the interviewees experiences. Noteworthy, however, is the fact that the interviewer was attentive not to conduct an interview that was "consulting" in nature. If participants asked for advice or help, the interviewer was prepared to provide them with appropriate resources and references.

While most of the questions asked during the interviews focused on the experiences of these women, questions were also asked in order to appreciate each participant's perception of the interviewing process and whether it was having an impact on them. Women were also asked to assess how much time a day, on average, they think about issues regarding food, their body shape/size, exercise, etc. Additionally, each participant was asked to give feedback and comment on various magazine articles. Specifically, participants were given a magazine at the end of the second interview and asked to make notes on what they thought and how the felt; this was then discussed at the beginning of the third interview.

Each interview was recorded with an audio recording device. This device was in plain view, and the participant was asked if she minded its use. The importance of recording the interviews was explained, which was to ensure maximal data retrieval. This allowed the researcher to review the interview many times and collect as much data as was needed. The process of recording also minimized error in data collection. A further benefit to the use of an audio recorder was to facilitate a more natural interaction between the interviewer and the interviewee. The latter might not have otherwise been possible had the interviewer been taking notes.

Data Analysis

Phase 1: Quantitative Data

The data collected using the quantitative questionnaires was assessed in order to identify four women at risk for developing an eating disorder. As such, questionnaires were scored according to the proper scoring methods developed by the developers of each, with the exception of the EAT-26, as previously discussed. Each participant's

multiple questionnaire scores were entered into a numerical spreadsheet. Such a format permitted a visual overview of the results obtained. These results were used to identify four participants who were at risk for developing an eating disorder.

Phase 2: Qualitative Data

Although the phenomenological approach is one that leaves a lot of liberty to the participant in discussing their experiences, a certain structure was used in order to classify and structure the data obtained. The data collected was transcribed and entered into Microsoft Word, which allowed themes to be sorted. Data entry took place during the phase in which interviews were conducted, as well as after the interview phase was completed. Further steps of analysis were performed using Bachelor and Joshi's (1986) phenomenological approach. These authors explain that there are five steps to be followed in the analysis of data.

Step One

The analysis began with a global overview of the written form of the participant's discourse. As such, the four interviews conducted with each of the participants were transcribed verbatim.

Step Two

This step entailed identifying sentences that address the subject of research, in this case, eating disorders. More specifically, various situations that seem to be impacting moments in the daily lives of women at risk were identified. Examples of such situations were buying clothes, choosing her meal, encounters with men, etc.

Step Three

The attained information was then classified according to two strategies of analysis. The first strategy entailed creating "integrator themes" to thematically regroup qualitative data. These integrator themes permitted a more global understanding of the experiences had by each participant. To note is that integrator themes were unique to each participant given that they were created to be as specific and representative of the data they regrouped.

The second strategy entailed regrouping qualitative data according to the six dimensions of the Wellness Model (Donatelle, et al., 2001). The model illustrates that there are six dimensions of health that interact with one another. The premise of the model is that health should be defined in accordance with each of these dimensions, both individually and with respect to their interactions. To be noted is that these spheres are not mutually exclusive. Donatelle, et al. (2001) renders a suitable account for the distinctions between spheres.

The Wellness Model was conceptualized after many years of discussions regarding the concepts wellness and health. The World Health Organization (WHO) and many other national and international organizations have entertained a variety of definitions for these concepts. The greatest impacting definition of health was put forth by the WHO, in 1947. The WHO's mandate stipulated that health involves not just the absence of disease or infirmity, but rather complete physical, mental and social well-being (WHO, 1947). This definition was revolutionary in that it emphasized health as being more than just an absence of disease.

Given the value and impact of that definition of health, René Dubos used the definition and expanded it to state, "Health involves social, emotional, intellectual, spiritual, and biological fitness on the part of the individual, which results from adaptations to the environment." (Dubos, 1968, p. 15). This definition encompassed many aspects of life and many components. From this, the term wellness came to exist, and although it is commonly used interchangeably with "health", the two are different. According to Donatelle, et al. (2001), wellness refers to the "...achievement of the highest level of health in each of several key dimensions." (p.3). It is these dimensions that are the components of the Wellness Model, as presented in Donatelle et al. (2001).

Donatelle, et al. (2001) elaborated on the six different dimensions in the following manner. **Physical** health refers to physical characteristics of the individual. Examples are sensory acuity, body functioning, body shape and size, ability to recuperate from sickness and disease. **Environmental** health encompasses the external environment and the individual's function in protecting, improving and preserving the environment. **Intellectual** health encompasses decision-making, the ability to grow from experience and learn. It also includes intellectual capabilities. **Emotional** health embodies feelings and the ability to express and control them appropriately. Examples of feelings include trust, love, self-efficacy, self-confidence, sadness, loneliness, and happiness. **Social** health addresses interactions with others, the ability to adapt to various social situations and have satisfying relationships. Finally, **spiritual** health is less restricted and definitive in its definition. It may include the belief in a superior being. It may also include one's ability to wonder about one's purpose or in life, one's role in the universe or one's experiences. It may also include one's feeling of unity with one's environment

and with nature. In comparing the different dimensions, it becomes clear that the dimensions are not mutually exclusive and they all influence each other (Donatelle et al., 2001).

Although the Wellness Model is most commonly used by health organizations and fitness promotion programs. As of yet, there are no known published eating disorders studies that have used the Wellness Model. It is believed that the Wellness Model (Donatelle, et al., 2001) is the most appropriate model for this study, given that it aptly illustrates the different dimensions of a person's life that can contribute to health and wellness. Consequently, it is believed that these dimensions will completely and fully encompass the different aspects of a young woman's life that may affect to the development of an eating disorder. It is also believed that these dimensions will, in a converse fashion, aid in highlighting certain aspects of a young woman's life that are not as developed. As such, it may be said that the nature of the Wellness Model and its dimensions is ideal in fully exploring the experiences of a woman at risk for developing an eating disorder.

Step Four

The fourth step consisted of the analysis of the principal themes. More specifically, this step entailed sub-classifying the information classified according to the six dimensions of the Wellness Model (Donatelle, et al., 2001) in order to identify more specific factors within these dimensions. These factors allowed a more detailed description within the dimension categorization. The following is an illustration of such sub-categorization.

Within the physical dimension of the Wellness Model (Donatelle, et al., 2001) are factors pertaining to the participants' involvement in physical activity, dietary concerns, eating habits, etc. Factors within the emotional dimension are concerns, worries, and emotions. Social factors, within the social dimension, will include relationship issues with family, friends, roommates, boyfriends, professors, and employers. Another social factor might be issues related to social standing and "fitting in". Within the environmental dimension are factors such as issues pertaining to clothes and the impact the participants' surroundings have on them. Intellectual factors, within the intellectual dimension, might be issues pertaining to tests, projects, grades, understanding of matter, academic/career goals, comprehension of school and life related issues. Finally, within the spiritual dimension, are spiritual factors that would identify aspects relating to the participants' morals, values, beliefs and soul.

Step Five

Finally, the fundamental structure of the phenomenon being studied was described. In other words, the essential factors that were found to have an impact on the daily experiences of the women at risk were identified.

Methodological Issues: Validity, Reliability and Trustworthiness

Given the mixed nature of this project, concerns regarding 1) validity and reliability, as well as, 2) authenticity and credibility were appreciated and assessed.

Phase 1: Validity and Reliability of Quantitative Measures

It has been found that the SPAS demonstrates concurrent validity and discriminant validity and criterion-related validity (Ostrow, 1996). Ostrow (1996) goes on to state that the SPAS has an alpha reliability coefficient of 0.90 and 0.82 for an 8-

week test-retest reliability coefficient. The Q-EDD is a fairly new assessment tool, however, published psychometric information indicates that the tool has very good test-retest reliability and interscorer agreement (Mintz, O'Halloran, Mulholland, & Schneider, 1997). These authors cite the instrument as having 1 to 3 month test-retest reliability kappa values ranging from 0.54 to 0.64. The same study continues to indicate that the 2-week test-retest reliability was more stable, however, with a kappa values ranging from 0.85 to 0.94. Mintz, et al. (1997) also found the questionnaire to demonstrate convergent validity, criterion validity and incremental validity. The EAT-26 is one of the most widely used assessment tools, and with good reason. This later questionnaire is valid according to Garner, Olmsted, Bohr and Garfinkel (1982). These authors also indicate the EAT-26 is reliable with an alpha coefficient of 0.90.

It is evident from the list of questionnaires presented, that there were many questionnaires used in this study. It was important that they be reliable and valid. It is for this reason that psychometric studies investigating their psychometric values were scrutinized very attentively.

Phase 2: Trustworthiness of Qualitative Phase

In this phase, endeavours to attain trustworthiness, specifically authenticity and credibility, were executed. For example, it was important for the interviewer to identify and appreciate her assumptions and perspectives prior to the interviews and analyses. This was in order to minimize the extent to which it altered or affected the analysis of the perspective of the informants. This endeavour was carried out in order to increase neutrality. This being said, however, the researcher was aware that despite all attempts to be neutral, there were times that human subjectivity occurred, which is common with

qualitative research. Objectivity was continually being re-instilled within the researcher during her constant discussions and consultations with her thesis supervisor, who was not having personal contact with the participants.

Credibility was another component of trustworthiness that this project made efforts to attain. Credibility is the notion that there is a correspondence between how well the research conveys the viewpoint of the informants and their actual perception of the social constructs (Dallaire, 2001). Contributing to credibility was executed in a variety of ways. There were prolonged engagements with the participants in that these young women were interviewed over a period of time. This ensured that enough data was collected, thereby contributing to credibility. During the last interview, the interviewer reviewed the transcriptions of the previous interviews with the participant. This ensured that the transcripts were correct. The researcher also consulted her supervisor, in order to understand and appreciate the ways by which analyses ought to be conducted. A final method used by the interviewer, in ensuring credibility, was the use of a reflexive journal. It is within this journal that the interviewer/researcher kept track of changes in methodology, decisions made and the reasons for these.

Given the overlapping nature of the dimensions of the Wellness Model (Donatelle, et al., 2001) trustworthiness was a concern in the qualitative phase of this study. As previously mentioned, the dimensions are not mutually exclusive. As such, a particular challenge of this study was the classification and categorization of the data that was collected. Great efforts were needed in order to ensure consistency in the classification of information. This was carried out via interrater reliability; the researcher's supervisor concurrently categorized information according to the variables.

Furthermore intrarater reliability was conducted by the principal researcher, who re-analysed data at various times to ensure that categorization methods were consistent.

In terms of transferability, the study will clearly identify the other groups, contexts or settings to which the information presented may be applicable. It is anticipated that this study is quite specific to university undergraduate women aged 18-24 who are at risk for developing an eating disorder. There is hope, however, that perhaps some of the methodological issues can be applied to interviews with at-risk women of different age groups and contexts, i.e. non-university settings. Furthermore, a detailed description of the sample and a reflexive journal will be kept on the part of the researcher. Such rigorous detailing will also contribute to the attainment of dependability of this study.

Advantages and Limitations of Study

The above section addresses many concerns that either contribute to or hinder the appropriateness of the chosen method, techniques and strategies for this study. As a result, it may be said that the present study has a variety of methodological advantages and possible limitations. For example, although the chosen quantitative questionnaires may have been found to be psychometrically appropriate in measuring each of their variables, the effect of combining them and administering them together is unknown. As such, the yielded quantitative results may unknowingly be unrepresentative of the respondent's true situation. Furthermore, the overlapping nature of the dimensions of the Wellness Model (Donatelle, et al., 2001) may prove to be a limiting characteristic in terms of its use in the present study.

As with any study investigating human behaviour, there is always the concern of participant bias. The two most common types of participant bias are social desirability bias and obeying demand characteristics bias (Mitchell & Jolley, 1996). In the case of the former, the participant answers with responses they believe are more socially desirable (Mitchell & Jolley, 1996). In the case of the latter, participants answer in a way they believe will fulfill the needs of the study (Mitchell & Jolley, 1996). These issues are concerns in this study. Related to the notion of obeying demand characteristics, it must be said that the rapport that will likely (hopefully) develop between interviewer and interviewee will further contribute to the risk for such biases occurring. It is also hoped that, in conveying the individuality of experience that is inherent in the phenomenological approach taken, participants will understand the value in simply telling their story, their way.

Despite these possible limitations, however, it is still believed that the methods used are the most appropriate for collecting the needed information. The interview process is the most appropriate method for gathering the intended information given its more personal nature. It is the more personal nature that is essential in the strategy of a phenomenological approach. Furthermore, as has also been repeatedly indicated, it is this strategy that will ensure a rich, detailed account of the experiences of women at risk for developing eating disorders.

Significance of Study

There is no doubt that much research has been conducted on eating disorders. Unfortunately very few are of qualitative methodology. Furthermore, no known literature to date discusses the experiences had by women at-risk for developing an eating

disorder. These qualities are the unique features of the present study and those that contribute to its value.

It is believed that understanding the everyday experiences of women at risk for developing eating disorders is crucial in the creation and development of appropriate and tailored treatment programs. The value in appropriately designed treatment programs is, of course, evident in the attempts to stop the occurrence of eating disorders. It is further believed that the present study may be valuable in the design and implementation of preventative programs, to stop the development of eating disorders before they start. As such, it may be said that the present study has a great number of possible clinical implications. Further clinical implications of this study include the possibility that other researchers, in reading the present study report, will be incited to develop new assessment tools that may investigate different aspects of eating disorders, perhaps even areas that remain to be investigated.

Regardless of the way in which the information to be attained from this study is used, there is value in knowing what these women experience. It is believed that the present research will highlight *how* various factors seem to contribute to the development of eating disorders. Consequently, the benefits would be multi-fold, especially in considering the contribution such knowledge could make in stopping the occurrence of eating disorders.

PART II:

RESULTS OF THE STUDY

Running Head: EXPERIENCE OF BEING AT RISK

The Experience of Being at Risk for Developing an Eating Disorder

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Abstract

While a variety of studies have investigated eating disorders, most have used quantitative methodology; few are qualitative. The phenomenological approach would be useful in gaining a deep understanding of the experiences of being at-risk on a daily basis, information that is crucial to the prevention of eating disorders. This study investigates such experiences using both quantitative and qualitative methodology. Four undergraduate university women were identified as being at risk using three quantitative questionnaires. Using a phenomenological approach, four qualitative interviews were conducted with each participant, over a period of two months. The focus was gaining an appreciation of their experiences. Results are presented in the form of case study narratives in order to highlight the various experiences that are associated with at-risk behaviours. Value and importance of phenomenological approach within field of eating disorders is discussed.

The Experience of Being At-Risk for Developing an Eating Disorder

Society is constantly bombarded with images of culturally determined "beauty", body shape and size. Unfortunately, these ideals are becoming thinner and thinner (Nemeroff, Stein, Diehl & Smilack, 1994). As a result, young women often torture themselves in the hopes of attaining the unattainable – the unreasonable and thus can suffer both physically and mentally (Tomori & Rus-Makovec, 2000). It is important that further research be conducted in order to attain a better understanding of this societal problem, as well as possible resolutions and treatments.

The most effective way to overcome such maladies is to stop women from developing an eating disorder, before it happens. As such, focusing on risk factors is of prime importance. The present study specifically investigates, "What are the experiences of women at risk for developing an eating disorder?" Attaining a better knowledge of the daily experiences of at-risk women gives a better understanding of possible forces that drive these women to, or impede the development of an eating disorder (Sharpe, Ryst, Hinshaw, & Steiner, 1997). This study investigates these experiences using broad-open ended questions in order to allow the participants to explain their experiences in the way that is most representative to what they are living on a daily basis.

While most studies within the field of eating disorders use a quantitative clinical approach (Thompson, 1996), as seen by the available literature, the present study identifies the value of using a phenomenological approach. The latter allows an investigation that attains a deeper, more profound appreciation of the life experiences had by these women. This present study uses both quantitative and qualitative methodology

in order to 1) identify a population at risk, and 2) gain a profound understanding of their daily experiences of being at-risk.

Literature Review

Many studies have been conducted in the field of eating disorders. Despite the uniqueness of each study, when one peruses the literature as a whole, distinct categories of research become evident. This is seen in the vast array of reports that have investigated issues such as pathology, prevalence/risk factors, body image, beliefs/perceptions, treatment programs and psychometry. The literature also indicates that different theoretical frameworks (e.g. developmental, sociocultural and perceptual) drive the various issues being explored. Closer examination of the studies in the field of eating disorders indicates that the majority are conducted using quantitative methodology. While such methods have clear advantages, they do not capture the benefits that a qualitative methodology and phenomenological approach can offer.

As discussed in Bryman (1988), qualitative methodology offers a means by which a more "sustained contact" (p.95) with the participant may be obtained, thus facilitating a gathering of richer and deeper data. Consequently there is tremendous attention to intricate detail, which accommodates a complete account of the phenomenon being investigated (Bryman, 1988). Deslauriers (1991) emphasizes that such methodology facilitates learning about a phenomenon in a more natural setting, a context that does not remove the impact of social factors. Given the numerous studies that have investigated the social component of eating disorders, it is evident that such methodology has tremendous benefits.

Having pointed out the benefits of qualitative data, it is important to note that the value of quantitative data is not being denounced. Instead, it must be recognized that, as stated in Bryman (1988, p.106), "... quantitative and qualitative research are each appropriate to different kinds of research problem, implying that the research issues determines (or should determine) which style of research is employed." A limited number of studies in the field of eating disorders have used qualitative methodology, however, the obtained results demonstrate the appropriateness of the methodology in accordance with the desired type of data.

There are few qualitative studies that have been conducted in the field of eating disorders, and of those that are available, most are dissertations. A few qualitative studies investigated treatment program efficacy and the process of recovering from an eating disorder (Milstein, 2001; Laberg, Toernkvist, & Anderson, 2002; Matoff & Matoff, 2001). For example, Marek (1995) evaluated an eating disorder treatment program for college women that incorporated biological, social and psychological components. The qualitative interviews and focus groups that evaluated the biopsychosocial approach of the treatment revealed that participants, in discussing the treatment program, discussed issues pertaining to all three components of the treatment. For example, participants mentioned biological aspects (the need for nutritional information; changing eating patterns), psychological aspects (the need for personal understanding and identification of needs and body image; emotion exploration; feeling understood; self-care; setting goals) and social aspects (family relations; need to feel connected to others; sharing).

Milstein (2001) conducted a similar study, which investigated the components involved in the ongoing recovery process. The researcher conducted interviews with a variety of researchers in the field and was consequently able to determine that a variety of themes pertaining to the recovery process emerged. These included personal factors, such as, self-development, commitment to recovery, perseverance and determination. Themes relating to interpersonal factors also emerged, including: the development of trust, safety and security; and the value of relationships with psychotherapists and other professionals. Laberg, Toernkvist, and Andersson (2002) attained similar findings by conducting interviews with patients of cognitive-behavioural therapy. Obtained data was regrouped according to the following themes: treatment duration and intensity, treatment components, therapist qualities, experience of group therapy, identity and personal relations, consequences, and course of disorder and treatment.

The experience of the eating disorder recovery process has also be explored using a case-study approach (Matoff & Matoff, 2001), in which researchers were able to gain insight into matters pertaining to the recovery process, turning points within the process, intervention modalities, coping strategies, and lessons learned. Having used a feminist perspective, these researchers identify the need for women overcoming eating disorders to restore their social and emotional well-being, positive self-esteem and daily confidence. Additionally Matoff and Matoff (2001) emphasize the notion that recovery is a process measured more so by time as opposed to a specific measured outcome at a specific time.

While the above-mentioned qualitative literature highlights the research investigating the recovery process and treatment, there are also studies in the field of

eating disorders that have been published on issues related to body image and exercise. For example, Hill and Brackenridge (1989) performed a qualitative investigation into the experiences of girls and women with respect to physical activity, school physical education and body image. When discussing the issue of appearance, although a few of the six women indicated a few positive comments, there were many who expressed embarrassment with regards to their shape and their menstrual periods (Hill & Brackenridge, 1989). Many of these women also expressed a dislike for the exercise clothing and negative attitudes towards their physical abilities (Hill & Brackenridge, 1989). Hill and Brackenridge (1989) went on to indicate that the development and maintenance of positive body image and self concept were important in ensuring that children remain involved in physical activity.

In reviewing available qualitative literature in the field of eating disorders, most studies focus on the actual experience of having an eating disorder. For example, Blok (2002) explored the relationship between 1) communication strategies used by eating-disordered women, their families and romantic partners in managing conflict, and 2) the development and maintenance of eating disorders. Results indicated that the majority of anorexic women experience little or no overt communication of conflict with their families. Contrarily, bulimic women reported more expressed conflict with their families. Most women reported not feeling confident in resolving conflict in their romantic relationships given that they, according to participants, never learned appropriate conflict management skills.

In terms of appreciating the experience of women with concerns about eating, Budd (2002) conducted a research with 15 college women specifically exploring their

eating behaviours. Findings from this study indicated that there are three main groups of eating behaviour: functional eating behaviours, transiently dysfunctional eating behaviours and dysfunctional eating. Participants exhibiting the latter believed that such actions would contribute to their health. Consequently, the author of the report highlights the need for investigating multiple levels of health and social policies in order to increase knowledge and education.

While the above studies give an overview of the few qualitative studies conducted in the field of eating disorders, it must be noted that even fewer studies have been conducted using a phenomenological approach. In fact, to date, only one known study has used phenomenology in investigating eating disorders. Pearson (1998) investigated the experience of eating disorders, using a population of five university women athletes. The author conducted phenomenological interviews, which revealed that athletes found their lives to be dualistic in that they experienced actions, thoughts, feelings and behaviours that they struggled with during their eating disorder. Pearson, in conjunction with athletes, came to discuss the paradoxical nature in terms of 'The Monster' and the 'Recovery/ The Real Me.'

Despite the fact that studies have been conducted on the experience of having an eating disorder, at present, none seem to explore the experience of being *at-risk* of developing an eating disorder with a female university population. Most studies investigating experience focus on women who have (or have had) an eating disorder. Exploring the experiences had by those at risk is an important line of questioning still needing to be addressed and is thus the focus of the present study. It is in further appreciating these everyday experiences that one may come closer to understanding how

women at risk live their lives and how they are affected by being at risk. The concept of experience, in this study, will be strongly guided by perceptual, developmental and sociocultural perspectives given that the present study wishes to examine women's experiences of being at-risk using a global approach. As such, this approach aims to include not only aspects related to the individual herself, but also those related to interpersonal, institutional, community and societal levels (U.S. Department of Health and Human Services, 1999). It is believed that this global perspective will not only provide a more complete understanding of the experiences of at-risk women but it will also compliment the phenomenological approach to the interviews.

Methodology

Phase 1: Quantitative Questionnaire Phase

Participants

The present study was conducted in two phases. The purpose of the first phase, which was quantitative, was to identify women at risk of developing eating disorders. A "convenience" sampling of women (n=22), aged 18-22 years, was used. These women, all in their first year university, completed a consent form and three quantitative questionnaires.

Assessment Methods/ Questionnaires

Social physique anxiety (SPA) was evaluated using the SPAS: Social Physique Anxiety Scale (Hart, Leary, & Rejeski, 1989). The SPAS, a 12-item questionnaire using a 5-point Likert scale, measured the degree to which participants become anxious when their physique is observed or evaluated by others. In order to make a diagnostic differentiation in the participants' physical activity and dietary attitudes and behaviours,

the Q-EDD: Questionnaire Eating Disorders (Mintz, O'Halloran, Mulholland, & Schneider, 1997) was administered. This questionnaire served to differentiate between "non-eating-disordered" and "eating disordered". The former category can be subdivided into asymptomatic and symptomatic.

The EAT-26: Eating Attitudes Test (Garner & Garfinkel, 1979), was also administered. With 26 Likert-scale items, the EAT-26 is one of the most common measurements in the field of eating disorders, in that it assesses participants' attitudes and behaviours characteristic of eating disorders. Admittedly one shortcoming in having used this measure with a non-clinical population is attributable to the fact that the scoring method that is described by Garner and Garfinkel (1979) does not account for non-clinical differentiation. As such, in the present study, the scoring method outlined by Wells, Coope, Gabb & Pears (1985) were used given that it does not collapse the non-anorexic response distribution.

Data Analysis

The results of each participant were assessed to determine if they met the criteria to be eligible to take part in the second phase of this study. The first criterion, given that this study investigated women *at risk*, was that they be categorized as "non-eating-disordered (symptomatic or asymptomatic)" by the Q-EDD evaluation. The second criterion was that the young women had to attain a SPAS score of greater than 37. Such a score would put them above the mean of a non-clinical population, according to Hart, Leary and Rejeski (1989). The third criterion was that their EAT-26 score would have to be greater than 60. This score was determined according to the cut-off scores cited in

Garner, Olmsted, Bohr and Garfinkel (1982) and the recommended scoring method for non-clinical populations suggested by Wells, Coope, Gabb and Pears (1985).

Phase 2: Qualitative Interview Phase

Participants (n=4) for the second phase of the study were those which met the criteria outlined in the quantitative phase of the study, phase 1. In order to more fully appreciate their experiences at different times during a two-month period, four interviews were conducted with each of these four participants. Different issues were raised and questions asked during each of the four interviews in order to cover many aspects pertinent to the participant at each interview time. As such, the same questions were not asked during each interview. Examples of questions are, "What is it like for you when you go shopping?", "What do you feel like when you go shopping?", "What is your family's approach to food and exercise?".

The design of the present research was a multiple single case study using a phenomenological approach. The interviewer performed "open-structured" interviews with each participant. The term "open-structured" is used because the extremely flexible nature of this method may not even be qualified as "semi-structured". "Open structured" was most appropriate, however, given the qualitative nature of the study and the adaptable structure, which was befitting of the study design: a multiple single case study using a phenomenological approach. The advantage of using the phenomenological approach during the interviews is getting the "real story" and everyday life experiences of the participants, thus enriching the data gathered. According to VanManen (1990, p. 10), "... phenomenology is the systematic attempt to uncover and describe the structures,

internal meaning structures, of lived experience." As such, phenomenology focuses on meaning and the explanation of the meaning that is lived in our everyday existence.

All interviews started with casual conversation in order to break the ice and help the participant feel at ease. Once a rapport was established, the participant was asked, "Have you recently either experienced an event or been particularly preoccupied by your eating habits, your weight or your body shape?" The broad nature of the question allowed many aspects to be investigated in a free and open manner. During her discourse, further questions were asked in order to assist the participant in elaborating on her recent experiences. It is this variety that renders the interaction unique and un-predetermined. An interview guide was available to outline a variety of possible questions that could be asked. In other words, interviews were guided by various possible questions, yet the participants were able to interpret them according to her experiences, her phenomenology.

While most of the questions asked during the interviews focused on the experiences of these women, questions were also asked in order to appreciate each participant's perception of the interviewing process and whether it was having an impact on them. Women were also asked to assess how much time a day, on average, they think about issues regarding food, their body shape/size, exercise, etc. Additionally, each participant was asked to give feedback and comment on various magazine articles. Specifically, participants were given a magazine at the end of the second interview and asked to make notes on what they thought and how the felt; this was then discussed at the beginning of the third interview. All interviews were audio-recorded.

Data Analysis

The qualitative analyses of this study were guided by the steps outlined in Bachelor and Joshi (1986) phenomenological analysis. More specifically, the four interviews conducted with each of the participants were transcribed verbatim, for a total of 16 interviews. Then, sentences that addressed the various situations that were impacting moments in the daily lives of women at risk were identified. Examples of such situations were buying clothes, choosing her meal, encounters with men, etc. Once this information was attained, it was then classified into "integrator themes", which aided in organizing the different aspects of a young woman's life that may affect the development of an eating disorder. These integrator themes thus allowed the full exploration of the experiences of a woman at risk of developing an eating disorder.

Integrator themes were then analyzed by sub-classifying the information within them into more precise sub-themes. This allowed the identification of more specific factors within these integrator themes. These sub-themes allowed data to be presented in a more detailed descriptive fashion, thus allowing a clear portrait of the fundamental structure of the essential factors that impacted the daily experiences of the women at risk. Once the themes and sub-themes were identified, a narrative representing the personal accounts of each participant was created.

Results

Phase 1: Quantitative Questionnaires

A total of 22 women completed the questionnaire package. It is from this sample that four women were selected to take part in phase 2 of this study. In order to compare quantitative results were calculated for: a) the phase 1 population excluding those

selected for phase 2 (n=18) and b) the phase 2 participants (n=4). These results are found in Tables 1 and 2, respectively.

Insert Table 1 about here

Insert Table 2 about here

It is interesting to note that the phase 2 participants' results for the SPAS and EAT-26 questionnaires were all greater than those of the phase 1 participants. All phase 2 participants had scores greater than the cut-off scores of 37 and 60 for the SPAS and EAT-26 questionnaires respectively. The Q-EDD indicated that all three of the four phase 2 participants were asymptomatic; the fourth was symptomatic. While some phase 1 participants had scores above these cut-offs, they did not all reach the cut-off scores for *all three* measures, as the phase 2 participants did.

Phase 2: Qualitative Interviews

The results obtained for each participant will be presented case by case. Results for each participant will begin with a narrative of her situation. An elaboration of the different integrator themes and how they are manifested in her daily experiences will follow this. In this section, the importance attributed to each theme will be represented by the order in which they are discussed, the first being the theme that was most talked about by the participant.

Participant A (pseudonym Annie)

Narrative. Annie lives close to campus with three friends and hopes to be a schoolteacher. She goes to the gym, runs, cycles and lifeguards. Exercising gives her confidence and so, during exam period, when she exercises less, she has lower self-esteem. Her self-esteem around guys is also impacted given that she believes that most of them only prefer "skinny" girls. Annie believes the fact that she is not dating someone right now is, in part, attributable to her size. Her major areas of concern are her legs and stomach. When she looks at the thin-ideals that are depicted on TV and in magazines, Annie sometimes finds it depressing.

Annie tries to eat healthy foods. Her major concerns regarding food are specific to junk food, sweets, fried foods and large meals. Her beliefs and thoughts are greatly influenced by her mom, who is a strong advocate of healthy eating and exercise. Annie has found some of her mom's comments with regards to Annie's weight hurtful. While Annie indicates that her mom's intentions are not to be mean, the result is still the same. When Annie's mom visits her, she observes her fridge in order to assess what Annie has or hasn't been eating. Her mom is not aware that Annie has been taking Ephedrine, a diet aid. Annie has also tried Slim Down and has plans to start the Atkins diet with her roommate.

Themes in relation to everyday experiences. Annie spoke at great length about her experiences with her mother. This data was grouped according to the theme "Mother passes, sometimes hurtful, comments in regards to her exercise & eating habits". Examples of such experiences are the fact that, according to Annie, "Mom's comments regarding weight and weight lose have an impact –whether encouraging or depression."

Additionally, from a day-to-day perspective, Annie explains, "When I eat ice cream, I think about how Mom thinks I am fat and that I shouldn't eat it and exercise more. I feel guilty, bad and embarrassed."

The theme "Uses Ephedrinee and tries Atkins and Slim Down" refers to the fact that Annie often discussed the various diet aids she has tried, most of which have been a result of seeing her friends try them. This is seen by the fact that Annie explained, "My roommate came home one day and told me she was trying Ephedrine. I thought I would try it too." and "After watching a TV show on the Atkins diet, my roommate and I have decided to go on it." Such data was also seen in experiences that were classified within the "Tries different diets with friends; is aware of what they eat" theme. An additional example of such experiences is the fact that, "If I have cooked a big meal and someone is eating something small, I feel like a pig."

Television also plays another role in Annie's life, as is seen by the data regrouped according to the theme "TV and magazines can be depressing due to constant depiction of thin women." An example of a daily experience had by Annie, which falls within this theme is, "During TV shows, I compare my body to those of other women in bathing suits. I try not to, but it just happens, to the point of not watching the show."

Annie also indicated specific concerns regarding particular foods. The data referring to such issues was grouped according to the theme "Limits junk foods, sweet foods, fried food and large meals." From a day –to-day basis, issues relating to this theme are seen in the fact that she gets discouraged when she snacks, as opposed to eating regular meals. Annie has a tendency to snack on unhealthy food when she is stressed out and very busy with school.

Annie also discussed her various exercise activities, which were grouped according to the theme "Goes to gym, runs & lifeguards; exercise has an impact on self-esteem". More specifically, data within this theme addressed the fact that Annie was very physically active in the summer. She biked to her lifeguard job and went for long runs. As a result, she lost some weight. During the school year, she is less physically active than in the summer, but goes to the gym fairly regularly, all the while maintaining her running. She also indicated that, "I will go exercise, to feel better, after I have eaten big meals, which can make me feel down."

Data found within the themes of "Major areas of concern are legs and stomach" were highly related to those found in "Wishes could wear clothes that 'skinny' girls do; clothing industry doesn't cater to realistic sizes." More specifically, Annie discussed that she has "...always been self-conscious of my legs. Ever since I can remember, I didn't want to wear a bathing suit." Her concerns regarding her stomach also impact her choice of clothes, "My belly button is an area of concern and is more apparent in solid colour tops. I also do not wear see-through tops." In further discussing clothes, Annie described experiences that indicate that she has difficulty buying clothes that fit. "The fashion industry promotes smaller sizes by making them more available than the more realistic larger sizes."

Annie also discussed issues pertaining to dating and men; these were classified according to the theme of "Boys prefer to date small/ thin women." An example of Annie's experiences in this domain is the fact that her male friends always seem to look at women who are thinner than Annie. She always sees guys that she likes talking to thin

women. She also has difficulty talking to guys she is interested given that she is self-conscious of her body.

Finally, the themes that were briefly talked about were "Enjoys living close to campus with three friends" and "Wants to be a school teacher." Information collected and classified according to these themes discussed: 1) her living situation, and 2) her future career plans, as well as, her present university projects and assignments experiences.

Participant B (pseudonym Betty)

Narrative. During the 15 years that Betty was a modern ballet dancer, she was very conscious of her weight and body shape. This had direct impacts on her eating habits. She recalls times where she and other ballet dancers would not eat for extended periods of time. Many of her ballet friends were bulimic and/ or anorexic. According to Betty, she was perhaps at risk of developing an eating disorder, but back then she did not think anything was out of the ordinary.

No longer with a dance company these days, Betty no longer feels pressure to maintain a certain weight. She admits, however, that she rarely eats meals per se. She rarely cooks and will sometimes eat a bagel or a fruit, thereby skipping meals. At present, she considers herself to be too lazy to do a lot of exercise. She does, however, go to the gym a few times a week and sometimes to the dance studio.

Betty's family is fairly athletic and healthy. She is a parliamentary page, a job that is time-consuming but that has also given her the opportunity to make many friends. Betty has a strong interest in women's issues and suggests that her future job will be related to this domain. With such an interest in the portrayal of women in the media, she

is very astute to the thin ideal. As for her own body, Betty considers that she has a large bum and legs, the latter being muscular as a result of her intense ballet training.

Themes in relation to everyday experiences: "Many years in ballet greatly impacted her exercise and eating habits" is a theme which regroups data pertaining to the different pressures Betty had during her ballet years and how she and her ballet friends dealt with them. For example, "At a certain point, there were three bulimics I knew, as well as many who did not eat. They would all not eat for a couple of days." Having been in such an environment, Betty explains that she got to think that bulimia was a lot more normal than it should be. Betty indicated that she herself would go a few days without eating, "I am sure I was at risk for or really close to developing an eating disorder while in ballet. I would stop eating for two or three days."

Information pertaining to Betty's present eating habits were regrouped according to the theme "Does not cook many meals, rather eats small snacks; often skips meals." Data within this theme demonstrated that, from a day-to-day basis, Betty rarely eats three meals a day. She rarely cooks meals, and often finds herself having a single item as opposed to a meal. For example, "I probably gained weight at Christmas, so I am probably eating less right now. I may have a hot chocolate, but I won't eat for the rest of the day." Betty also indicated that she never eats breakfast, citing that she is too lazy to do so.

The information Betty gave in regards to her family was grouped according to the theme "Physical activity and healthy of family members". She spoke at great length about the physical activity they perform. For example, her father plays golf, curling and basketball. Her brother used to play basketball for his high school team. Her sister and

mom, however, are not as active. All of her family members are tall and on the slender side.

The theme "Interest in feminism; job as a parliamentary page" regrouped the data pertaining to Betty's job as a page and her passion for issues surrounding women. Examples of her daily experiences pertaining to such aspects are the fact that she works everyday as a page and the fact that she involves herself in charities and organisations that assist women and battered women. Betty also discussed that she believes in stopping violence against women and that women are equal to men.

During the interview process, Betty discussed her daily experiences that pertain to the images of thinness that are depicted in the media. Betty can look at a magazine and pick out very clearly what she does and does not like about the different bodies that are shown. This type of data was grouped according to the theme "Thoughts regarding the bodies of various people in the media". Betty, in looking at a magazine image indicated:

> This girl has a really nice body, like the ideal body type.
> She is really tall and has thin legs. She is long and slim. She
> also doesn't have a big bum. Her overall look is quite ideal
> and I would like to look like that.

Having said this though, Betty is also very aware of images that are possibly airbrushed. "This actress, in this picture, no longer has her ghetto booty. They might have airbrushed the image. I think her arms are airbrushed."

When discussing her daily experiences pertaining to clothes, Betty discussed in great detail that, due to her long legs and arms, she often finds it difficult to find clothes that fit her properly. Her bum and leg sizes, however, do not seem to cause her any

difficulty in buying clothes. This being said, Betty also said that "I have a fairly large bone structure and jean stores tend to make their clothes smaller. So, I buy my clothes at other stores that have a more reasonable sizes." She also indicated that she doesn't like tube tops or sleeveless shirts because she prefers to have a strap to cut her shoulders. These daily experiences were classified according to the theme "Clothing preferences and size; perception re: own body shape."

Betty's current experiences with exercise are, according to her, that she does not do that much. She goes to the gym a few times a week and maybe to the dance studio to keep up her skills. She indicates that she is lazy with respect to exercise. All of the data pertaining to this subject matter was classified according to the theme "Considers self lazy in regards to exercise."

"Guys and attending the bar scene" was a theme created to re-group the data discussing dating and going out. Admittedly, Betty did not have much to say in regards to this theme. Her experiences indicate that she is not fond of dance/ "meat-market" bars. Instead, she prefers pubs where she can sit with her page friends. She is not currently dating anyone, but she has had a few boyfriends in the past.

Participant C (pseudonym Christy)

Narrative. Living in residence for the first year, Christy has found this new experience a challenge given the differences between she and her roommate. Her relationship with her boyfriend, however, seems to make Christy happy in that she discusses him a great deal and seeks his opinion in regards to her choice of outfits. Christy has indicated that his comments are more positive than the one's that have been

given from her mom. Christy has been hurt by her mom's comments in the past and dislikes how her mom seems to place great importance on impressing people.

Christy found the first month of school a challenge given that she was barely eating. This was in part due to the fact that she was unable to find the time to get groceries given all the frosh activities and the added pressure of moving all her belongings by herself. At the time of the interviews, she was feeling more comfortable with cooking and was doing so with friends.

Christy, who is contemplating being a children's' book author, sees her body as being wide and like a block or man. She does not like many, if any, parts of her body. She does not engage in much physical activity in the winter, but does enjoy swimming in the summer.

Themes in relation to everyday experiences. Christy discussed at great length her relationship with her boyfriend, whom she has been seeing for nearly a year. She feels very close to him and indicated that she thinks, "...I know him as well as you can know a person." Her comments regarding their daily interactions were regrouped according to the theme "Very close to boyfriend: shopping for clothes and going out". Despite feeling close to him, however, she indicated that when they go shopping, she does not try on clothes in front of him because she is worried she would come out of the change room looking horrible. It seems his opinion of what she wears and how she looks is important given that she almost always asks him his opinion on her outfits prior to going out.

Christy's daily experiences pertaining to food were clustered according to the theme "Didn't eat during first month of school; food preparation and purchase okay now". Data within this category revealed that Christy found herself too busy to shop for

groceries given all the frosh activities and the responsibility of moving all her belongings by herself. As such, Christy rarely ate during the first month of school and lost 15lbs in the first month. Since then, however, she has found the time to go do groceries and is getting used to cooking and shopping for herself. She and friends cook meals together. She also indicated, "When I first started buying food for myself, I would buy the stuff my mom used to buy. Then I would get home and not know why I bought it because I knew I would never eat it."

Her mom seems to have another big impact on Christy with regards to the comments mom makes about Christy's clothes. The experiences that Christy relived pertaining to this subject were categorised according to the theme "Mom's negative comments re: her clothes; mom's opinion of others appearance." Christy explained that, "There are a few tops my mom says I look 'pregnant' in... My boyfriend and friends are surprised to hear that my mom says things like that to me.... I thought everyone's mom was like that." Christy, from day to day, also lives the experience of seeing her mom critique the appearance of others. This leads Christy to wonder what her mom thinks about her.

The theme "Body is shaped like a block and wide" was used to assemble the data Christy revealed concerning her everyday thoughts about her body shape. Christy was very clear in saying, "I am pretty unhappy with most of my body. I hate the way I look. I always feel disproportioned." The lack of proportion specifically refers to the fact that Christy believes she has very broad shoulders and limited definition in her hips and waist. This consequently has an impact on the clothes that she chooses. "Preferences for clothes while shopping and in regards to her own clothes" was the theme used to classify her

daily experiences regarding clothes. It is her dislikes for certain body parts that lead Christy to not wear tank tops, short skirts, boat-necked shirts, pants that are tight around the thighs and, rarely, dresses.

Christy thoughts and daily experiences with the media were assembled using the theme "Women in media who are beautiful" given that she was able to clearly indicate who she does and does not think is beautiful and why. For example, she finds Kate Hudson to be slim, but with a healthy body. Christy also thinks that it is okay to look slim and tall in a magazine, but that such a person would not look normal outside the context of a magazine. Ironically, this was in direct contrast to Christy's expressed desire to be taller.

The experiences relating to the eating habits of friends were either categorised according to the "Friends from high school and their eating habits" or "Difficulties with roommate and roommate's eating habits" themes, depending on who Christy was referring to. It appears as what, during high school "I can probably name most of my friends that starved themselves. I know a lot of girls in high school who did that." Interviews with Christy also revealed that her present roommate does not eat much either. "I have never actually seen her cook or eat an actual meal. I don't know how she sustains herself. The same amount of food will sit in the drawers and cupboards. Her side of the fridge only carries condiments."

Participant D (pseudonym Dana)

Narrative. Dana is very particular about what she eats in that all the food she cooks is either lean, light, lite or low fat. She also tries to minimise the number of carbohydrates she eats by typically eating salads, soups and stir fries. She has, in the

past, developed anaemia as a result of no longer eating red meat. As a result of this, her mom still worries that Dana is not eating enough. Dana believes that she does eat enough over the course of the day, however, she focuses on eating meals more often that are smaller in proportion. Dana has also admitted to, in the past, chewing her food and spitting it out. She only did this with desserts and explained that her doing this was merely due to the fact that she found the desserts too rich and she would be concerned about them being in her body.

Dana is very dedicated to working out 5-6 times a week. Her workouts will typically last 1.5 hours, during which time she commonly does two sessions of cardiovascular activity and an abdominal workout.. She does these exercises citing that it makes her feel better and that if she doesn't, then she will "feel gross". Dana has always been very physically active, having played on many sports teams during high school.

Themes in relation to everyday experiences. Exercise is a major part of Dana's daily activities and, as such, discussed it at great length. Aspects related to exercise were classified according to the theme "Exercise: how body 'feels'; what exercise does for her; routine". Dana guides her exercise routines according to how she feels. For example, "On days where I don't feel right and don't have the energy because I didn't eat enough, I won't push myself." The concept of feel is also used by to judge her weight. Specifically, she explains, "I don't go by numbers, but rather how I feel. I am at a healthy weight for my age and height, but I think I would feel better if I lost a little weight." Dana also indicated that on a day-to-day basis, exercise makes her feel better about herself. She also specified that doing cardio makes her feel better physically and more awake than doing weights.

Dana revealed that her daily experiences relative to body areas of concern are specific to her hips and legs. She says, "I don't have concerns about my upper body, just my hips and thighs... basically from my belly button down to my knees." Issues related to these concerns were classified according to the "Body areas of concern: hips and legs" theme, as were the data that referred to body image. For example:

> I think it sucks that I have these worries and guilt about what I eat and how I exercise, compared to all other people who don't. But those people either 1) have a high metabolism and can eat whatever they want, or 2) they eat what they want and gain weight. I would not be happy gaining weight like that and would not feel good physically about myself.

The parents of Dana have concerns regarding her health; these have been classified according to the theme "Mom and dad's concerns that she is not eating enough". On a day-to-day basis this results in Dana experiencing her parents asking her what and how much she has eaten. Despite the fact that this may not happen as much given that she lives in a different city, Dana indicated that, "I told my parents that I wish they wouldn't bring it up as much or worry. I appreciate the concern, but I just wish they wouldn't worry because it is not a big deal." She understands, however, that their concerns are based on the fact that she developed anaemia in high school from not eating enough protein.

"How classes are going; sociology project of interest" is the theme that was used to gather the data pertaining to Dana's thoughts regarding school, assignments and career

plans. Her daily experiences with school are such that she finds that the work load it not as intense as in high school. This is mainly due to the fact that in high school she was very busy with many sport teams. Of her university assignments, her sociology one interests her the most. It entails investigating the different interactions between men and women in the gym. Dana also explained that she hopes to become a police officer.

In discussing her sociology project, media images were also discussed. Dana seems to be realistic in knowing which messages and body shapes/ sizes are reasonable. As such, the theme "Able to know that ads are deceiving" classified such data. The way Dana experiences media images is the following: "Seeing women on TV does have an impact on me emotionally... I still wish that I could look like that". This, however, is despite the fact that she indicates "On TV there are some skinny girls. Yet, I don't think very skinny is attractive. I like toned and trim, not scrawny."

In regards to relationships with men, her thoughts and experiences with them have been grouped according to the theme "Guys checking out women & gawking". The title for this theme was chosen given that, while Dana has had a serious boyfriend in the past, her present experiences are mainly related to men in bars. "There is more emphasis on how women look as compared to men. Of course I feel good when guys at bars say stuff about how I look, but I also feel a little embarrassed because I am self-conscious." When Dana recalls her serious relationship, she indicates that, "Sometimes, during times of intimacy, I would tense up a little bit. Like if they touched my stomach, I wanted to suck it in.".

While Dana goes to bars with her friends, most of the conversation regarding them addressed their eating and exercise habits, as indicated by the theme "Eating and

exercise habits of friends". Dana indicated that, "Of my friends here and back home, 60-65% of them have problems or issues with regards to their bodies. This is high considering how they actually look and how they want to look." She also explained that a lot of her friends focus on the "number weight" as opposed to judging one's weight by how one feels.

"Clothes preferences" was the theme used to collect data regarding how clothes fit her and what she likes with respect to her clothes selection. Her experiences in this domain indicate that she does not have trouble fitting clothes on top, but because her waist is very small, clothes that fit her at the hips and thighs are too big at the waist. Consequently, Dana is very pleased with the low-rise trend of pants, given that "I can wear the pants low and not worry about them not fitting at the waist." Dana also chooses not to wear long skirts given that they hang from the widest part of her body, her hips.

Discussion

While the data is sorted according to integrator themes that are individual to each participant, a more all-encompassing view of the data collected reveals that there are some commonalties within the themes, which are revealed in Figure 1.

Insert Figure 1 about here

Such a figure reveals that there are many aspects of a woman's life that interplay and are affected by her being at risk. The phenomenological approach is conducive to fully understanding all of these aspects, which is evident in the three main findings of this research. The following findings not only summarize the gathered data, but they are also

reflective of the nature of the phenomenological approach, specifically: 1) the person is considered as a whole, 2) experiences are unique, and 3) emphasis on the phenomenon of interest (in this case, eating disorders).

Individual is Whole - All Areas of Life are Affected

Results indicate that, for women at risk for developing eating disorders, all areas of life interact with their state of being at risk. The integrator theme analysis, which led to the creation of common themes, illustrated that there are many common themes that are affected by being at risk of developing an eating disorder. When one looks at these common themes, it is seen that they encompass all areas of life: exercise, eating, friends, clothing, thinking, living arrangements, family, society & media.

This finding is of great consequence given that most researchers investigate one aspect of eating disorders at a time. For example, while some studies investigating eating disorders use a perceptual approach (e.g. Furnham & Atkins, 1997), others use a socio-cultural one (e.g. Cusumano & Thompson, 1997) or even a developmental approach (e.g. Fabian & Thompson, 1989). While these various approaches are valuable in targeting a specific aspect of eating disorders, they tend to overlook the value of the interactions that occur between all of the aspects involved. The present study's use of the phenomenological approach and common themes has permitted a data collection process that captures all three theoretical frameworks. The common themes "society and media" and "friends/ living arrangements" have encompassed the sociocultural framework. The "thinking" and "family" common themes have classified data that is similar to that which is found in developmental frameworks. The "exercise", "eating" and "body (image)"

common themes are consistent with aspects researched using a perceptual framework, as are the.

Uniqueness of Experiences

Another finding revealed by the results of this study is that, while all of the aspects of the participants' lives may be affected, their experiences are all very unique and individual. An example of this may be seen by the data within the "eating" common theme. Participant B discussed at great length her ability to go days without eating if she wanted to lose weight quickly, and used to do so for ballet. This is in contrast to participant A, who spent a great deal of time discussing her first month at university, at which time she barely ate anything due to a very busy school beginning. While these examples are quite different in their details and specifics, both deal illustrate the experiences had by participants A and B within the "eating" common theme.

The uniqueness of the experiences is further supported by the fact that different common themes were discussed to varying extents by each of the four participants. For example, the extent to which participant C expressed data pertaining to the exercise common domain was less than participant D. Specifically, participant D spoke at great length about her workout routine, whereas participant C's experiences relative to her boyfriend ("friend" common theme) were more prominently discussed. The phenomenological approach advocates considering experiences as being unique.

Demonstration of Behaviours, Thoughts and Emotions Affiliated with Eating Disorders

A third finding that this study reveals is the fact that, all of the participants demonstrate some behaviours or cognitions, in all common themes, that have been affiliated with eating disorders, as demonstrated by the available literature. For example,

participants cited feelings such as guilt, depression, and hurt. These feelings are consistent with those discussed in the literature, which indicates that women with eating disorders express such feelings (Snyder, 1997). All participants expressed their experiences with eating and described habits that would be considered indicative of possible eating issues. These behaviours, which include skipping meals, limiting carbohydrates and taking Ephedrine to decrease appetite, have all been discussed at great length within the literature (e.g. Pipher, 2001). The same may be said of the statements made by participants indicating that they believe that people are never satisfied and always want to improve themselves. Such thoughts and perceptions are common among women with eating disorders given the strong presence of perfectionism traits (Vohs, Bardone, Joiner, Abramson & Heatherton, 1999). The data pertaining to friends, family and their social circles is also consistent with data collected by other researchers in the field of eating disorders in that women spoke at great length about their mom's and girlfriends. Similar findings were attained by: 1) Haworth-Hoeppner (2000) who discussed impact mother's eating attitudes and beliefs have on their daughters, and 2) Fabian and Thompson (1989) who discusses the role peers and teasing have in the development of eating disorders. Additionally, Sharpe, Ryst, Hinshaw and Steiner (1997) discusses the influence daily stress has on the possible development of eating disorders. Such information is reflective of the collected data, which detailed the amount of stress participants were feeling in regards to the various school assignments and exams. The same may also be said of the stress related to living away from home and/ or in regards to roommates.

The data provided by the participants, as indicated by the thematic analyses, has contributed to the identification of various behaviours, thoughts and beliefs that may be considered as red flags in their at-risk assessment. Interestingly, this acknowledgement was not provided by the quantitative questionnaires that were used in the first phase, which merely indicated that the women had not reached clinical eating disorder thresholds. For example, all women were categorized as being "non-eating–disordered" according to the Q-EDD. The behaviours, thoughts and emotions discussed by the participants, however, leads one to question whether or not such a quantitative assessment is able to gather all important facts in the assessment of women at risk. This finding supports the use of the phenomenological approach in the data collection process, which was able to retrieve this vital information. An additional suggestion is that there are limitations to the use of some quantitative questionnaires. This notion was put forth by Bryman (1988), which stated that various methodologies are appropriate for various research problems and that it is the latter that ought to determine the methodology used. Specifically, these findings lend support for the use of qualitative methodologies, in a field that is predominantly clinical and quantitative.

Conclusion and Recommendations

The unique feature of the present study was the use of a health perspective to gain a better understanding of the daily experience of women at risk for developing an eating disorder. The results indicate that multiple areas of a woman's life are involved when she is at risk for developing an eating disorder. The use of integrator and common themes enabled the categorization and summary of a vast amount of detailed data pertaining to the everyday experiences. While the details of these experiences prove to be unique from

participant to participant, it is evident that many behaviours are consistent with those represented within the eating disorder literature. Additionally, the importance that is attributed to each of these themes is individual from participant to participant. Despite this individuality, however, results highlight the need to consider multiple aspects of a young woman's life given that the interaction between these aspects impacts on the experiences of being at risk. The detailed data obtained from the different aspects of life emphasizes the richness of the information collected using the phenomenological approach.

From a research perspective, it is believed that the present study highlights the value of a phenomenological approach in gathering rich, detailed data. Further supported is the use of a mixed methodology, particularly given that qualitative research can compensate and obtain information that may sometimes be overlooked by quantitative-only methods. Unfortunately quantitative questionnaires are designed to ask specific questions that can limit the scope of investigation, whereas qualitative methodology obtains a tremendous depth and richness of information.

Recommendations

It is believed that future studies ought to observe the results of this study in the conceptualisation of their research given that the present discussion focuses on the notion that aspects of a woman's life ought not be looked at in isolation, but rather in conjunction with all other aspects. It is a global perspective that will enable research to attain a more comprehensive understanding of the issues at hand. Such knowledge is crucial to the development and improvement of treatment programs. For example, future prevention programs may wish to base their structure on information gathered using

phenomenological assessments. This would ensure that a thorough understanding of all aspects involved in being at risk of developing an eating disorder are accounted for and addressed.

With regards to research, it is suggested that future investigations incorporate both aspects of qualitative and quantitative methodologies. Such mixed methodology provides relief from shortcomings that may arise as a result of using a one methodology or the other.

Should other qualitative investigations focusing on experiences be conducted, it may prove to be useful to investigate the impact such a process has on the participating women. Are there any therapeutic advantages? Do they learn anything about themselves or their environment? Do women's perspectives of media messages alter? Are any of their behaviours, thoughts or emotions transformed? Furthermore, the notion of experience ought also be used to investigate what prevents one at-risk woman from developing an eating disorder, compared to an at-risk woman who does develop an eating disorder. Specifically, how are their experiences different and/or similar?

Regardless of the approach taken with future studies, the present results indicate that additional studies ought to be conducted using a variety of methodologies and approaches and that the knowledge gained will contribute to the development and improvement of preventative programs.

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Table 1: Quantitative Data for Phase 1 Participants (n=18, excluding phase 2 participants)

	mean	range
Age (years)	19.1	18-22
Present BMI	22.1	17.3-29.18
Desired BMI	20.9	15.8-24.3
SPAS	34.7	15-49
EAT-26	52.8	37-76

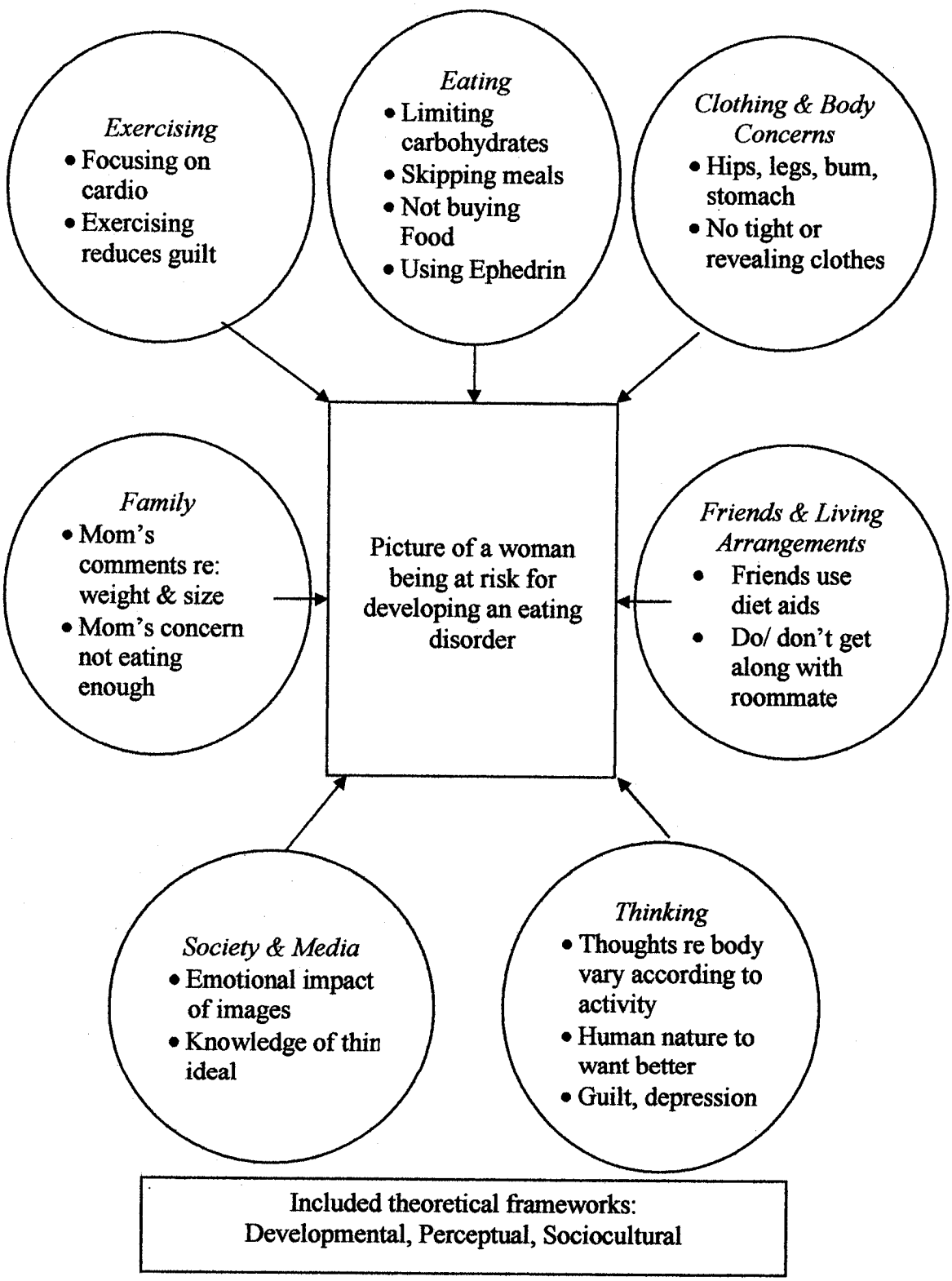
Table 2: Quantitative Data for Phase 2 Participants (n=4)

	Participant A	Participant B	Participant C	Participant D	mean
Age (years)	20	19	19	19	19.3
Present BMI	27.30	22.78	22.78	21.52	23.6
Desired BMI	22.75	21.06	21.21	20.42	21.4
SPAS	42	40	43	38	42.0
EAT-26	70	72	64	93	74.8
Q-EDD*	NED asymptomatic	NED asymptomatic	NED asymptomatic	NED symptomatic	

*NED: non-eating disordered

Figure Caption

Figure 1. Common themes experienced by women at risk for developing an eating disorder


Exercising
• Focusing on cardio
• Exercising reduces guilt
Eating
• Limiting carbohydrates
• Skipping meals
• Not buying Food
• Using Ephedrin
Clothing & Body Concerns
• Hips, legs, bum, stomach
• No tight or revealing clothes
Family
• Mom's comments re: weight & size
• Mom's concern not eating enough
Picture of a woman being at risk for developing an eating disorder
Friends & Living Arrangements
• Friends use diet aids
• Do/ don't get along with roommate
Society & Media
• Emotional impact of images
• Knowledge of thin ideal
Thinking
• Thoughts re body vary according to activity
• Human nature to want better
• Guilt, depression
Included theoretical frameworks:
Developmental, Perceptual, Sociocultural

Running Head: HEALTH PERSPECTIVE OF EATING DISORDERS

Being at Risk for Developing an Eating Disorder, from a Health Perspective

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Abstract

Eating disorder literature demonstrates that most studies are conducted with quantitative methodology. While few qualitative studies are available, none are specifically aimed at gaining a deep understanding of the experience of being at-risk, information that is crucial to the prevention of eating disorders. The present study investigates such experiences using both methodologies. Four undergraduate university women were identified as being at risk using three quantitative questionnaires. Four qualitative interviews were conducted with each participant, using a phenomenological approach. The focus of these interviews was gaining an appreciation of the experiences of the participant. Using the Wellness Model (Donatelle, Davis, Munroe, & Munroe, 2001) to organize the information collected, results demonstrated that all dimensions of a woman's life are affected when she is at risk for developing an eating disorder. Findings suggest that qualitative data may be useful for identifying "red flags" with regards to at risk women. Implications for the need for treatments to address all these dimensions are discussed.

Being at Risk for Developing an Eating Disorder, From a Health Perspective

Eating disorders, as is seen by available literature, are usually investigated using a clinical and/or quantitative approach, regardless of the specific focus within this large domain. Unfortunately, despite this vast amount of research, women continue torture themselves in the hopes of attaining the unattainable – the unreasonable and thus can suffer both physically and mentally (Tomori & Rus-Makovec, 2000). This is, in part, due to the fact that society is constantly bombarded with images of culturally determined "beauty", body shape and size (Fallon, 1990). As such, one must question if the knowledge we have gained so far has captured all the issues involved in the development of eating disorders. It is believed that further research must be conducted to attain a better understanding of this health problem.

Investigating all of the dimensions of a person's life that are affected by being at-risk for developing eating disorders is of prime importance to the prevention of such maladies. As such, the present study specifically investigates, "What are the experiences of women at risk for developing an eating disorder?" Attaining a better knowledge of the daily experiences of at-risk women may give a better understanding of the possible forces that drive these women to develop eating disorders, or impede them from attaining clinical levels (Sharpe, Ryst, Hinshaw, & Steiner, 1997). This study investigates these experiences using broad open-ended questions in order to allow the participants to explain their experiences in the way that is most representative to what they are living on a daily basis.

The present study also identifies the value of qualitative methodology in order to gain a deep, profound appreciation of the life experiences had by these women. The use

of a health perspective will allow the identification of, not only behaviours that put the women at risk, but also the healthy behaviours that have kept them, thus far, from developing an eating disorder. As such, the use of a health perspective will allow a complete understanding of all of the dimensions involved in being a woman at-risk for developing an eating disorder.

Literature Review

A recent paper has discussed the value of eating disorders being studied by researchers from other fields (Austin, 2000). Austin suggests that since the aetiology of eating disorders has origins within various fields, e.g., sociology, history, women's studies, biology, anthropology, health, etc., researchers of various backgrounds should come together in the investigation process. It is this reasoning that drives the present study.

Risk factor studies

A variety of studies have investigated factors that place women at greater risk for developing an eating disorder. These have often focused on demographic factors (e.g. as age, gender, socio-economic status and ethnicity) as well as personal attributes.

Age. Women of various ages are at risk for developing an eating disorder. This is seen by the fact that available studies discussing the presence of eating disorders in young girls (Fabian & Thompson,1989) versus adolescents (Wardle & Marsland, 1990; Button, Loan, Davies, & Sonuga-Barke, 1997) versus adults (Fairburn, Cooper, Doll, Norman, & O'Connor, 2000). When one looks at the literature on eating disorders, it is seen that the research pertaining to adolescents investigates developmental issues, such as puberty and

maturation. Studies focusing on adult populations, however, focus more on issues of perception and socialization.

While women are at risk for developing eating disorders at any age, most studies indicate that the ages of 16 and 17 are the most at-risk (Wakeling, 1996). The present study wished to examine women who are between the ages of 18-24, however, given that for women entering university, this time of life is filled with a vast number of changes. As is indicated in the literature, a factor that contributes to being at risk is being in a life stage that encompasses a lot of change and instability (Sharpe, Ryst, Hinshaw, & Steiner, 1997).

Gender. Thompson (1996) provides a thorough review of studies and indicates that eating disorders were more prevalent among women, as compared to men. An example of such a study is Serdula, et al. (1993). Cook, Reiley, Stallsmith, and Bray Garretson (1991) also studied the frequency of eating concerns among men and women. This study took place at two Christian colleges and two non-sectarian colleges. Results indicated that women had significantly greater eating concerns compared to men, who had a degree of concern much higher than that indicated in the literature. Men's concerns, however, were more so in regards to the desire to gain weight.

Socio-economic status. Slater, Guthrie, & Boyd (2001) indicate that most adolescent girls that are affected by this are of middle or upper-middle class families. This is not, however, to imply that girls of other socio-economic classes are not affected, given that other studies would contradict such findings. Wakeling (1996) provides a suitable review of literature discussing various findings regarding socio-economic status and its relationship with eating disorders.

Ethnicity. Rucker and Cash (1992) indicate that eating disorders are more prevalent among Caucasians versus other ethnicities. Thompson (1996) also stated that Caucasian females are at relatively greater risk than any other ethnicity. This report is followed up, however, by another statement indicating that other studies (e.g. Pumariega, Gustavson, Gustavson, Motes, & Ayers, 1994) have found African American women to be at equal risk as Caucasian women. This is consistent with Serdula et al. (1993), which indicated that women's trying to lose weight is comparable across "Hispanic", "Black", "Caucasian" and "other" races.

Personal attributes. A variety of personal attributes have also been identified as either impeding or contributing to the development of eating disorders. For example, a woman's ability to communication effectively (Blok, 2002), a woman's level of self-efficacy in refuting social thin-idealization messages (Cusumano & Thompson, 1997), and a woman's level of social support (Melrose, 2000) all contribute to the likelihood of her overcoming the pressures to be thin.

While these different studies investigated various risk factors linked to the appearance of eating disorders, one thing remains common. Most literature readily recognizes the role that societal representations of beauty and thinness play in the existence of this health problem. As such, one can ask where does "being-at-risk" of developing an eating disorder lie on a illness-to-wellness continuum? Where would those "at risk" be situated between adopting behaviours to reach the ideal representation of beauty & thinness, and adopting health habits?

Health perspective literature

The use of a health perspective has been shown to have great benefits in the investigation of other domains, given that the emphasis is placed on healthy living habits. Such a perspective focuses on the behaviours that ought to be carried out, versus ones that should be avoided. Health Canada, for example, has released many publications in regards to the promotion of healthy life habits, whether they pertain to exercise (Health Canada, 1998) or nutrition (Health Canada, 1997). Other studies have investigated the understanding held by adolescents in regards to the difference between health and fitness (Beaudion, Mathias, & Frasier, 2003). Despite the known value of this approach, it is still absent from the literature addressing eating disorders. As such, it is believed that the use of the Wellness Model (Donatelle, et al., 2001) would accommodate such a gap, given that it presents the various dimensions of life as they pertain to health.

The Wellness Model (Donatelle, et al., 2001) was conceptualized following the definition of health put forth by the World Health Organization (WHO), in 1947. The WHO's mandate stipulated that health involved not just the absence of disease or infirmity, but rather complete physical, mental and social well-being (WHO, 1947). This definition was revolutionary in that it emphasized health as being more than just an absence of disease. Dubos (1968, p.15) expanded the definition to state, "Health involves social, emotional, intellectual, spiritual, and biological fitness on the part of the individual, which results from adaptations to the environment." This definition broadened health to more aspects of life and many components. From this, the term wellness came to exist, and although it is commonly used interchangeably with "health", the two are different. According to Donatelle, Davis, Munroe, & Munroe (2001),

wellness refers to the "...achievement of the highest level of health in each of several key dimensions." (p.3).

Donatelle, et al. (2001) elaborates on the six different dimensions, which are not mutually exclusive, in the following manner. **Physical** health refers to physical characteristics of the individual. Examples are sensory acuity, body functioning, body shape and size, ability to recuperate from sickness and disease. **Environmental** health encompasses the external environment and the individual's function in protecting, improving and preserving the environment. **Intellectual** health encompasses decision-making, the ability to grow from experience and learn. It also includes intellectual capabilities. **Emotional** health embodies feelings and the ability to express and control them appropriately. Examples of feelings include trust, love, self-efficacy, self-confidence, sadness, loneliness, and happiness. **Social** health addresses interactions with others, the ability to adapt to various social situations and have satisfying relationships. Finally, **spiritual** health is less restricted and definitive in its definition. It may include the belief in a superior being. It may also include one's ability to wonder about one's purpose or in life, one's role in the universe or one's experiences. It may also include one's feeling of unity with one's environment and with nature.

Although the Wellness Model is most commonly used by health organizations and fitness promotion programs, as of yet, to our knowledge, there are no known published eating disorders studies that have used the Wellness Model. It is believed that the Wellness Model (Donatelle, et al., 2001) is the most appropriate model for this study, given that it aptly illustrates the different dimensions of a person's life that can contribute to health and wellness. Consequently, it is believed that these dimensions will

encompass the different aspects of a young woman's life that may affect the development of an eating disorder. It is also believed that these dimensions will aid in highlighting certain aspects of a young woman's life that are not as healthy. As such, it may be said that the nature of the Wellness Model and its dimensions is ideal in fully exploring the experiences of a woman at risk of developing an eating disorder.

Exploring the experiences had by those at risk is an important line of questioning still needing to be addressed and is thus the focus of the present study. It is in further appreciating these everyday experiences that one may come closer to understanding how women at risk live their lives and how they are affected by being at risk. This study will be strongly guided by a global health perspective, which aims to not only include aspects related to the individual herself, but also those related to interpersonal, institutional, community and societal levels (U.S. Department of Health and Human Services, 1999). It is believed that this global health perspective will provide a more complete understanding of the experiences of at-risk women.

Methodology

This study had two phases. The first phase entailed administering quantitative questionnaires to first year university women in order to identify a sub-group of women who, according to the validated questionnaires, would be considered to be at risk for developing an eating disorder. The second phase consisted of conducting qualitative interviews with the women who were identified from the first phase. Interviews attained to gain better knowledge of their everyday experiences of being at risk.

Phase 1: Quantitative Questionnaire Phase

Participants

A "convenience" sampling of 22 women, aged 18-22 years, was used. The mean age of the sample was 19.1 years. Participants had a mean actual BMI of 22.3 and a mean desired BMI of 21.0. They were enrolled in first year courses such as math, psychology and sociology at the University of Ottawa. Each woman completed a consent form and three quantitative questionnaires.

Assessment Methods/ Questionnaires

Social physique anxiety (SPA) was evaluated using the SPAS: Social Physique Anxiety Scale (Hart, Leary, & Rejeski, 1989). The SPAS, a 12-item questionnaire using a 5-point Likert scale, measured the degree to which participants become anxious when their physique is observed or evaluated by others. In order to make a diagnostic differentiation in the participants' physical activity and dietary attitudes and behaviours, the Q-EDD: Questionnaire Eating Disorders (Mintz, O'Halloran, Mulholland, & Schneider, 1997) was administered. This questionnaire served to differentiate between "non-eating-disordered" and "eating disordered". The former category can be subdivided into asymptomatic and symptomatic. Participants for phase 2 needed to not have a "non-eating disordered" classification, either symptomatic or asymptomic. The Q-EDD is a self-report questionnaire that contains 50 questions.

The EAT-26: Eating Attitudes Test (Garner & Garfinkel, 1979), was also administered. It is a shortened version of the common EAT-40 (Garner & Garfinkel, 1979; Appendix G), having 26 items, all of which are answered using a 6-point Likert Scale. The EAT-26 is one of the most common measurements in the field of eating

disorders, in that it assesses participants' attitudes and behaviours characteristic of eating disorders. Admittedly one shortcoming in having used this measure with a non-clinical population is attributable to the fact that the scoring method that is described by Garner and Garfinkel (1979) does not account for non-clinical differentiation. As such, in the present study, the scoring method outlined by Wells, Coope, Gabb & Pears (1985) was used given that it does not collapse the non-anorexic response distribution.

These three questionnaires were specifically chosen given that they are known to assess characteristics known to characterize women at risk for developing eating disorders (Ostrow, 1996; Kay, 1996). The results from these three questionnaires were then used to identify four at-risk women to be examined in the second phase of this study, the qualitative interview phase.

Data Analysis

Each participant's multiple questionnaire scores were entered into a numerical spreadsheet. The results of each participant were then assessed to determine if they met the criteria to be eligible to take part in the second phase of the study. The first criteria, given that this study investigated women *at risk*, was that they be categorized as "non-eating-disordered (asymptomatic or symptomatic)" by the Q-EDD evaluation. The second criteria was that the young women had to attain a SPAS score of greater than 37. Such a score would put them above the mean of a non-clinical population, according to Hart, Leary and Rejeski (1989). The third criteria was that their EAT-26 score would have to be greater than 60. This score was determined according to the cut-off scores cited in Garner, Olmstead and Garner (1982) and the recommended scoring method for non-clinical populations suggested by Wells, et al. (1985).

Phase 2: Qualitative Interview Phase

The design of the present research was a multiple single case study using a phenomenological approach. The researcher performed "open-structured" interviews with each participant (n=4), during a two-month period. The advantage of using the phenomenological approach during the interviews is getting the "real story" and everyday life experiences of the participants.

All interviews started with casual conversation in order to break the ice and help the participant feel at ease. Once a rapport was established the participant was asked, "Have you recently either experienced an event or been particularly preoccupied by your eating habits, your weight or your body shape?" The broad nature of the question allowed many aspects to be investigated in a free and open manner. During the participants' discourses, additional questions were asked in order to assist the participant in elaborating on recent experiences. It is this variety that rendered the interaction unique and un-predetermined. An interview guide was available to outline a variety of possible questions that could be asked. In other words, interviews were guided by various possible questions, yet the participants were able to interpret them according to her experiences, her phenomenology.

While most of the questions asked during the interviews focused on the experiences of these women, questions were also asked in order to appreciate each participant's perception of the interviewing process and whether it was having an impact on them. Women were also asked to assess how much time a day, on average, they think about issues regarding food, their body shape/size, exercise, etc. Additionally, each participant was asked to give feedback and comment on various magazine articles.

Specifically, participants were given a magazine at the end of the second interview and asked to make notes on what they thought and how the felt; this was then discussed at the beginning of the third interview.

Each interview was audio-recorded in order to ensure maximal data retrieval. This allowed the researcher to review the interviews many times and collect as much data needed. A further benefit to the use of an audio recorder was to facilitate a more natural interaction between the interviewer and the interviewee. The latter might not otherwise be possible were the interviewer taking notes.

Data Analysis

The four interviews conducted with each of the participants were transcribed verbatim, for a total of 16 interviews. Then, statements that addressed the various situations that seem to be impacting moments in the daily lives of women at risk were identified. Examples of such situations are buying clothes, cooking her meal, encounters with men, etc. Once this information was attained, it was then classified into into six themes, in accordance with the six dimensions of the Wellness Model (Donatelle, et al., 2001), as previously described. This model aided in organizing the different aspects of a young woman's life that may affect the development of an eating disorder. These six dimensions thus allowed the full exploration of the experiences of a woman at risk of developing an eating disorder. Interrater reliability was conducted in that the researcher's supervisor independently coded results; this analysis was then compared to that of the principal researcher. Furthermore, intrarater reliability was carried out given that the principal researcher analyzed data at various repeated instances.

Results

Phase 1: Quantitative Questionnaires

In order to compare phase 1 and phase 2 participants, quantitative results were calculated for: a) the phase 1 population excluding those selected for phase 2 (n=18) and b) the phase 2 participants (n=4). These results are found in Tables 1 and 2, respectively.

Insert Table 1 about here

Insert Table 2 about here

It is interesting to note that the phase 2 participants' results for the SPAS and EAT-26 questionnaires were all greater than those of the phase 1 participants. All phase 2 participants had scores greater than the cut-off scores of 37 and 60 for the SPAS and EAT-26 questionnaires respectively. The Q-EDD indicated that all three of the four phase 2 participants were asymptomatic; the fourth was symptomatic. While some phase 1 participants had some scores above these cut-offs, they did not all reach the cut-off scores for *all three* measures, as the phase 2 participants did.

Phase 2: Qualitative Interviews

Qualitative data obtained from the interviews with each participant was analyzed and categorized according to the six dimensions of the Wellness Model (Donatelle, et. al., 2001) and is summarized in Figure 2. While the specific details of each participant's experiences were unique, each participant, in their narratives, raised issues that pertained

to each of the six dimensions of the Wellness Model. The following text will present the results of the participants in accordance with these six dimensions.

Emotional Dimension

During the interviews, the four participants cited a variety of emotions that resulted from experiences associated with being at risk for developing an eating disorder. Results indicated that there are emotions that are unique to each individual participant, as well as emotions that are common among them. For example, three of four participants expressed that they feel guilt, which was seen from participants' comments such as: "When I eat ice cream, I think about how Mom thinks I am fat and that I shouldn't eat it or should exercise more. I feel bad, guilty and embarrassed" (participant A); "I felt really guilty throughout class and felt like I should go dancing because of these chips and chocolate bar, even thought I pretty much hadn't eaten all day, other than a bagel" (participant B); "If I eat chocolate, then later I will eat less or better quality or exercise more. The odd time I won't and will just deal with feeling guilty" (participant D).

Unhappiness, hurt and depression were also common emotions that were cited among three of the four participants. "I am comfortable with my upper body, except my arms and shoulders – I am not happy about those" (participant B). Participant A said, "My mom's pressures to lose weight would hurt, despite mom not wording it in a 'mean' way" and "It is depressing to compare myself to the thin women on TV." As for participant C, she indicated, "I would say I am pretty unhappy with most of my body."

As previously mentioned, while participants expressed some common emotions, there were other emotions that were unique to each participant's experiences. For example, in the interviews conducted with Participant D, the concept of "feeling" was

discussed at great length in regards to feeling good about her body. Examples are, "I just think I would feel better if I lost a little bit of weight. It wouldn't affect the activities that I do or the clothes that I wear. I would just feel better, confidence mostly... emotionally." and "I don't know what my ideal body shape/size would feel like, but I think if I lose a couple pounds, I would feel better. My body proportions don't have an impact on how I feel physically. It is all psychological."

Another unique emotion that was cited was that of jealousy, as expressed by participant C's experiences. "I can get really jealous because my boyfriend has a lot of female friends. I have trust issues with my boyfriend because I always assumed that he would want somebody slimmer than me." Participant C also expressed the unique emotion of nervousness, as seen by her stating, "I get nervous when I think I have gained weight."

Physical dimension

With regards to the physical dimension of their experiences, all participants expressed their thoughts regarding their weight and/or body shape. For example, participant B indicated, "I have a 'ghetto booty' [larger bum]. I like my back, but I don't like having bare shoulders, I prefer to have straps to cut my shoulders." Whereas participant C commented on many more body parts, as well as her attitudes towards clothes:

> I have always hated the way I look in dresses because they don't hang right and I look bigger in them than I am. I don't wear tank tops because my arms are too big. I don't wear boat-necked shirts because they make

> my shoulders look too broad. I don't wear short skirts because of my legs. And I don't like showing off my stomach at all.

Participants also discussed various issues related to exercise and eating, which fall within the physical dimension. Participant D, being an avid exerciser, spoke at great lengths about how exercising makes her feel:

> I will do 20-30 minutes of cardio and then do abdominal work. Then sometimes I do a second cardio session. I know 45 minutes of cardio may be a lot, but I typically do 30 minutes on the elliptical. Sometimes I will get lazy on my second cardio session and only go for 20 minutes as opposed to 30 minutes.

In comparison, participant C's exercise involvement was less rigorous and routine, " I am bad at winter sports, so I pretty much wait for summer to come, at which time I swim. I haven't gone to the gym yet, but I would go if others went with me."

Eating habits were another subject that were accommodated by the physical dimension of analysis. As participant A explained:

> Fatty foods and junk foods are the main concerns. But I am also concerned about sweet foods and fried foods. Even big meals can make me feel down, so I will go exercise to feel better. There are also times, late at night, after the bars, that I will eat something greasy. The next day I think, 'Oh my God, what did I do?' and "I need to go exercise."

Participant A is also the only one of the four who indicated that she has used, and continues to use, diet aid products periodically. "I use diet pills every once in a while.

Maybe once or twice a week –tops. I have been taking Ephedrine on and off, so I will probably continue until the bottle is done."

Intellectual Dimension

Within this dimension, information pertained mostly to university courses, projects, assignments, exams and future career plans. All participants were from the faculty of Arts and studying a full course load. Their specializations, however, were different. For example, one participant's courses focused more on history and another in social sciences. Foreseen career choices for the participants included police work, teaching, and children's book author.

Participants were also asked to take notice of how much they thought about exercise, food, their body shape and/or size within a one or two-hour period. Results from this question indicated that participants think about these issues to varying amounts, as was indicated from participant A and D. Participant A explained:

> In a two-hour period, I thought about these things to a varying amount. It varied according to the stimulants in my environment. If other things distract me, then I don't tend to think about it as much as I do if I have nothing else on my mind. Like walking through a mall, there are mirrors I see myself in and other people's bodies that I compare myself to.

Whereas participant D stated, "The amount of time I think about body issues varies with what I am doing." Participant D also believed she thinks about such issues more than most people:

> I think it sucks that I have these worries and guilt about what I eat and how I exercise, compared to all other people who don't. But those people

> are either people with high metabolism who can eat whatever they want and not gain weight, or they eat what they want and they do gain weight. I would not be happy gaining weight like that.

Participant B viewed the amount to which she has thoughts regarding food, exercise and body in such a way:

> I think the thought of food is constant – always there. Thinking about these things is constant for me, like thinking about clothes or a job. I think about it when I am going to cook. It is a major factor in my life, but I think it should be because it is necessary to survival.

Social Dimension

The obtained data that was classified within the social dimension addressed various issues: family, friends/roommates, dating and cultural messages.

Family. All four participants were from families in which 1) the parents were still married, and 2) there were two other siblings. While the participants were similar in this regard, many other differences were revealed from the collected data. While participants discussed at great lengths their interactions with their mothers, not all participants had mothers who addressed eating and weight issues in supportive manners. For example, participant C recalled, "There are a few tops that my mom says I look 'pregnant' in, despite the fact that I like them. Sometimes I'll put one and recall my mom telling me that I look huge in it. People or my boyfriend are surprised to hear that my mom says things like that to me." Similarly, participant A recollected interactions with her mom:

> My mom's comments regarding weight and weight loss have an impact on me – whether encouraging or depressing. A painful memory remains

one in which my mom made a comment about my need to lose weight. My mom's comments from the past motivate me and keep me in check. But she should have known that those comments would be really upsetting. I think she should have known better.

Participant D's experiences with her mom, on the other hand, seem to have been more supportive, "Mom worries that I don't eat healthy, especially since my having been anaemic. And now that I am on my own, cooking and getting groceries, Mom mainly worries about my eating enough. She calls to ask what I have eaten."

Results regarding family illustrate the strong maternal interaction. Little mention was made regarding fathers. For example, participant A explained, "My dad is busy so he is not really around to have an influence on comments regarding my weight." She also went on to describe her siblings in the following manner, "My brothers sometimes make comments because they know I am self-conscious. Their intentions are not to be mean, but rather funny. They don't know that it upsets me a lot. I think if they know they would ease off." Meanwhile participant D's indicated, "One of my sisters doesn't say much to me about eating because I think she kind of understands. My other sister will make comments about my not eating enough, but not to the point where I get angry or frustrated."

Friends/roommate(s). Results indicate that not only do family members have an impact on participants' eating habits, but so do friends and roommates. Sometimes it is merely being aware and taking note of one's roommate's eating habits. Participant C described, "I have never actually seen her eat a meal. I don't actually think that she eats that often. I tell her how she should be eating. Maybe she doesn't need t a lot of food to

keep her going." Participant B's friends, on the other hand, are 'big eaters'. During an interview, she wondered, "I don' t know if my friends end up feeling guilty when they eat. Probably not my roommate." The impact roommate's eating habits have was clearly stated when Participant A explained:

> My roommates eating influences me a little in that sometimes if I see them eating something, I may think it looks good. The amount they eat also influence me. If I have cooked a big meal and someone is eating just something small, I feel big.

Participant A has also gone on diets with her friends, "Doing the diet with a friend is a motivation because if you cheat, they will know. I don't want my friend to think I am cheating. Seeing if we can lose weight on the diet is a motivation." The interest friends have in dieting is also seen by Participant D's comment, "Of my friends here and back home, 60-65% of them have problems or issues with regards to their bodies. I do consider this high, but it is especially scary considering how they actually look and how they want to look."

Dating. Three of the four participants were not romantically involved with any one at the time of the interviews. This situation seems fine by participant B and D, the latter of whom explained:

> There is a stigma for women who don't have a boyfriend, compared to vice-versa. I think it is almost seen that guys choose the girls. I don't personally have that stigma because I have made a choice. Dating is not my priority right now, but rather school is.

Participant A, on the other hand, made some comments that seem to suggest that she makes a connection between her physical size and dating:

> Weight concerns play a role in being able to get a date. Friends who are thinner do not have this problem. Weight also affects my courage to talk to a boy. I like to think that it is not just the thin women who get the men, but it is seems like it. Guys claim they date heavier women, but when you look, they are always with thin women.

Participant C does have a boyfriend and had this to say with regards to her experiences with him, in relation to her concerns regarding her shape:

> My boyfriend is always telling me that I don't look fat, but I always think that he is telling me this because he is expected to. I try to believe that that is what he actually thinks, but often I just think that he is saying it to get me to stop talking about the subject. But he tells me that he does really want me to feel better about myself. I try to believe him, but I can't just turn my whole life around and everything I have learned in the media, just because he says I look fine.

Cultural messages. At various points during the interview process, participants expressed their opinion regarding cultural messages concerning size. All of them agree that media encourages the thin-ideal. According to participant C, "You would think that magazines would want models to look like the majority of women so they could market to a range of women that actually exist. This all started with Twiggy, because before her, the hourglass figure was desired." Participant B, in looking at a magazine, remarked:

> In magazines, they put the ideal – to what you want to aspire. In seeing Jamie Lee Curtis like this – flab on the side, a love handle roll and large thighs that touch – it does not make me want to aspire to that. She portrays realism and in so doing, makes herself less attractive.

Spiritual Dimension

While participants may be able to recognize media images and messages, this has not necessarily had an impact on their beliefs and values regarding health, which were classified within the spiritual dimension. For example, participant C believed, "A girl could have great self-confidence and think she looks fine, but if she has a person in her life who she values and who tells her she can look better, I think she is at risk for developing an eating disorder... if the reason to change is there." Interestingly, participant C expressed a viewpoint that was also shared by two other participants in their individual interviews. Specifically participant C stated:

> I think anorexia may be caused by the simple fact that women lose weight and they look great, but inside they still think they can look better. I think that has a lot to do with the society we are in. It is always wanting to go further and further. You look great, but you want to look better.

Participant D's illustrates this viewpoint by saying:

> Given that I don't put a number on my goal, sometimes I wonder whether I would even realize I had attained my goal. At what point do you stop? I would like to think that I would know when to stop, but I am not quite sure I would, given that I have never been in that position. I would like to

> think that I would be able to recognize that enough is enough and slow down a little bit.

Participant B also shared a similar thought by explaining:

> I have bulimics and seen to what extremes they go to try and look like that model. So I know that it is unrealistic and I am never going to look like that. It is an aspect of our society, however, that we can work on ourselves and do anything we want to.

Environmental Dimension

Much of the information gathered pertaining to this dimension addresses the housing situations of the participants. Interviews revealed that all four participants lived away from home, three of which lived in university residence accommodations with a roommate. Two of the participants living in residence were finding this to be a positive experience. "I live in residence, which is really nice. I live with my best friend and we still get a long great," (participant A). "I live in residence with a roommate. We get along well. Living away from home was hard at first, but after a few weeks it was okay," (participant D). Unfortunately, participant C did not find her residence experience as enjoyable, "My roommate will be nice to my face, but then she will do things she knows I don't like. She had a big party at our place without forewarning. Because of these things that she does, I really dislike her, but I am trying really hard because I realize that we are very different." Participant B lived off-campus, "I live in walking distance to school with two roommates, whom I met through a friend from high school, who also lives with me." Again, the environmental dimension is one that highlights how each participant is unique.

Discussion

While the results of this study contain a lot of data and rich information, there are three main findings needing to be highlighted for an overall perspective.

All Dimensions of Wellness are Affected

The first finding is that, for women at risk for developing eating disorders, all dimensions of the Wellness Model interact with their being at risk. This is seen in the fact that all of the data gathered during the interviews can be classified according to the six dimensions of the Wellness Model (Donatelle, et al., 2001), as illustrated with Figure 1. This is extremely important information given that most researchers investigate one aspect of eating disorders at a time. For example, while some studies investigating eating disorders use a perceptual approach (e.g. Furnham & Atkins, 1997), others use a socio-cultural one (e.g. Cusumano & Thompson, 1997) or even a developmental approach (e.g. Fabian & Thompson, 1989). While these various approaches are valuable in targeting a specific aspect of eating disorders, they tend to overlook the value of the interactions that occur between all of the factors involved. The present study's use of the Wellness model has permitted a data collection process that captures all three theoretical frameworks. The social and environmental dimensions have encompassed the sociocultural framework. The intellectual and emotional dimensions have classified data that is similar to that found in developmental frameworks. The physical and spiritual dimensions are consistent with aspects researched using a perceptual framework.

Uniqueness of Experiences

The second finding, as illustrated in Figure 1, is the fact that while all of the dimensions of the participants' lives may be affected, their experiences are all very

unique and individual. Within the social dimension, for example, participant B discussed at great length her page friends and roommate, whereas participant A spent a great deal of time discussing her experiences with her mom's hurtful comments.

The uniqueness of experiences is further visible given that the different dimensions of Wellness have varying degrees of importance for each participant. For example, the extent to which participant C expressed data pertaining to the physical domain was less than participant B. Specifically, participant D spoke at great length about her workout routine (physical dimension), whereas participant C's experiences relative to her boyfriend (social dimension) were more prominently discussed, and thus important. Noteworthy is the fact that, during the analysis, data was sometimes difficult to classify given the overlapping nature of the dimensions. This was particularly true in regards to the spiritual and environmental dimensions. This could also be an indication, however, that these dimensions are not as prominent in the lives of these at risk women, or it could indicate that the dimensions are not all that precise with respect to classification purposes. Further investigation is needed with regards to these dimensions.

Demonstration of Behaviours, Thoughts and Emotions Affiliated with Eating Disorders

A third finding which this study reveals is the fact that, all of the participants demonstrate some behaviours or cognitions, in all dimensions of the Wellness Model, that have been affiliated with eating disorders, as demonstrated by the available literature. For example, within the emotional dimension, participants cited feelings such as guilty, depression, and hurt. These feelings are consistent with those discussed in the literature, which indicates that women with body image concerns express such feelings (Snyder,

1997). Within the physical dimension, all the participants expressed their experiences with eating and described habits that would be considered indicative of possible eating issues. These behaviours, which include skipping meals, limiting carbohydrates and taking Ephedrine to decrease appetite, have all been discussed at great length within the literature (e.g. Pipher, 2001). The same may be said of the spiritual dimension, which regrouped information indicating that participants believe that people are never satisfied and always want more. Such thoughts and perceptions are common among women with eating disorders given the strong presence of perfectionism traits (Vohs, Bardone, Joiner, Abramson & Heatherton, 1999). The social dimension is also consistent with data collected by other researchers in the field of eating disorders in that women spoke at great length about their mom's and girlfriends. Similar findings were attained by (Haworth-Hoeppner, 2000) who discusses impact mother's eating attitudes and beliefs have on their daughters and (Fabian & Thompson, 1989) who discusses the role peers and teasing have in the development of eating disorders. Additionally, Sharpe, Ryst, Hinshaw and Steiner (1997) discusses the influence daily stress has on the possible development of eating disorders. Such information is reflective of the data that was collected and classified according to the intellectual dimension, which detailed the amount of stress participants were feeling in regards to the various school assignments and exams. The same may also be said of the stress revealed within the environmental dimension, specifically that related to living away from home and/ or in regards to roommates.

The data provided by the participants, as indicated by the thematic analysis, reveals their experiences, and the analysis conducted with the Wellness model, have contributed to the identification of various behaviour and thought patterns that may be

considered as red flags in their at-risk assessment. Interestingly, this acknowledgement was not provided by the quantitative questionnaires that were used in the first phase, which merely indicated that the women had not reached clinical eating disorder thresholds.

Conclusion and Recommendations

With so many clinical and quantitative studies within the field of eating disorders, the unique features of the present study is the use of qualitative methodology and the focus on the experiences of women at risk for developing eating disorders.

The results indicate that multiple areas of a woman's life are involved when she is at risk for developing an eating disorder. The use of the dimensions of the Wellness Model enabled the categorisation and summary a vast amount of detailed data pertaining to the everyday experiences. While the details of these experiences prove to be unique from participant to participant, it is evident that many behaviours are consistent with those represented within the eating disorder literature. What the eating disorder literature fails to explain, but which the present results demonstrate, is that women at risk may be considered with in a large grey zone situated in between the illness-wellness continuum. This is specifically seen when appreciating their various thoughts, behaviours and emotions. Many of these fall close to the illness end of the illness-wellness continuum, however, these women also demonstrate thoughts, behaviours and emotions which may be considered fairly healthy. As such, it is imperative that the community investigating eating disorders be weary of being short-sighted in their consideration of at-risk behaviour, thoughts and emotions. Taken further, it is believed that eating disorder researchers and therapists might also take the time to evaluate those

thoughts, behaviours and emotions which are considered healthy in order to strengthen and reinforce the positive aspects demonstrated by at-risk individuals.

From a research perspective, it is believed that the present study highlights the value of a mixed methodology, particularly given that qualitative research can compensate and attain information that may sometimes be overlooked by quantitative-only methods. Unfortunately quantitative questionnaires are designed to ask specific questions that can limit the scope of investigation, whereas qualitative methodology obtains a tremendous depth and richness of information.

Recommendations

It is believed that future studies ought to observe the results of this study in the conceptualisation of their research given that the present discussion focuses on the notion that aspects of a woman's life ought not be looked at in isolation, but rather in conjunction with all other aspects. It is a global perspective that will enable research to attain a more comprehensive understanding of the issues at hand. Such knowledge is crucial to the development and improvement of treatment programs. For example, future prevention programs may wish to base its structure on the dimensions of the Wellness model in order to ensure that all aspects involved in being at risk of developing an eating disorder are accounted for and addressed. Such a comprehensive organisation of themes may particularly be useful in the educational component of such a program. Other possible treatment programs might take a more positive approach and focus more on the importance of being healthy as opposed the negativity involved in being thin.

With regards to research, it is suggested that future investigations incorporate both aspects of qualitative and quantitative methodologies. Such mixed methodology provides

relief from shortcomings that may arise as a result of using a one methodology or the other.

Should other qualitative investigations focusing on experiences be conducted, it may prove to be useful to investigate the impact such a process has on the participating women. Are there any therapeutic advantages? Do they learn anything about themselves or their environment? Do women's perspectives of media messages alter? Are any of their behaviours, thoughts or emotions transformed? Furthermore, the notion of experience ought also be used to investigate what prevents one at-risk woman from developing an eating disorder, compared to an at-risk woman who does develop an eating disorder. Specifically, how are their experiences different and/or similar?

Regardless of the approach taken with future studies, the present results indicate that additional studies ought to be conducted using a variety of methodologies and that the knowledge gained will contribute to the development and improvement of preventative programs.

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Table 1: Quantitative Data for Phase 1 Participants (n=18, excluding phase 2 participants)

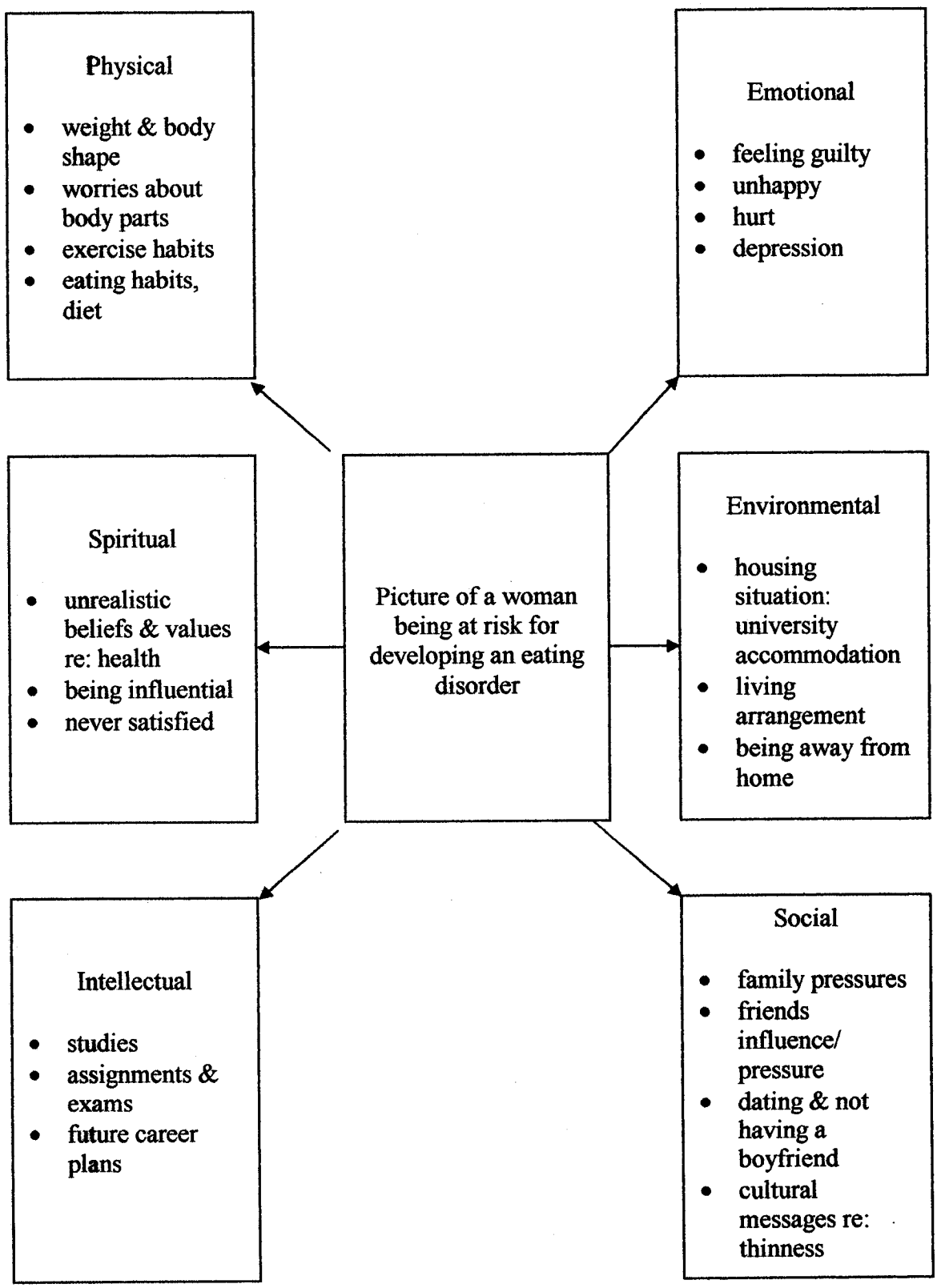
	mean	range
Age (years)	19.1	18-22
Present BMI	22.1	17.3-29.18
Desired BMI	20.9	15.8-24.3
SPAS	34.7	15-49
EAT-26	52.8	37-76

Table 2: Quantitative Data for Phase 2 Participants (n=4)

	Participant A	Participant B	Participant C	Participant D	mean
Age (years)	20	19	19	19	19.3
Present BMI	27.30	22.78	22.78	21.52	23.6
Desired BMI	22.75	21.06	21.21	20.42	21.4
SPAS	42	40	43	38	42.0
EAT-26	70	72	64	93	74.8
Q-EDD	NED asymptomatic	NED asymptomatic	NED asymptomatic	NED symptomatic	

*NED: non-eating disordered

Figure 1. Common facets of being at risk for developing an eating disorder, expressed by participants, in relation to the six dimensions of wellness.


Physical
• weight & body shape
• worries about body parts
• exercise habits
• eating habits, diet
Emotional
• feeling guilty
• unhappy
• hurt
• depression
Spiritual
• unrealistic beliefs & values re: health
• being influential
• never satisfied
Picture of a woman being at risk for developing an eating disorder
Environmental
• housing situation: university accommodation
• living arrangement
• being away from home
Intellectual
• studies
• assignments & exams
• future career plans
Social
• family pressures
• friends influence/ pressure
• dating & not having a boyfriend
• cultural messages re: thinness

PART III:

DISCUSSION AND CONCLUSION OF THE ARTICLES

CHAPTER VI

DISCUSSION

While the results of this study contain a lot of data and rich information, there are three main findings needing to be highlighted for an overall perspective. Interestingly, these three main findings were found to be true using both methods of analysis: the integrator theme analysis and the Wellness Model analysis. This indicates that while the two methods of analysis may have been slightly different, the findings of this study remain the same, and thus further supported. The following three principal findings, are illustrated and summarized in Table 2 (Appendix H), using the common themes, and Table 3 (Appendix I), using the Wellness Model dimensions.

All Areas of Life/ Dimensions of Wellness are Affected

Results indicate that, for women at risk for developing eating disorders, all areas of life/ dimensions of the Wellness Model interact with their state of being at risk. The integrator theme analysis, which led to the creation of common themes, illustrated that there are many common themes that are affected by being at risk of developing an eating disorder. When one looks at these common themes, it is seen that they encompass all areas of life: exercise, eating, friends, clothing, thinking, living arrangements, family, society & media.

The same can be said in regards to the analysis performed using the Wellness Model (Donatelle, et al., 2001), which details six dimensions of life needing to be considered in the quest for wellness. Given that 1) the Wellness Model (Donatelle, et al., 2001) presents such a comprehensive representation of wellness and 2) it was possible to

categorize all data using all six dimensions, the results indicate that all dimensions of wellness are affected when a woman is at risk of developing an eating disorder.

This finding is of great consequence given that most researchers investigate one aspect of eating disorders at a time. For example, while some studies investigating eating disorders use a perceptual approach (e.g. Furnham & Atkins, 1997), others use a socio-cultural one (e.g. Cusumano & Thompson, 1997) or even a developmental approach (e.g. Fabian & Thompson, 1989). While these various approaches are valuable in targeting a specific aspect of eating disorders, they tend to overlook the value of the interactions that occur between all of the aspects involved. The present study's use of common themes and the Wellness Model has permitted a data collection process that captures all three theoretical frameworks. The common themes "society and media" and "friends/ living arrangements", and two Wellness Model dimensions (social and environmental) have encompassed the sociocultural framework. The intellectual and emotional Wellness Model dimensions have classified data that is similar to that which is found in developmental frameworks, just as have the "thinking" and "family" common themes. The physical and spiritual Wellness Model dimensions are consistent with aspects researched using a perceptual framework, as are the "exercise" and "eating" common themes.

Uniqueness of Experiences

Another finding revealed by the results of this study is that, while all of the dimensions of the participants' lives may be affected, their experiences are all very unique and individual. An example of this may be seen by the data within the "eating" common theme and physical dimension. Participant B discussed at great length her

ability to go days without eating if she wanted to lose weight quickly, and used to do so for ballet. This is in contrast to participant A, who spent a great deal of time discussing her first month at university, at which time she barely ate anything due to a very busy school beginning. While these examples are quite different in their details and specifics, both deal illustrate the experiences had by participants A and B within the "eating" common theme and physical dimension of the Wellness Model.

The uniqueness of the experiences is further supported by the fact that different common themes and dimensions of the Wellness Model have varying degrees of importance for each participant. The attributed importance is related to the extent to which experiences were discussed. For example, the extent to which participant C expressed data pertaining to the physical domain was less than participant D. Specifically, participant D spoke at great length about her workout routine ("exercise" common theme, physical dimension), whereas participant C's experiences relative to her boyfriend ("friend" common theme, social dimension) were more prominently discussed, and thus important.

Demonstration of Behaviours, Thoughts and Emotions Affiliated with Eating Disorders

A third finding that this study reveals is the fact that, all of the participants demonstrate some behaviours or cognitions, in all common themes and dimensions of the Wellness Model, that have been affiliated with eating disorders, as demonstrated by the available literature. For example, participants cited feelings such as guilt, depression, and hurt. These feelings are consistent with those discussed in the literature, which indicates that women with eating disorders express such feelings (Snyder, 1997). All participants

expressed their experiences with eating and described habits that would be considered indicative of possible eating issues. These behaviours, which include skipping meals, limiting carbohydrates and taking Ephedrine to decrease appetite, have all been discussed at great length within the literature (e.g. Pipher, 2001). The same may be said of the statements made by participants indicating that they believe that people are never satisfied and always want more. Such thoughts and perceptions are common among women with eating disorders given the strong presence of perfectionism traits (Vohs, Bardone, Joiner, Abramson & Heatherton, 1999). The data pertaining to friends, family and their social circles is also consistent with data collected by other researchers in the field of eating disorders in that women spoke at great length about their mom's and girlfriends. Similar findings were attained by (Haworth-Hoeppner, 2000) who discusses impact mother's eating attitudes and beliefs have on their daughters and (Fabian & Thompson, 1989) who discusses the role peers and teasing have in the development of eating disorders. Additionally, Sharpe, Ryst, Hinshaw and Steiner (1997) discusses the influence daily stress has on the possible development of eating disorders. Such information is reflective of the collected data, which detailed the amount of stress participants were feeling in regards to the various school assignments and exams. The same may also be said of the stress related to living away from home and/ or in regards to roommates.

The data provided by the participants, as indicated by the thematic and Wellness Model analyses, have contributed to the identification of various behaviours, thoughts and beliefs that may be considered as red flags in their at-risk assessment. Interestingly, this acknowledgement was not provided by the quantitative questionnaires that were used

in the first phase, which merely indicated that the women had not reached clinical eating disorder thresholds. For example, with the exception of participant D, all actual BMI values of the phase two participants were greater than those of the women identified as not being at risk. This consequently puts into uncertainty the value of using a low BMI as an indicator of risk. One may even go so far as to question, or hypothesize, whether or not a high BMI is more related to at risk behaviours, thoughts and emotions, as is evidenced by the present results. Regardless, this principal finding supports the notion, as put forth by Bryman (1988), that various methodologies are appropriate for various research problems and that it is the latter that ought to determine the methodology used. Specifically, these findings lend support for the use of qualitative methodologies, in a field that is predominantly clinical and quantitative.

In terms of the utility of the Wellness Model for analysis purposes, it should be noted that sometimes it was difficult to classify given the overlapping nature of the dimensions. This was particularly true in regards to the spiritual and environmental dimensions. This could also be an indication, however, that these dimensions are not as prominent in the lives of these at risk women, or it could indicate that the dimensions are not all that precise with respect to classification purposes. Further investigation is needed with regards to these dimensions. Regardless, the Wellness Model has been useful in the identification of possible "red flags" with regards to assessment.

CHAPTER VII

CONCLUSION, RECOMMENDATIONS AND RESEARCHER REFLECTIONS

With so many clinical and quantitative studies within the field of eating disorders, the unique features of the present study is the use of qualitative methodology and the focus on the experiences of women at risk for developing eating disorders. The results indicate multiple areas of a woman's life are involved when she is at risk for developing an eating disorder. The use of common themes and the dimensions of the Wellness Model enabled the categorisation and summary a vast amount of detailed data pertaining to the everyday experiences. While the details of these experiences prove to be unique from participant to participant, it is evident that many behaviours, thoughts and beliefs are consistent with those represented within the eating disorder literature. Additionally, the importance that is attributed to each of these themes and dimensions is individual from participant to participant. Despite this individuality, however, results highlight the need to consider multiple aspects of a young woman's life given that the interaction between these aspects impacts on the experiences of being at risk.

From a research perspective, it is believed that the present study highlights the value of a mixed methodology, particularly given that qualitative research can compensate for and obtain information that may sometimes be overlooked by quantitative-only methods. Unfortunately, quantitative questionnaires are designed to ask specific questions that can limit the scope of investigation, whereas qualitative methodology obtains a tremendous depth and richness of information. This being said, however, qualitative methodologies are sometimes limited in their transferability of findings. Also known as specificity, qualitative results tend to be applicable to particular

groups, contexts or settings. For example, this study's results are relevant to university undergraduate women aged 18-24 who are at risk for developing an eating disorder. There is hope that perhaps some of the methodological issues can be applied to interviews with at-risk women of different age groups and contexts. Regardless, the challenge of transferability of qualitative data could thus be counterbalanced using quantitative methods within a mixed methodology.

Other methodological considerations within qualitative research are neutrality, credibility, and trustworthiness. Neutrality, the researcher being aware of their perspective in order to minimise bias during analysis, was difficult to maintain given that the researcher had to continually work to see the data from an objective viewpoint. Neutrality was assisted through the discussions the principal researcher had with her supervisor, who had no contact with the participants.

Credibility, the notion that there is a correspondence between how well the research conveys the viewpoint of the informants, was executed by a variety of means. There was prolonged engagement with the participants in that these young women were interviewed over a period of time. Consequently a great amount of data was collected, thereby contributing to credibility. Furthermore, during the last interview, the interviewer transcriptions of previous interviews with the participant were reviewed, thus ensuring that the transcripts were correct.

Recommendations

It is believed that future studies ought to observe the results of this study in the conceptualisation of their research, given that the present discussion focuses on the notion that aspects of a woman's life ought not be looked at in isolation, but rather in

conjunction with all other aspects. It is a global perspective that will enable research to attain a more comprehensive understanding of the issues at hand. Such knowledge is crucial to the development and improvement of treatment programs. For example, future prevention programs may wish to base its structure on the dimensions of the Wellness model in order to ensure that all aspects involved in being at risk of developing an eating disorder are accounted for and addressed. Such a comprehensive organisation of themes may particularly be useful in the educational component of such a program.

With regards to research, it is suggested that future investigations incorporate both aspects of qualitative and quantitative methodologies. Such mixed methodology provides relief from shortcomings that may arise as a result of using a one methodology or the other.

Should other qualitative investigations focusing on experiences be conducted, it may prove to be useful to investigate the impact such a process has on the participating women. Are there any therapeutic advantages? Do they learn anything about themselves or their environment? Do women's perspectives of media messages alter? Are any of their behaviours or thoughts transformed? Furthermore, the notion of experience ought also be used to investigate what prevents one at-risk woman from developing an eating disorder, compared to an at-risk woman who does develop an eating disorder. Specifically, how are their experiences different and/or similar?

Regardless of the approach taken with future studies, the present results indicate that additional studies ought to be conducted using a variety of methodologies and that the knowledge gained will contribute to the development and improvement of preventative programs.

Researcher Reflections

Over the course of a student's career, it is very likely to become involved in research. Often this contribution to science is either done as a participant or as an assistant to a researcher. When a student embarks on the journey of conducting his or her own research, however, the adventures, challenges and benefits are very different. In the hopes of assisting any students planning to perform their own research, I have put together a few comments regarding the challenges, lessons learned and joys I have experienced in undertaking my thesis research.

While I have never been a person who keeps a journal, per se, my supervisor's suggestion to keep a journal of notes, thoughts, questions and concerns was a wise one. In doing so, this research tool assisted me in being organized. Furthermore, the use of a journal allows you to revisit the progress and decisions you have made in order to ensure the development of your thesis is consistent with various concerns and issues raised in previous stages. I also found that the use of a journal was a great place to keep notes regarding each interview I had with each participant. A journal format is particularly appropriate for this information given that you do not want confidential information floating around slips of paper.

The interview process I had with the four participants of my study was an exciting yet delicate stage. While I was very keen to learn of the experiences these young women had, it was also important to demonstrate professionalism and sincerity. The repeated nature of the interviews was quite special in that it allowed me to develop a familiarity and ease with the participants, which I believe assisted them in opening up. I think it also

helped that we were close enough in age that we could relate to similar things and understand various sayings common to our age population.

While my open and forthcoming interactions with these young women proved to be beneficial with regards to the data collection process, the analysis process seemed to be slightly challenged. Specifically, I found myself seeing their experiences through their eyes and, at times, losing objectivity. Given that none of these women, when asked, believed that they were at risk for developing eating disorders, I started to question how well I had selected my participants for the second phase of my study. It is at this point that I found my supervisor's objectivity and guidance to be most useful. Given that she was only seeing the interview transcripts, she saw the statements objectively and plainly. Our multiple discussions thus helped diminish my subjectivity and increase my impartiality, a perspective that was crucial in carrying out analyses with neutrality. It must be said that my supervisor, as a human being, also has her own biases. Having performed qualitative research for many, many years, however, she is a very skilled and objective analyst. Furthermore, objectivity and reliability were attained using two strategies. Interrater reliability was conducted in that the researcher's supervisor independently coded results; this analysis was then compared to that of the principal researcher. Secondly, intrarater reliability was carried out given that the principal researcher analyzed data at various repeated instances.

The analysis process did prove to be a challenge given that it is a more arduous process than analysing quantitative data with a statistical program, as I had been used to. The qualitative analysis I performed, at times, seemed less clear-cut and black and white than I am used to. In part, I believe this is due to the overlapping nature of the Wellness

Model dimensions. Given that I also conducted an analysis using specific integrator themes and found the same thing, however, I believe that perhaps the qualitative methodology itself is less definite than quantitative. It is for this reason that I believe the inter- and intrarater reliability checks that were carried out were so crucial in minimizing this aspect. Consequently, the qualitative results obtained in the second phase of this study were able to demonstrate how quantitative methods can overlook some crucial aspects. I never suspected that I would obtain the results that I did. It is only in conferring with my supervisor that the difference in results obtained with qualitative methodology versus quantitative methodology became clear. This is especially true in regards to my suggestion that the BMI is questionable in its reliability and that a thematic analysis provides "red flags" in the assessment of at-risk women. As such, it may be said that it was in writing the discussion and conclusion of this thesis that such knowledge was attained.

The writing of the thesis report did seem arduous. I won't deny it. It was a long process. I attribute this to the fact that the Results section was, according to departmental regulations, required to be written in the form of two publishable articles. Consequently, tremendous redundancy was noted given the strong use of the "cut and paste" function. Despite this, however, I do not know that I regret this format given that I do have intentions to publish these articles. For any student not intending to publish, the two-article format is not suggested.

Overall, I have no regrets, but instead I have tremendous satisfaction and pride. This is the first research I have conducted that has been my own and it is the first research project I have worked on for a period of two years. There were definitely times that I

interacted more with my computer than with humans, which illuminated the extent to which I enjoy working with others and missed such interactions. If asked, however, "Would you do it again?" I would answer, "Absolutely."

PART IV:

CONTRIBUTION OF COLLABORATORS

CHAPTER VIII

STATEMENT OF CONTRIBUTION OF COLLABORATORS

The proceeding document was developed and written solely by the author, Michelle Mathias. Dr. Charlotte Beaudoin, thesis supervisor, provided guidance in regards to conceptual, methodological and report-writing considerations.

PART V:

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Appendix A: Sample of Possible Interview Questions

Intellectual factors:

- Tell me about your present school situation (program, year, courses, interests).
- How are you finding school at the present time?
- Are there any particular concerns or excitements that come to mind either in the present past or future?
- What is the emotion that best represents your feeling towards school at the present time? Why?

Physical/physiological factors:

- What do you think of your physical health? What does it mean to you?
- Does exercise play a role in your life? If so, how?
- Tell me about how you view food and eating.
- How are you finding being responsible for your own eating habits now that you are no longer living at home?
- Do you find you have time to eat, given your school and life schedule?

Social Factors:

- Tell me about your relationships (family, friends, roommates, boyfriends, professors, employers, coaches)
- Do you have any relationship concerns?
- Is anything exciting happening at this time?
- Is there a particular relationship that occupies a lot of your thoughts?
- Who do you talk to when you get upset?
- What was eating like in your family?
- What is your perception of your parents' attitude towards physique and eating?

Emotional Factors:

- What kinds of concerns, worries occupy the majority of your time these days?
- What are the main joys that nurture your soul?
- Are there any prominent emotions you wish to discuss or express?
- How would you describe the state you are in these days (positive, muddled, cloudy, clear, energized, future-focused, present-focused)

Environmental Factors:

- Do you ever think about what other people think of you? If so, what do you think they think?
- Do you have any issues or concerns regarding clothes?
- What do you like about your clothes?
- Do you ever look at magazines? If so, which ones? Why do you look at them? What do you like/dislike about them?
- Do you watch TV? If so, which programs do you watch and why? What do you think of the programs that you watch?
- Do you have any role models from the media?

Spiritual Factors:

- What do you think it means to be a spiritual person? Do you think you are a spiritual person?
- Do you have any activities that you do to soothe your soul?
- Do you have any particular strong beliefs that guide your life from day to day?
- Are there specific values, beliefs or morals with which you were raised? What role, if any, do these play in your life?

Appendix B: Table 1: Operationalisation of Concepts of Present Study

Table 1: Description of Operationalisation of Concepts of Present Study

	Concepts	Variables	Indicators
Phase 1 ▲ ⋮ ▼	*Women at risk for developing an eating disorder...*		*Quantitative Questionnaires* (numerical)* Purpose: to identify which women are at risk for developing an eating disorder
		social physique anxiety	**SPAS** (Hart, Leary, & Rejeski, 1989)
		physical activity and dietary attitudes and behaviours	**Q-EDD** (Mintz, O'Hallran, Mulholland, & Schneider, 1997);
		dietary attitudes and behaviours	**EAT** (Garner & Garfinkel, 1979)
Phase 2	What are their *experiences?*		*Qualitative Interviews/ case studies (nominal)* Purpose: posing questions related to the following themes:
		physical/physiological factors (involvement in physical activity, dietary concerns, eating habits)	• physical/physiological factors
		emotional factors: (concerns, worries, thoughts, emotions)	• emotional factors
		social factors (family, friends, roommates, boyfriends, professors, bosses, social standing, fitting in)	• social factors
		environmental factors (clothes issues, impact surroundings have on person)	• environmental factors
		intellectual factors (tests and/or projects of the past and or the future; grades; understanding of matter; academic/career goals)	• intellectual factors
		spiritual factors (morals, values, beliefs, matters of importance, soul)	• spiritual factors

Appendix C: Social Physique Anxiety Scale (SPAS)

SPAS

We are interested in obtaining your honest input concerning the questions that follow. All answers will remain anonymous and confidential. If you have any questions, feel free to ask the representative involved. The completion of this questionnaire implies your informed consent. We thank you in advance for your participation.

Sport: _____ Level: _____ # of years: _____
Age: _____ Gender: _____
Current weight: _____ Desired weight: _____ Height: _____

Using the scale below, please indicate in the spaces provided the degree to which the following statements are characteristic or true of you.

1	2	3	4	5
Not at all	**Slightly**	**Moderately**	**Very**	**Extremely**

1. I am comfortable with the appearance of my physique/figure. _____
2. I would never worry about wearing clothes that might make me look too thin or overweight. _____
3. I wish I wasn't so uptight about my physique/figure. _____
4. There are times when I am bothered by thoughts that other people are evaluating my weight or muscular development negatively. _____
5. When I look in the mirror I feel good about my physique/figure. _____
6. Unattractive features of my physique/figure make me nervous in certain social settings. _____
7. In the presence of others, I feel apprehensive about my physique/figure. _____
8. I am comfortable with how my body appears to others. _____
9. It would make me uncomfortable to know others were evaluating my physique/figure. _____
10. When it comes to displaying my physique/figure to others, I am a shy person. _____
11. I usually feel relaxed when it is obvious that others are looking at my physique/figure. _____
12. When in a bathing suit, I often feel nervous about the shape of my body. _____

Appendix D: Questionnaire Eating Disorders Diagnostic (Q-EDD)

Q-EDD

Please complete the following questions as honestly as possible. The questions refer to current behaviours and beliefs, meaning those that have occurred in the last 3 months.

Sex: (please check) ☐ male ☐ female

Age: _____

School/Occupational status: (please check)

☐ College Student please specify year: _____
☐ University Student please specify year: _____
☐ Employed please specify:_____

Race/ethnicity: (please check)

☐ Caucasian/ White
☐ African-American/ Black
☐ Hispanic/ Latino/ Mexican-American
☐ American Indian
☐ Asian American/ Pacific Islander
☐ Other: _____ (specify)

Present Height: _____
Present Weight:_____
I would like to weigh: _____

My body frame is: (please check) ☐ small ☐ medium ☐ large

1. Do you experience recurrent episodes of binge eating, meaning eating in a discrete period of time (e.g. within any 2 hour period) an amount of food that is definitely larger than most people would eat during a similar time period?

   ☐ **Yes** ☐ **No**

   If yes, continue to answer the following question

   If no, skip to question #4

2. Do you have a sense of lack of control during the binge eating episodes (i.e., the feeling that you cannot stop eating or control what or how much you are eating)?

   ☐ **Yes** ☐ **No**

3. Circle the answers within the 2 sets of **[bold brackets]** below that best fit for you:

   On average, I have had **[1, 2, 3, 4, 5, 6, more]** binge eating episodes a <u>WEEK</u> for at least **[1 month, 2 months, 3 months, 4 months, 5 months, 6-12 months, more than one year.**

4. Please check the appropriate responses below concerning things you may do **currently** to prevent weight gain. If you circle **YES** to any question, please indicate how often on the average you do this and how long you have been doing this.

a) Do you make yourself vomit to prevent weight gain? ☐ YES ☐ NO

How often do you do this?

☐ Daily ☐ Twice/week ☐ Once/week ☐ Once/month

How long have you been doing this?

☐ 1 month ☐ 2 months ☐ 3 months ☐ 4 months ☐ 5-11 months ☐ more than a year

b) Do you take laxatives? ☐ YES ☐ NO

How often do you do this?

☐ Daily ☐ Twice/week ☐ Once/week ☐ Once/month

How long have you been doing this?

☐ 1 month ☐ 2 months ☐ 3 months ☐ 4 months ☐ 5-11 months ☐ more than a year

c) Do you take diuretics (water pills) to prevent weight gain? ☐ YES ☐ NO

How often do you do this?

☐ Daily ☐ Twice/week ☐ Once/week ☐ Once/month

How long have you been doing this?

☐ 1 month ☐ 2 months ☐ 3 months ☐ 4 months ☐ 5-11 months ☐ more than a year

d) Do you fast (skip foods for 24 hours) to prevent weight gain? ☐ YES ☐ NO

How often do you do this?

☐ Daily ☐ Twice/week ☐ Once/week ☐ Once/month

How long have you been doing this?

☐ 1 month ☐ 2 months ☐ 3 months ☐ 4 months ☐ 5-11 months ☐ more than a year

e) Do you chew food but spit it out to prevent weight gain? ☐ YES ☐ NO

How often do you do this?

☐ Daily ☐ Twice/week ☐ Once/week ☐ Once/month

How long have you been doing this?

☐ 1 month ☐ 2 months ☐ 3 months ☐ 4 months ☐ 5-11 months ☐ more than a year

f) Do you give yourself an enema to prevent weight gain? ☐ YES ☐ NO

How often do you do this?

☐ Daily ☐ Twice/week ☐ Once/week ☐ Once/month

How long have you been doing this?

☐ 1 month ☐ 2 months ☐ 3 months ☐ 4 months ☐ 5-11 months ☐ more than a year

g) Do you take appetite control pills to prevent weight gain? ☐ YES ☐ NO

How often do you do this?

☐ Daily ☐ Twice/week ☐ Once/week ☐ Once/month

How long have you been doing this?

☐ 1 month ☐ 2 months ☐ 3 months ☐ 4 months ☐ 5-11 months ☐ more than a year

---

h) Do you diet strictly to prevent weight gain? ☐ YES ☐ NO

How often do you do this?

☐ Daily ☐ Twice/week ☐ Once/week ☐ Once/month

How long have you been doing this?

☐ 1 month ☐ 2 months ☐ 3 months ☐ 4 months ☐ 5-11 months ☐ more than a year

---

i) Do you exercise a lot? ☐ YES ☐ NO

How often do you do this?

☐ Daily ☐ Twice/week ☐ Once/week ☐ Once/month

How long have you been doing this?

☐ 1 month ☐ 2 months ☐ 3 months ☐ 4 months ☐ 5-11 months ☐ more than a year

5. If you answered YES to "exercise a lot", please answer questions #5a-d. If you answered NO to "exercise a lot", skip to question #6.

5a. Fill in the blanks below:

I_____(types of exercise, e.g., jog, swim) for an average of _____hours at a time.

5b. My exercise sometimes significantly interferes with important activities.

☐ YES ☐ NO

5c. I exercise despite injury and/or medical complications.

☐ YES ☐ NO

5d. Is your primary reason for exercising to counteract the effects of binges or to prevent weight gain? ☐ YES ☐ NO

For the following questions, circle the response that best reflects your answer:

6. Does your weight and/or body shape influence how you feel about yourself?

1	2	3	4	5
Not at all	A little	A moderate amount	Very much	Extremely or Completely

7. How afraid are you of becoming fat?

1	2	3	4	5
Not at all	A little	A moderate amount	Very much	Extremely or Completely

8. How afraid are you of gaining weight?

1	2	3	4	5
Not at all	A little	A moderate amount	Very much	Extremely or Completely

9. Do you consider yourself to be:

1	2	3	4	5	6
Grossly obese	Moderately Obese	Overweight	Normal Weight	Low Weight	Severely underweight

10. Certain parts of my body (e.g. my abdomen, buttocks, thighs) are too fat.
☐ YES ☐ NO

11. I feel fat all over. ☐ YES ☐ NO

12. I believe that how little I weight is a serious problem.
☐ YES ☐ NO

13. I have missed at least 3 consecutive menstrual cycles (not including those missed during a pregnancy). ☐ YES ☐ NO

Appendix E: Eating Attitudes Test–26 (EAT-26)

EAT

Please circle the response that applies best to each of the numbered statements. All of the results will be strictly confidential. Please answer each question honestly and carefully. Thank you.

A-Always	VO-Very Often	O-Often	S-Sometimes	R-Rarely	N-Never

1. I am terrified about being overweight.

A	VO	O	S	R	N

2. I avoid eating when I am hungry.

A	VO	O	S	R	N

3. I find myself preoccupied with food.

A	VO	O	S	R	N

4. I have gone on eating binges where I feel that I may not be able to stop.

A	VO	O	S	R	N

5. I cut my food into small pieces.

A	VO	O	S	R	N

6. I am aware of the calorie content of foods that I eat.

A	VO	O	S	R	N

7. I particularly avoid foods with a high carbohydrate content.

A	VO	O	S	R	N

8. I feel that others would prefer if I ate more.

A	VO	O	S	R	N

9. I vomit after I have eaten.

A	VO	O	S	R	N

10. I feel extremely guilty after eating.

A	VO	O	S	R	N

11. I am preoccupied with the desire to be thinner.

A	VO	O	S	R	N

12. I think about burning up calories when I exercise.

A	VO	O	S	R	N

13. Other people think that I am too thin.

A	VO	O	S	R	N

14. I am preoccupied with the thought of having fat on my body.

A	VO	O	S	R	N

15. I take longer than others to eat my meals

A	VO	O	S	R	N

16. I avoid foods with sugar in them.

A	VO	O	S	R	N

17. I eat diet foods.

A	VO	O	S	R	N

18. I feel that food controls my life.

A	VO	O	S	R	N

19. I display self-control around food.

A	VO	O	S	R	N

20. I feel that others pressure me to eat.

A	VO	O	S	R	N

21. I give too much time and thought to food.

A	VO	O	S	R	N

22. I feel uncomfortable after eating sweets.

A	VO	O	S	R	N

23. I engage in dieting behaviour

A	VO	O	S	R	N

24. I like my stomach to be empty.

A	VO	O	S	R	N

25. I enjoy trying new rich foods.

A	VO	O	S	R	N

26. I have the impulse to vomit after meals.

A	VO	O	S	R	N

Appendix F: University of Ottawa Ethics Approval Certificate

Université d'Ottawa · University of Ottawa

Cabinet du vice-recteur à la recherche
Office of the Vice-Rector, Research

COMITÉ D'ÉTHIQUE DE LA RECHERCHE EN SCIENCES DE LA SANTÉ ET SCIENCE

ATTESTATION D'APPROBATION DÉONTOLOGIQUE

La présente attestation certifie que le Comité d'éthique de la recherche en Sciences de la Santé et Science de l'Université d'Ottawa a examiné la demande d'approbation déontologique présentée par Michelle Mathias, supervisée par Charlotte Beaudoin, pour son projet de recherche **Experiences of University Women at Risk of Developing an Eating Disorder (Dossier H06-02-09).** Le Comité d'éthique a déterminé que la demande respectait les principes déontologiques établis par l'Énoncé de politique des trois conseils et par les règles de procédure des Comités d'éthique de l'Université d'Ottawa. Le Comité d'éthique a donc accordé une catégorie 1a (approbation) à ce projet. La présente attestation est valide pour un an à partir de la date indiquée ci-dessous.

Catherine Paquet
Responsable de la déontologie en recherche
Pour le Président du CÉR en Sciences de la santé et Science
Daniel Lagarec

7 novembre 2002
Date

550, rue Cumberland
Ottawa (Ontario) K1N 6N5 Canada

550 Cumberland Street
Ottawa, Ontario K1N 6N5 Canada

(613) 562-5270 • Téléc. / Fax : (613) 562-5271

Appendix G: Participant Consent Form

CONSENT FORM

Michelle Mathias, B. Sc., (Masters Candidate)
Dr. Charlotte Beaudoin, PH. D.
University of Ottawa, Faculty of Health Sciences, School of Human Kinetics
Telephone number: 562-5800, x 4259
Email: ichema2@yahoo.com

Whenever a research involves humans, the written consent of the research participants must be obtained. This is a standard practice, in accordance with the research conducted at the University of Ottawa. The purpose of the consent from is to inform the participant of any possible benefits and/or risks, should they exist.

I, ( ), am interested in participating in the research conducted by Michelle Mathias of the School of Human Kinetics in the faculty of Health Sciences at the University of Ottawa. This project is part of Michelle Mathias's Master's thesis, which is under the supervision of Dr. Charlotte Beaudoin. The purpose of this research is to gain a better understanding of the experiences, perceptions and beliefs of university women with regards to their bodies and eating habits. It is hoped that in gaining a better understanding of what these women experience, a better appreciation of what women face relative to their body and eating habits will be attained.

My participation will consist essentially of attending five sessions. The first session will entail filling out a consent form. The last four sessions entail having an interview, with the researcher, about my perception regarding my body and my eating habits. Each of these 4 sessions is anticipated to last approximately one hour. I understand that the contents of the interviews and the questionnaires will be used for research purposes only and that my confidentiality and will be respected. Only the researcher and her thesis supervisor, Dr. Charlotte Beaudoin, will have access to the raw data. The data will be stored in a locked filing cabinet in Dr. Beaudoin's office.

The potential benefits of participating in this study are self-reflection and an opportunity to express myself freely and openly. As well, it is possible that I will learn about eating and health issues from the interactions with Michelle Mathias. I additionally understand that since this activity deals with very personal information, it may cause me some discomfort or embarrassment that may, at times, be difficult. I have received assurance from Michelle Mathias that every effort will be made to minimize these occurrences. The discussion will take place in a safe, nonjudgmental environment. I also understand that I will not be forced to participate in the interview. Nor will I be forced to answer any question(s) that I do not wish to answer. The results of the research will not be used for any other purposes, such as an evaluation of myself in any of my classes.

I am free to withdraw from the project at any time, before or during an interview, as well as in between any of the sessions. I may also refuse to participate and refuse to answer questions without prejudice.

I have received assurance from Michelle Mathias that the information I will share will remain strictly confidential. Anonymity will be assured in the following manner: each study participant will be assigned a pseudonym. Under no circumstances will my name be mentioned in the documents produced form this research. At the end of the research, tape recordings of the interviews will be destroyed. Other raw data will be kept for a period of 5 years.

Any information requests or complaints about the ethical conduct of the project may be addressed to the University Research Ethics Board, or by calling the Protocol Officer for Ethics in Research, 550 Cumberland, room 159, 562-5387, or by emailing: ethics@uottawa.ca

There are two copies of the consent form, one of which I may keep. The researcher will keep the other in a locked filing cabinet.

If I have any questions, I may contact the researcher, Michelle Mathias, at MNT 372b, 562-5800 (4950). I am also free to contact her supervisor, Dr. Charlotte Beaudoin, MNT 340, 562-5800 (4259)

Participant's signature: _____ Date: _____

Researcher's signature: _____ Date: _____

I, _____(name) hereby consent to being audio taped.

Participant's signature: _____ Date: _____

Appendix H:

Table 2: Summary Data – Portrait of Participants, Using Common Theme

Table 2: Summary of Data – Portrait of Participants, Using Common Themes*

	Participant A	Participant B	Participant C	Participant D
Common Themes (organized by importance)	**Eating** -Ephedrine use	**Exercising** -thinness pressures from ballet years	**Friends** -doesn't try on clothes with boyfriend	**Exercise** -5-6x/week for 1.5 hours each time
	Family -Mom's comments	**Eating** -ability to skip meals	**Eating** -didn't eat during first month of school	**Eating** -chewing and spitting out food
	Exercise -to feel better after eating certain foods	**Family** **-healthy & active**	**Family** -mom's negative comments	**Family** -parents worry she doesn't eat enough
	Friends & Living Arrangements **-roommate's eating habits**	**Society & Media** **-interest in feminism**	**Body Concerns & Clothes** **-body wide and blockey**	**Society & Media** **-knows that ads are deceiving**
	Society & Media -TV can be depressing	**Clothing & Body Concerns** -concern re: bum and legs	**Society & Media** -humans never satisfied	**Friends & Living Arrangements** **-feels uncomfortable when guys check her out**
	Clothes & Body Concerns -legs and stomach	**Thinking** -humans always want better	**Friends & Living Arrangements** -some had eating disorders	**Clothes & Body Concerns** -hips and thighs
	Thinking about body **-varies with activity**	**Friends & Living Arrangements** **-happy with roommate**		

*red font indicates "red flags"

Appendix I:

Table 3: Summary of Data – Portrait of Participants, Using Wellness Model Dimensions

Table 3: Summary of Data – Portrait of Participants, Using Wellness Model Dimensions*

	Participant A	Participant B	Participant C	Participant D
Wellness Dimensions (organized by importance)	**Emotional** -hurt, depressed, discouraged	**Emotional** -guilty, depressed	**Emotional** -unhappy, nervous	**Emotional** -guilty, embarrassed, concerned
	Physical -she compares herself (physically) to other women	**Physical** -keeping track of your weight makes you worry	**Physical** -keeps clothes wants to fit into one day	**Physical** -good vs bad days determined by what has eaten
	Social -fashion industry promotes smaller sizes	**Social** -had a lot of ballet friends with eating disorders	**Social** -roommate doesn't eat very much	**Social** -60-65% of friends have eating / body concerns
	Intellectual -subconsciously thinks about body issues	**Intellectual** -sometimes weight is a preoccupation	**Intellectual** -school is a challenge	**Intellectual** **-school takes mind off of body concerns**
	Spiritual **-have realized not everyone is thin**	**Spiritual** **- cardio is the right thing to do because it is good for you**	**Spiritual** -believes guys should be bigger than her	**Spiritual** -doesn't go by numbers on scale
	Environmental **-likes roommates**	**Environmental** **-likes residence**	**Environmental** -doesn't get along with roommate	**Environmental** **-happy with roommate**

*red font indicates "red flags"