Societal Pressures to be Thin:

The Development of a Self-Report Instrument

Grounded in Women's Experiences

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Submitted in partial fulfilment of
the requirements for GED 613
August, 1994

DEDICATION

This thesis is dedicated to my mother, **Veva Moulton**, who, through her own struggles and accomplishments, showed me that anything is possible when you follow your dreams.

ABSTRACT

Most of the literature on eating disorders is dominated by a psychiatric perspective, so tends to be conceptualized by an individualistic, medical model orientation. Self-report instruments have been developed mostly by male treatment providers (e.g., psychiatrists) as an aid in detecting the prevalence of eating disorders. These measures are developed from the clinical literature and based on clinical samples. The purpose of this present study was to develop an instrument that examines eating behaviours of "normal" women from a broader socio-cultural perspective than the current medical model. Items contained in the present measure were derived from interviewing 16 "normal" female high school and university students regarding societal pressures to be slim from significant others, the media and the fashion industry. The initial item pool was administered to 124 undergraduate and 7 graduate female students. A factor analysis of the questionnaire items revealed five underlying dimensions, specifically, "Body Dissatisfaction and Dieting", "Comparing Self to Others and Being Evaluated By Others", "Pressures to be Thin from Significant Others and the Media", "Comments Made about Appearance and Self-Consciousness" and "Valuing Thinness". Although these subscales were derived using a relatively small sample size, they do indicate that concern about body shape and appearance is largely normative for women.

ACKNOWLEDGEMENTS

I wish to acknowledge the insightful contributions of my committee members, **Rilda van Feggelen** and **Kim Travers**. Thank you to the **Northside–Victoria School Board**, **Mt. St. Vincent University**, **St. Mary's University** and **St. Francis Xavier University** for their cooperation in this endeavour. I wish to thank **Paula Mayich**, Graduate Education Secretary, Mt. St. Vincent University, for helping with all the "red tape" and for being such a great listener. A very special thank you to my husband **Jack Daw**, for his patience and understanding.

Most of all, I wish to thank my thesis advisor, **Mary Delaney**, for her never ending optimism, encouragement, generosity and sense of humour.

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CHAPTER I

INTRODUCTION

During the past two decades there has been an alarming rise in the number of female adolescents diagnosed with the eating disorder bulimia (Howat & Saxton, 1988; Phelps & Bajorek, 1991; Schwartz, Thompson, & Johnson, 1982). Bulimia is a disorder characterized by binge eating, followed by purging behaviours (which typically involve laxative and/or diuretic misuse, vomiting, and excessive exercise) to prevent weight gain (Garfinkel, 1992). The popular media has taken an interest in this phenomenon, partly due to famous people coming forward with their personal stories recounting their struggle with an eating disorder. For example, Karen Carpenter's death from anorexia nervosa (an eating disorder characterized by self–induced starvation), Jane Fonda's admission that she was bulimic for years, and Cherry Boone's bout with anorexia nervosa all have drawn attention to eating disorders.

Phelps and Bajorek (1991) estimate that between 18–20% of high school adolescents are affected by an eating disorder of some sort, with bulimia being more common than anorexia. Locally, Nova Scotia Department of Health Statistics indicate that more than 7,000 Nova Scotians have an eating disorder with 576 new cases each year (Mellor & Conrad, 1993). It is imperative that the education system play an active role in helping identify adolescents with bulimia or who are at risk, as bulimic symptoms appear to peak in high school (Howat & Saxton, 1988).

Eating disorders have typically been treated by the medical profession, with psychiatry taking ownership. This appears to be accepted by the general public as well, who typically see eating disorders as a form of mental illness (O'Grady & El-Sobky, 1987). The medical model views bulimia from an individualistic perspective as opposed to a larger socio-cultural perspective, in which other influences come into play such as the fashion industry, the media and pressure from others to be slim.

According to the medical model, the eating disordered female is seen as the patient who is in need of medical or psychiatric treatment (typically provided by males). This places women in a difficult situation in which their attempts to conform to society's standards of thinness are viewed as a form of psychopathology.

The assumption that bulimics are qualitatively different from "normal" women has been based on scant empirical evidence. Self-report instruments have been developed during the past two decades as an aid in detecting the prevalence of bulimia and to identify those who are at risk for developing bulimia; however, they have failed to include measures of "normal" women's experiences with food, dieting and body image concerns. Self-report instruments have been dominated by the medical model. Items have been generated by mental health professionals who treat bulimics, based on the American Psychiatric Association's Diagnostic and statistical manual (DSM) criteria and on the clinical literature. There is a need for an instrument to be developed that measures "normal" women's experiences with food and dieting and the impact this has on body

image. Perhaps bulimics are not qualitatively different from "normal" women, but lie on a continuum of "normal" eating behaviours.

Dieting, excessive exercise and concern with appearance are part of the female experience in Western society (Rodin, Silberstein, & Striegel-Moore, 1985). The purpose of this study was to develop a self-report measure grounded in women's experiences with food, dieting and body image concerns. The newly developed instrument may be useful for educators (teachers, guidance counsellors and school psychologists) to help identify adolescent females with potentially problematic eating behaviours.

The measure differs from other self-report instruments of bulimia in that items were generated from "normal" women's experiences with weight and appearance. It is also conceptualized from a feminist, socio-cultural viewpoint with the adoption of an interdisciplinary perspective encompassing psychology, education, sociology and nutrition. This broadens the current medical model perspective of eating disorders.

CHAPTER II

REVIEW OF THE LITERATURE

The pertinent literature relative to bulimia and self–report measures of bulimia are reviewed in this chapter. Socio–cultural pressures placed on women in Western society to conform to a "thin ideal" are examined from a feminist perspective. The concept of "beauty" is viewed historically, illustrating how "beauty" is a social construction. Cross–cultural definitions of beauty are also examined. The value of attractiveness for women in Western society is discussed in order to understand why so many women go to such lengths to achieve the "ideal" look. The discussion highlights how issues with weight and food affect women more negatively than men. The final section of the literature review examines, in detail, the most widely used self–report instruments for bulimia. It reveals how the present measure differs from, or improves upon, existing ones. The present measure differs substantially from the measures currently in use in that it is grounded in the experiences of "normal" women themselves and encompasses social and socio–cultural factors.

The Thin Ideal

There is tremendous pressure on women in our society to conform to the standard of beauty currently in vogue. Beauty is considered a feminine attribute and a worthwhile, perhaps even imperative, goal for women (Rodin et al.,1985). Historically, concepts of feminine beauty have varied to reflect the standards of the time. Artwork of the 17th century illustrates the beauty standard of that time: large women with ample breasts, full

stomachs and thighs (Garner, Garfinkel, Schwartz, & Thompson, 1980). The nineteenth century woman had to mutilate her body for the sake of "beauty" by wearing tight corsets. This practice was even encouraged by the medical profession of the day, as it was believed that women were physically weak and needed the support of a corset. Tight fitting corsets caused serious health problems for women, ranging from shortness of breath and constipation to fractured ribs and internal organ damage (Rodin et al., 1985).

The latter part of the twentieth century has seen a significant change in beauty standards for women. It has evolved from the Marilyn Monroe "hourglass" shape of the 1950's, which was very curvaceous, to the Twiggy "tubular" shape of the 1960's, which resembled a prepubescent boy's body (Garner et al., 1980; Kaschak, 1992). The 1990's woman must be physically fit and very thin, according to the ideal presented in the media. This current standard of beauty, which McCarthy (1990) terms the "thin ideal", is largely unattainable physiologically for the average woman. Some researchers have questioned whether this societal preoccupation with thinness is responsible for the recent alarming rise in eating disorders for women (Rodin et al., 1985; Rozenzweig & Spruill, 1987).

According to Brownell (1991), the notion of the thin ideal is based on the assumption that the female body is capable of drastic alterations which may be achieved through proper diet, exercise and, in extreme cases, plastic surgery. Once this ideal body shape is obtained, many women envision their lives will improve: that anything will be attainable. For the majority of women, the thin ideal may be reached only through dieting

and exercising relentlessly. Lague, Lynn, Armstrong, Sheff-Cahan, Saveri & Sanderson Healy's (1993) article "Skin and bones", discusses the new "waif" look of the 1990's. The current supermodel of the day is 5' 7" tall and weighs less than 100 pounds. Her emaciated body shape is displayed on city billboards and in advertisements in magazines and on television. For many women, these images are cause for distress as they are constant reminders that they can never attain this body shape.

The media's portrayal of women affects even those who actively resist such messages. Women are bombarded daily with images of other women who are depicted as sex objects. Commercials, music videos and television shows equate a woman's self worth with her appearance. A female character is not seen as a "whole" but rather as a variety of body parts. Even in "real life", women are subjected to offhand comments regarding their appearance. Butler and Paisley (1980), add a useful observation of the impact of media images on girls and women:

> Images formed from mediated percepts become part of a woman's conception of herself. Mediated perceptions of the status and abilities of other women (e.g., stereotypic housewives and girl fridays in the television comedies) affect her image of her own status and abilities. Plans are formed partly from images of the roles that other women play.....Language tells a woman she's an afterthought, a linguistic variant, an et cetera. Images shape her plans for life. Although she may be able to ignore the affronts of language, she probably cannot eliminate media images from her "construction of reality" (pp. 49-50).

This daily reminder to women that they must meet society's expectations regarding their role and physical appearance negatively affects body image and self worth.

Researchers have examined the changing shape of fashion models from 1967–1987 and empirically documented the trend towards a more tubular shape for women (Morris, Cooper, & Cooper, 1989). Over this period, models became taller and their waist size increased, but not their hip size. This tubular shape is counter to a woman's natural shape, since for most post–pubertal females, body fat accumulates on the thighs and lower abdomen (Mueller, Joos, & Schull, 1985). Garner and associates (1980) examined the weight, height and body shape of Miss America Pageant contestants and Playboy magazine centrefolds. They reported a significant trend toward a thinner standard for pageant contestants and centrefolds, as well as a preference for a more lean, muscular look. Actuarial statistics from the past thirty years, however, show a trend for North American women actually to be heavier. It is ironic that as standards for beauty emphasize thinness, in reality, women in general are actually weighing more. This discrepancy is putting more and more pressure on women to reach an unattainable standard.

Some theorists have conceptualized eating disorders as women's pathological reaction to societal pressure to be thin. Rodin and colleagues (1985) point out that this preoccupation with dieting and exercise reflects an undercurrent in contemporary Western society and has become the norm for women in general. Girls are socialized at an early age to be concerned about their appearance and weight. They get this information from parents, teachers, doctors, peers and, of course, the media. Both men and women tend to see weight obsession and dieting as a natural "quirk" of the female personality (Kaschak,

1992). According to Kaschak (1992), the normal eating pattern for females is the dieting pattern.

There is a great deal of secrecy surrounding weight and food issues for women today. The female appetite is hidden from society's view. It is unfeminine for a woman to show her hunger by eating large, or even adequate, amounts of food in public (Leon & Finn,1984). It is not uncommon for some women to eat secretly before going out socially so that they will not appear hungry to the world (Kaschak, 1992). This secrecy and shame is reminiscent of the Victorian era and its views regarding female sexuality (Wolf, 1991). The fact that some women would rather answer questions regarding masturbation or homosexuality than disclose their weight provides evidence for the pervasiveness of this secrecy (Rodin et al., 1985). Quite often, women refuse to participate in a study in which they are required to report their weight (for example, Dolan, Birtchnell, & Lacey, 1987; Paxton, Wertheim, Gibbons, Szmukler, Hillier, & Petrovitch, 1991). Belgin and Fairburn (1992) examined the medical records of 39 anonymous subjects who had refused to participate in a study designed to evaluate a new eating disorder instrument. It is interesting to note that of these 39 nonparticipants, 10.3% had a history of anorexia, 5.1% a current eating disorder, 12.8% had other problems associated with eating disorders and 15.4% were clinically overweight. Belgin and Fairburn (1992) conclude that eating disorders are over-represented in women who refuse to participate in eating disorder studies.

It is obvious that the concept of "beauty" is a social construction which has evolved over the past century to the present thin ideal. The media and fashion industry have contributed to the pervasiveness of the thin ideal in Western society. Dieting, concern with weight and appearance are the norm for women today who live in this culture obsessed with thinness.

Societal Values

It is important to examine the role that attractiveness plays in the lives of women as it gives some insight into why many women devote much time and attention to their appearance. It is not surprising that most women spend a life-time striving for something that is so highly valued by the society in which they live.

Two common Western social norms are the stereotypes of "fat is bad" and "thin is beautiful" (Rodin et al., 1985). Thinness is equated with self control and even has some moral and religious overtones. A person who is thin epitomizes self control. Dion, Berschied and Walster (1972) (as cited in Rodin et al., 1985) found that attractive persons are perceived to have desirable qualities and are less discriminated against in Western society than those deemed unattractive. According to Dipboye, Arvey and Terstra (1977) (as cited in Rodin et al., 1985) attractive persons have a better chance of getting hired for a job and start work with higher salaries. Attractive persons have been considered less guilty and receive lighter sentences in simulated jury cases as compared to less attractive persons (Effran, 1974, as cited in Rodin et al., 1985). Rodin and associates

(1985) describe research which illustrates the differential treatment given to attractive children by teachers and parents. Teachers and parents have higher expectations of attractive children and rate them more favourably than unattractive children. Even children themselves rate attractive peers as more desirable playmates. We are socialized from an early age to believe that thinness is equated with attractiveness and that attractiveness is equated with goodness. This obsession with attractiveness by Western culture affects both males and females, but in differing ways.

Gender Differences

Researchers consistently report gender differences in the preoccupation with weight and appearance for men and women (Klesges, Mizes, & Klesges, 1987; Paxton et al., 1992; Pliner, Chaiken, & Flett, 1990). This gender difference is clearly illustrated by Dolan and associates (1987), who found that women were dissatisfied with their body weight and wished to weigh less than their current weight, while men were generally satisfied with their weight. Furthermore, the few men who were not happy with their current weight wished to weigh more.

Phelps, Johnston, Jimenez, Wilczenski, Andrea and Healy (1993) discuss gender differences in body image which begin to emerge during puberty. As young girls experience an increase in body fat, which is characteristic of normal female development, they become increasingly less satisfied with their bodies as they are deviating from the "thin ideal" and desire to return to their prepubescent body shape. However, as boys

experience puberty, they become physically bigger, gaining more muscle mass. This newly emerging body shape resembles the "male muscular ideal". Therefore, as adolescent boys mature, they become more satisfied with their body shape, whereas adolescent girls become less satisfied.

Obesity is viewed with disgust and met with discrimination for men and women, but especially so for women. McCarthy (1990) discusses the fact that obesity in Western society is less tolerated in women than in men, as physical appearance is regarded as more central to a women's self–esteem and identity. This is in sharp contrast with other cultures such as Kenya, in which fat body shapes are viewed more positively than thin shapes (Pate, Pumariega, Hester, & Garner, 1992). In Sudan, female obesity is considered sexually attractive and a sign of beauty (El–Sarrag, 1968, as cited by Pate et al., 1992).

According to Rodin and colleagues' (1985) review of physical attractiveness literature, there are gender differences in the importance that attractiveness plays in the lives of men and women. Traditional sex roles have allowed men to base their self worth on their position in society, income level and so on. Women, on the other hand, have not had the opportunity to pursue these goals and have had to rely on beauty to attract a man in order to gain access to his resources and position in society. Having a beautiful wife elevates the social status of a man; however, marrying an attractive man does not elevate a woman's status (Bar–Tal & Saxe, 1976, as cited in Rodin et al., 1985).

Feminism

The present measure is grounded in women's personal experiences with food and dieting and perceived societal pressures to achieve the "thin ideal". This use of feminist methodology, which validates women's experiences, is in sharp contrast with the way eating disorders have been conceptualized and treated to date. Eating disorders have been labelled by the medical profession as a psychiatric syndrome without first examining what is considered "normal" eating behaviours for women.

Many researchers question why the rise in eating disorders has coincided with the improvements in women's lives in terms of careers and education. It has been suggested that now women experience the multiple pressures of achieving professionally while balancing family needs and striving to achieve society's beauty standards (Rodin et al., 1985). Now, women must be beautiful and smart.

Chernin (1981) questions why men are attracted to thin women. Chernin hypothesizes that as women gain more power in previously male-dominated areas, men's preference for thin women is a symbolic way of stripping women of this newly acquired power. It is curious and disturbing that the standards of thinness over the past twenty years have become thinner, as women have begun to compete with men in areas that were previously exclusively male (Wolf, 1991).

There is debate as to why women conform to these standards. For some women, thinness may be a way to compete in a male-dominated world by minimizing their femininity. Studies have shown that large women, especially those who are large busted, are seen as less intelligent and less capable compared to thin women (van Strien, 1989). Boskind-Lodahl (1976) offers an alternate explanation regarding the stereotypical female role. She sees this obsessive pursuit of thinness as another path women take to validate their self worth through pleasing men. It also may be a way to distance themselves from their own mothers, many of whom were housewives whose identities were dependent on their children and husbands. This lack of personal identity left many women of the 1940's and 1950's dissatisfied and unfulfilled with their lives. The daughters of these women did not want to repeat their mothers' mistakes (Boskind-Lodahl, 1976).

Socio-cultural Factors

Socio-cultural explanations are just one of several theories put forth to explain the etiology of eating disorders. Two studies clearly illustrate the role of environmental factors in the development and maintenance of eating disorders. Several researchers have examined competitive environments where success was dependent on one's body shape and level of fitness (Brooks-Gunn, Burrow, & Warren, 1988; Garner & Garfinkel, 1980). Garner and Garfinkel (1980) compared the results of scores obtained on the Eating Attitudes Test (EAT), (a well known measure used in eating disorder research) of competitive ballet dancers, models, music students, anorexics and "normals". Models and dancers experienced significantly more anorexic symptoms than the control group or the

music students. The most competitive dance group experienced the highest level of anorexic symptoms. In another study examining the relationship between competitive environments and eating disorders, Garner and Garfinkel (1980) examined EAT scores of competitive music students not concerned with weight with competitive dance students concerned with maintaining a low body weight. They concluded that competitiveness alone did not affect EAT scores as both the music and dance students were in highly competitive environments; it was the weight demands of the environment that discriminated between the two groups. Thus, individuals who are in environments that are competitive and have stringent weight demands may be especially at risk for eating disorders. An alternative explanation for these environmental effects on the development of eating disorders is that girls with a predisposition for eating disorders may be attracted to environments in which extreme thinness is encouraged and accepted as the norm, such as modelling and ballet dancing (Garner & Garfinkel, 1980).

Thinness in Western society symbolizes "self-discipline, control, sexual liberation, assertiveness, competitiveness, and affiliation with a higher socioeconomic class, as well as the traditional value of attractiveness" (Pate et al., p.802). The present study attempts to examine societal pressures to attain the "thin ideal" by asking women themselves to describe their subjective experiences and feelings regarding weight, food and appearance. The majority of self-report measures of bulimia to date fail to address these socio-cultural pressures sufficiently.

Eating Disorders

The present study draws on the eating disorder literature, especially research on bulimia, as there are parallels in bulimics and "normal" women's experiences with food and dieting. Common to both groups, are yo-yo dieting, binge eating and compensatory behaviours to counteract calories consumed during a binge such as, exercise, drinking excessive water, diet pills, diuretic misuse and smoking (Greenfield, Quinlan, Harding, Glass, & Bliss, 1987; Kaschak, 1992; Klemchuk, Hutchinson, & Frank, 1990; Klesges et al., 1987; Nylander, 1971). In a classic study, Nylander (1971) found overlap between characteristics of anorexics and "normals". A significant number of females had ceased menstruating, suffered from fatigue and had bouts of poor concentration during high school due to strict dieting. These young women did not meet the criteria for anorexia, but were considered to be at the threshold.

Prior to the 1940's, bulimic symptoms were reported as one of several manifestations of anorexia nervosa (Garner & Garfinkel, 1987). It was not until the 1970's and 1980's that reports of binge eating in normal weight individuals were described in the literature. Central to the controversy regarding the relationship between bulimia and anorexia nervosa is whether bulimia is a distinct syndrome, or is simply a variant of anorexia nervosa. Mitchell, Hatsukami, Goff, Pyle, Eckert and Davis (1985) discuss the change in their patient population at a university eating disorder clinic. Prior to 1979, the majority of their patients were anorexics who may have experienced periodic bouts of bulimia. Over time, there was a shift toward normal weight individuals who had problems

with binge eating and self induced vomiting. Pyle, Mitchell and Eckert (1981) also reported bulimic symptoms in normal weight girls with no history of anorexia nervosa. By 1980, bulimia was recognized as a distinct syndrome in the Diagnostic and Statistical Manual, Third Edition (DSM-III) (Muuss, 1986).

Since the act of binge eating may occur in a variety of weight disorders (e.g., anorexia nervosa, bulimia nervosa, binge eating disorder and obesity), it is not surprising that there has been so much confusion regarding the definition and diagnostic criteria of bulimia. According to Johnson and Connors (1987), the act of binge eating may occur in individuals of varying weight, such as, low weight anorexics, normal weight bulimics and the obese. This confusion also is evident in the literature, where several terms are used to describe disorders involving binge eating : bulimarexia, bulimia, bulimia nervosa, dietary chaos syndrome and abnormal/normal weight control syndrome (Johnson & Connors, 1987).

Boskind-Lodahl (1975) was one of the pioneers in examining bulimic behaviours in normal weight females. Boskind-Lodahl observed a cyclical behaviour pattern, which she termed "bulimarexia", in the women she treated for eating disorders. This pattern was characterized by a cycle of binge eating followed by purging and then fasting. Several years later, Russell's (1979) classic work was published in which he described thirty normal weight bulimic patients, 80% of whom had a history of anorexia nervosa. However, Russell's sample may have included an unusually high number of bulimic

subjects with prior histories of anorexia nervosa. Since he was a well known expert in treating anorexia nervosa, physicians may have referred suspected anorexic patients to him (Fairburn & Cooper, 1984). Russell's paper did, however, create much discussion and controversy regarding the proper definition of bulimia.

It is interesting to note how the definition of bulimia has evolved over the past twenty years. The DSM–III labelled bulimia a psychiatric syndrome without having conducted sufficient empirical research. This is evident when one examines the American Psychiatric Association's revisions of the diagnostic criteria for bulimia in their Diagnostic and statistical manuals (DSM–III (1980), DSM–IIIR (1987) and DSM–IV (1994). The DSM–III criteria for bulimia are as follows:

A. Recurrent episodes of binge eating (rapid consumption of a large amount of food in a discrete period of time, usually less than two hours).

B. At least three of the following:
   (1) consumption of high–caloric, easily ingested food during a binge
   (2) inconspicuous eating during a binge
   (3) termination of such eating episodes by abdominal pain, sleep, social interruption, or self induced vomiting
   (4) repeated attempts to lose weight by severely restrictive diets, self–induced vomiting, or use of cathartics of diuretics
   (5) frequent weight fluctuations greater than ten pounds due to alternating binges and fasts

C. Awareness that the eating pattern is abnormal and fear of not being able to stop voluntarily.

D. Depressed mood and self–deprecating thoughts following eating binges.

E. The bulimic episodes are not due to Anorexia Nervosa or any known physical disorder (APA, 1980, pp. 70–71).

This latter criterion generated much debate (Johnson & Connors, 1987). As Russell (1979) and Boskind-Lodahl (1975) pointed out, some individuals are anorexic with bulimic symptoms or were bulimic with a prior history of anorexia nervosa. This controversy addressed the issue of weight history in the diagnosis of bulimia. The DSM-IIIR differed from the DSM-III in that the individual's eating behaviour appeared to be more central to the diagnosis of bulimia than weight history. In addition, the DSM-IIIR provided specific guidelines regarding frequency (Johnson & Connors, 1987; APA, 1980; APA, 1987).

The DSM-IIIR (see Appendix A) omitted several criteria: bingeing in secrecy, weight fluctuations as a result of bingeing and depressed mood/self deprecating thoughts after bingeing. Purging behaviour was expanded to include laxatives and vigorous exercise. Unlike the previous edition, the DSM-IIIR gives a specific time frame and also mentions body image disturbance. Wilson (1991) questions the inclusion of "rapid consumption" in criterion A of the DSMIII and DSM-IIIR. A review of the literature and a survey of professionals working in the field of eating disorders found little empirical evidence to support the requirement that the food during a binge be consumed rapidly. Wilson (1991) also states that there is little empirical evidence that supports the requirement that the binge be "large". This is a subjective term; there is no general consensus regarding what constitutes a "large" binge.

The issue of whether to include vomiting in the diagnostic criteria for bulimia has been one of contention for researchers. The DSM-III included self-induced vomiting in the five symptoms of bulimia. It was possible to exclude vomiting if three other criteria were met in the diagnosis of bulimia. The DSM-IIIR differed from the DSM-III in that vomiting was now considered an essential feature. In the DSM-IIIR individuals must engage in vomiting, laxative or diuretic abuse on a regular basis. Strict dieting or fasting and vigorous exercise also were included in the methods one could employ to counteract the food consumed during a binge.

According to the DSM-IV (1994), the diagnostic criteria for bulimia is being further refined (see Appendix B). A major change is the subdivision of bulimics into two categories: the purging type and the non-purging type. This is a radical change from the way bulimia has been previously conceptualized. An essential feature of bulimia was thought to be the act of purging by vomiting, laxative or diuretic abuse, excessive exercise or amphetamine abuse. The DSM-IV (1994) considers the non-purging subgroup to engage in strict dieting, fasting, excessive exercise but not purging per se. The DSM-IV (1994) also differs from the previous APA diagnostic manuals in that the terms "binge" and "purge" are more objectively defined (APA, 1991).

Researchers have differing opinions regarding the frequency of binging versus purging in diagnosing bulimia. Ortega, Waranch, Maldonado and Hubbard (1987) found that purge frequency was a more reliable indicator than binge frequency. Since the

meaning of the term "binge" is so highly subjective and difficult to define, these authors favour focusing on the more discrete activity of purging. Ortega and associates (1987) found great individual differences in what subjects considered to be a binge. Some subjects labelled eating episodes as binges even when small portions of food had been consumed. What appeared to be more salient than the amount of food ingested was the subject's feeling of being out of control. Purging, on the other hand, was more objective in nature. Subjects' self-reports of purging behaviour did not differ significantly from objective raters as it did for bingeing.

According to Vanderheyden and Boland (1987), bingeing is believed to be more important than purging in diagnosing the severity of bulimia. For instance, it is not uncommon for bulimics to report that their bingeing increased substantially prior to the onset of vomiting. In treatment, these authors have found that vomiting/purging typically ceases once the bingeing is brought under control.

Stein and Brinza (1989) discuss the increasing interest in eating disorders over the past 20 years by researchers and practitioners. Once thought to be rare disorders, bulimia and anorexia are now affecting women in rising numbers. The significant morbidity and mortality associated with eating disorders has been cause for concern for health professionals in particular (Garner, Olmstead & Polivy, 1983). Attempts have been made to measure the prevalence of eating disorders through the development of self-report instruments. As adolescents with maladaptive eating behaviours are at risk for developing

eating disorders, being able to identify these individuals would be beneficial for early intervention (Rosen, Silberg, & Gross, 1988). The present measure may be useful in the early identification of adolescents with problematic eating behaviours.

Self-Report Measures of Eating Disorders

The next section will discuss six of most commonly used self-report instruments in the detection of eating disorders, with an emphasis on bulimia in particular. Methods of item generation and analysis will be described, highlighting issues such as dominance of an individualistic, psychiatric perspective and a lack of sensitivity to women's experiences. Detailed examination of these issues will clarify why an instrument such as the present measure fills an existing gap in the literature. Primarily, the present measure is grounded firmly in "normal" women's experiences with food, dieting and appearance concerns in a social context.

Most self-report measures developed thus far are similar with regards to item generation. Items have tended to come from clinicians, such as psychiatrists and physicians, who typically have been the treatment providers for eating disordered women. Psychiatry, in particular has taken "ownership" of eating disorders. This is supported by the inclusion of anorexia and bulimia in the DSM Handbooks. Eating disorders have tended to be viewed as psychiatric disorders, with treatments based on the medical model. It is not surprising that most self-report measures have been developed by mental health professionals.

The majority of self-report instruments view the eating disordered person as a "patient". The disorders are seen in isolation; there is no attempt to examine the behaviour from the larger socio-cultural perspective. The rise in eating disorders today surely reflects in part how women are feeling about their role in society. Eating disorders may be viewed as a cry for help from a generation of girls and women who are feeling lost and confused about their lives. To fully understand eating disorders, it is imperative that anorexia and bulimia be conceptualized in a broader fashion. Self-report items ideally should tap into issues concerning perceived societal pressures to be thin, experiences with dieting, nutritional knowledge and the role of weight in forming women's self esteem. There is a need for a self-report instrument to be developed from a different perspective than the measures already available. The present measure generated items from women themselves, who are the experts in this area. Women are the ones who cope with the pressures placed on them from society. Women are the ones who often live in a state of hunger, constantly denying their physiological urges in order to be accepted and deemed worthwhile by a society that considers weight more important than who you are as a person and your personal accomplishments. These insights can only come from women.

To date, there are two widely used instruments in the detection of anorexia and bulimia: the Eating Attitudes Test (EAT) and the Eating Disorders Inventory (EDI). There are also several self-report instruments available in the detection of bulimia specifically: the Bulimia Test (BULIT), Binge Scale Questionnaire, and the Bulimia Investigatory

Test–Edinburgh (BITE). The Body Shape Questionnaire (BSQ) is another measure which examines the role that body shape plays in the etiology of eating disorders. Each of these will be discussed in turn in the following pages.

Eating Disorder Inventory (EDI)

The EDI is the most widely used self–report instrument in the measurement of eating disorders (Phelps & Bajorek, 1991). In designing this measure, Garner and associates (1983) wished to tap the psychological dimensions present in anorexia nervosa and bulimia. At the time, other diagnostic instruments were focusing more on behaviourial characteristics. Justification for developing the EDI was based on the assumption that anorexia is a "multidimensional disorder with considerable psychological variability across the heterogeneous patient population" (Garner et al., 1983, p. 16). Garner and associates (1983) were interested in distinguishing between the different subtypes of anorexics, those who exclusively restrict food intake with those who experience periodic bouts of bulimia. By examining the different psychological characteristics of these groups, a clearer understanding of their distinctiveness as well as implications for treating anorexia and bulimia could emerge. Ideally, such an instrument could aid in the early detection of individuals who may be on the pathway to developing unhealthy eating habits or an eating disorder.

As is typical of self-report measures, the 64 items contained in the EDI were drawn from a large pool of items generated by clinicians who were familiar with the research literature on eating disorders and had experience treating eating disordered individuals. Garner and colleagues (1983) retained items that significantly differentiated between an anorexic group and a control group and that were most highly correlated with the subscale to which they were conceptually supposed to belong.

The questionnaire was administered to an anorexic group and a control group. Garner and colleagues (1983) felt it was necessary to generate more items for some of the subscales. These new items were then administered to a second and third anorexic and control group. Subscales were required to have internal consistency coefficients of .80 or above for the anorexic group. Item scale correlations of .40 for the anorexic groups were considered acceptable; however, three items were retained that had item-scale correlations below .40 as they were considered to be conceptually related.

Items were designed to measure eleven constructs; however, only eight met the criteria for validity and reliability (Garner et al., 1983). The eight subscales of the EDI, including a sample item of each dimension, are provided in Appendix C. Empirical validation of the eight deductively derived subscales showed significant differentiation between anorexic groups and female control groups, with very little overlap (Garner et al., 1983). Garner and associates (1983) included data supporting the internal consistency of the eight subscales, and concurrent, criterion-related and construct validity of the

instrument. According to Crowther, Sheppard (1992), research has been conducted on the psychometric properties of the EDI since its development, ranging from test–retest reliability, concurrent and criterion–related validity and in the development of norms for adolescent boys and girls (Rosen et al., 1988). The EDI continues to be a widely used and studied self– report measure of eating disorders.

Eating Attitudes Test (EAT)

Garner and Garfinkel (1979) developed the Eating Attitudes Test (EAT) to measure attitudes and behaviours characteristic of anorexia nervosa. The EAT was originally validated on two independent groups of female anorexics and a female control group. Members of the anorexic groups varied in terms of severity and length of illness, as well as their current stage of treatment. The control group was comprised primarily of university students who were of roughly the same SES as the anorexic group.

Garner and Garfinkel (1979) selected the test items for the EAT based on a survey of the clinical literature of the time. An initial group of 35 items was selected and administered to an anorexic group (N=32) and a control group (N=34). Items for which the anorexic group scored significantly higher than the control group were retained. Some items had to be re–worded and new items were added in the second version of the EAT. The final version consists of 40 items. A factor analysis of the EAT–40, conducted by Garner and Garfinkel (1979) revealed the following seven factors: (1) food preoccupation;

(2) body image for thinness; (3) vomiting and laxative abuse; (4) dieting; (5) slow eating; (6) clandestine eating; and (7) perceived social pressure to eat.

Garner, Olmstead, Bohr and Garfinkel (1982), in a second study, re-factor analyzed the EAT-40, stating that:

> the relationship between symptom areas and clinical features of anorexia nervosa has not been established. The total EAT score is derived from a heterogeneous item pool, and while it may indicate the overall level of symptoms it does not provide item clusters which may relate to clinical characteristics of interest (pp. 871-872).

The purpose of the second study was to replicate the original factor analysis using a larger sample of anorexic patients and to examine whether item clusters are associated with clinical and personality characteristics.

According to Garner and associates (1982), the sample for the second study was comprised of restrictor (N=80) and bulimic (N=80) anorexics. Female university students (N=140) served as a control group. Three factors emerged this time, compared to the original seven, and corresponded to the following dimensions: (1) dieting, (e.g., "engage in dieting behaviour"); (2) bulimia and food preoccupation (e.g., "vomit after I have eaten"); and (3) oral control (e.g., "cut my food into small pieces") (Garner et. al., (1982). The goal of the second study was to obtain the most parsimonious structure. Fourteen items were eliminated from the EAT-40, thus creating the EAT-26. The 14 items were considered unnecessary as they did not increase the test's predictive power. The authors

concluded that the EAT-26 is "highly predictive of the EAT-40" (r=.98) and that it is a useful and economical measure (Garner et al., 1982).

The validity of the EAT-40 and EAT-26 for objectively measuring the symptoms of anorexia has been the subject of study by other researchers (Wells, Coope, Gabb, & Pears, 1985). Wells and colleagues (1985) examined the factor structure of the EAT-40 based on female students (N=901) of above average SES, who were attending private schools in New Zealand. In addition to the dieting factor, two other factors emerged, specifically, food preoccupation and social pressure to eat. The dieting factor dominated the EAT-40 scores for these schoolgirls. However, one limitation is the difficulty interpreting scores in the absence of knowledge of an individual's weight. That is, a high score on the dieting factor for an underweight subject is more indicative of pathology than it would be for a normal or overweight subject (Wells et al., 1985).

Wells and colleagues (1985) found that the relationship of vomiting to food preoccupation and binge eating appears to be sample dependent. Most self-report measures of bulimia use clinical samples. Garner and associates (1982) reported that for the anorexics they studied, vomiting was related to food preoccupation and binge eating; Wells and associates (1985) found no relationship between these variables with their sample of school girls. As Garner and associates' (1982) sample was comprised of anorexics, it is not surprising that vomiting items loaded on the same factor as food preoccupation and binge eating; vomiting is one way for binge eaters to control their

weight. Wells and colleagues (1985) conclude that the factor structure of the EAT–40 will vary depending on the sample used, therefore posing a threat to external validity. Thus, the factors derived from Garner and colleagues (1982) may be appropriate for an anorexic population; however, for the general population, Wells and associates (1985) advise researchers to conduct factor analysis studies on the factors derived from this study. This illustrates the importance of the population of women studied for findings. The present measure is intended for use in junior high and high school with items generated from a high school/ university population as opposed to the typical clinical sample.

Although the EDI and EAT are used widely in the field of eating disorders, they are considered "general" measures designed to assess a wide range of attitudes and behaviours commonly associated with anorexia and, to a lesser degree, bulimia. (Cooper & Fairburn, 1987). However, measures such as the Bulimia Test (BULIT), Binge Scale Questionnaire, Bulimia Investigatory Test–Edinburgh (BITE) and Body Shape Questionnaire (BSQ) have been developed to assess specific behavioural and attitudinal characteristics of bulimia alone.

Bulimia Test (BULIT)

The BULIT was originally developed by Smith and Thelen (1984) to assess bulimic behaviour and attitudes based on DSM–III criteria. At the time, the authors claimed there was a need for reliable and valid self–report instruments to assess bulimia, as most measures focused exclusively on anorexic symptomatology. The BULIT was

originally designed to meet the following goals: (1) to distinguish between bulimics and non-bulimics; (2) to distinguish between bulimics and individuals with other eating disorders; (3) to distinguish between the various subtypes of bulimia based on specific criteria (e.g., frequency of purging and binging); and (4) to examine the consequences of seeking treatment.

According to Smith and Thelen (1984) the BULIT was developed in separate but related studies. The first stage involved the generation of 75 items based on DSM-III criteria, encompassing all the diagnostic categories. This reliance on DSM criteria is typical and adds support to the earlier observation that psychiatry dominates the conceptualization of eating disorders. The initial item pool was administered to a normal control group (N=119) and a group of identified bulimic individuals (N=18). The 32 items that best discriminated between the two groups were retained. In stage two, the now 32 item BULIT, the Binge Scale and the EAT, were administered to bulimic individuals (N=22), a normal control group (N=99) and a group of anorexics (N=14). Using a cutoff score of 102 or above to identify bulimics, only one bulimic and two normal controls were misclassified. Of the 14 anorexics, 42% were classified in the bulimic category and 57% in the normal range. This is consistent with other reports of the percentages of anorexics who are of the bulimic subtype. Stage three involved determining the proportion of bulimics in the general population by administering the BULIT to a large sample of female undergraduate university students (N=652). Four percent had a score of 102 or higher suggesting they were possibly suffering from bulimia. This is consistent with other

published reports of the prevalence of bulimia in the general population ranging from 2–18% (Zerbe, 1993).

In another study to address the BULIT's construct and discriminant validity, the BULIT was administered together with the Binge Scale and the EAT to the bulimic subjects and control subjects who participated in stage two of the development of the BULIT. Comparison of the BULIT and Binge Scale classifications indicated that one subject in the bulimic group and ten in the normal control group were misclassified. In comparing the EAT and BULIT, four bulimic subjects and 13 normal controls were misclassified. According to Smith and Thelen (1984), their findings provide evidence that the BULIT is an objective, reliable and valid instrument in the detection of bulimia. The BULIT–R is an updated version of the BULIT designed to assess bulimia based on DSM–IIIR criteria (Welch, Thompson, & Hall, 1993).

Binge Scale Questionnaire

Another instrument designed to assess bulimia is the Binge Scale Questionnaire developed by Hawkins and Clement (1980) (as cited by Ortega et al., 1987). The Binge Scale Questionnaire is a 19 item multiple–choice, self–report instrument designed to measure behaviourial and attitudinal characteristics specific to bulimia. The instrument

has been criticized for being insufficiently comprehensive for epidemiological work and insensitive in identifying those with less severe eating disorders. It was designed to provide "descriptive and quantifiable information about behaviour and attitudes in binge-eating" (Ortega et al., 1987, p. 18) rather than serve diagnostic or screening functions. Items address binge frequency, purge probability and the number of calories consumed during a binge (Ortega et al., 1987).

Bulimia Investigatory Test-Edinburgh

Another self-report measure of bulimia is the Bulimia Investigatory Test-Edinburgh (BITE), developed by Henderson and Freeman (1987). The BITE was developed to identify binge eaters, to provide useful clinical information regarding the cognitive and behaviourial aspects of bulimia, and to provide a quantifiable method of measuring the severity of bulimic symptoms in response to treatment. The original items for the BITE were drawn from current literature at the time (e.g., Bruch, 1975; Russell, 1979; DSM III) regarding binge eating symptoms and behaviours of bulimics. These items were administered to a small group of bulimic individuals currently receiving treatment (N=7) and a group of normal controls (N=10). After discussion with the subjects, any questions that were ambiguous or misunderstood were omitted or reworded. The final scale contained 33 items, which were divided into two subscales: (1) the symptom subscale (i.e., symptoms and overt behaviours associated with binge eating); and (2) the severity subscale (i.e., the frequency of specific bingeing behaviours).

According to Henderson and Freeman (1987), the BITE can distinguish between normals, binge eaters and those with less severe pathology. Waller (1992) points out a major limitation of the BITE in that it was standardized on women who met the DSM-III criteria for bulimia, with emphasis on the criterion of binge eating; however, binge eating is only one criterion of bulimia. Also, binge eaters are not a homogeneous group, as bingeing may occur in non-eating disordered women, in some anorexics (bulimic subtype) and in bulimic individuals with or without a history of anorexia nervosa. This over reliance on the criterion of binge eating is a major limitation of the BITE.

Waller (1987) examined Henderson and Freeman's claim that the BITE can differentiate binge eaters from normals on the basis of bulimic symptoms. Waller (1987) compared the BITE scores of restrictor anorexics (no binge eating behaviour), bulimic subtype anorexics, normal weight bulimics with a history of anorexia and normal weight bulimics with no history of anorexia. In this study, the presence or absence of anorexia made no difference to the classification of bulimia. Problems arose in empirically classifying the bulimic subtype anorexics based on their BITE scores. They had significantly lower BITE scores than the other three bulimic groups, suggesting that bulimics do not respond to self-report questionnaires as a homogeneous group. Waller (1992) concluded that the BITE is capable of classifying normal weight bulimics adequately (although false negatives are possible); however, it is not an appropriate measure in classifying low weight binge eaters such as bulimic subtype anorexics.

Body Shape Questionnaire

Although concerns with body shape and body image are common among females in Western society, (Davies & Furnham, 1986; Fabian & Thompson, 1989; Halmi, Goldberg, & Cunningham, 1977; McCaulay, Mintz, & Glenn, 1988; Paxton et al., 1991; Thelen, Powell, Lawrence, & Kuhnert, 1992; Wardle & Foley, 1989) existing measures of eating disorders do not specifically address these issues (Cooper, Taylor, Cooper, & Fairburn, 1987). The Body Shape Questionnaire (BSQ) was developed by Cooper and colleagues (1987) to measure the relatively neglected area of body shape concerns and experiences with "feeling fat" for bulimics and anorexics. Furthermore, as societal standards demand thinner and thinner body shapes for women, it is not surprising that dissatisfaction with body shape is increasingly common for "normal " women as well.

According to Cooper and colleagues (1987), items for the BSQ were derived from subjects who were expected to have varying degrees of concern about body shape. Subjects were interviewed regarding their subjective concerns about "feeling fat". Open ended questions were used to illicit detail about their experiences of feeling fat and how it affected them behaviourally and emotionally. This interview method represents a positive change in the way items are generated for self-report measures. Women themselves expressed their subjective feelings and concerns regarding issues surrounding weight and body image. This is a radical shift from the typical reliance on DSM criteria and clinical "experts" in the area of treatment, using instead, qualitative information from women themselves. This method of generating items is adopted in the present study.

and clinical "experts" in the area of treatment, using instead, qualitative information from women themselves. This method of generating items is adopted in the present study.

The BSQ sample was comprised of 28 females, including women who were bulimic, anorexic, on strict diets, attending exercise classes and university students. Conceptual categories emerged from the qualitative information gathered through the interviews. Fifty one questions were then generated from the content of the transcribed interviews. These 51 questions were administered to bulimic individuals (N=19), family planning clinic attenders (N=331), occupational therapy students (N=119) and female undergraduate university students (N=85). All 51 items were intercorrelated and those items which correlated at least 0.60 with all others items were retained for both samples. Six items judged to be redundant were eliminated. In addition, items which did not statistically discriminate between the patient and non-patient groups were eliminated as were items describing behaviours rarely reported. A total of 34 questions were retained and constitute the final version of the BSQ.

It is interesting to note that there was overlap in the scores obtained by bulimic subjects and those in the community. This illustrates the point that concerns about body shape and feeling fat are not restricted to those with eating disorders. It is a common concern among women, eating disordered or not. Cooper and associates (1987) state that the BSQ should be used "as a measure of psychopathology rather than a means of case detection" (p. 490).

A recent study by Bunnell, Cooper, Hertz and Shenker (1992) illustrates the importance of body dissatisfaction in the etiology and maintenance of bulimia. The study also provides empirical evidence of the role body shape dissatisfaction plays in the lives of "normal" women as well. Bunnell and colleagues (1992) administered the BSQ to four clinical groups (anorexics, bulimics, subclinical anorexics, subclinical bulimics) and to a group of "normal" adolescents. Results indicated that the bulimic group was the only one that scored significantly higher on the BSQ than the other groups, suggesting that body dissatisfaction plays a critical role in bulimia. Bunnell and colleagues (1987) also emphasize that the control group did not score significantly lower than three of the eating disordered groups. This illustrates how important body shape concerns are to young female adolescents in general and adds support to the goal of the present study.

Research Question

The literature review of self-report measures of bulimia, indicates that the present measure fills an existing gap in the current literature. Reliance on DSM criteria and clinical experts for item generation has failed to examine eating disorders from a socio-cultural perspective, grounded in women's experiences with food, dieting and appearance. What is currently viewed as a form of psychopathology by the medical community may be an extreme form of behaviours which are largely normative for women living in Western society. The purpose of this study is develop a measure to investigate how "normal" adolescents and women deal with societal pressures to be thin and the impact this may or may not have on their eating and dieting behaviours. It is hoped that this, in turn, will give greater insight into bulimia and the potential for earlier detection of those at risk for developing the disorder.

CHAPTER III

METHOD

Purpose

A review of the eating disorder literature on bulimia reveals a general lack of self-report questionnaires that examine eating behaviours from a feminist perspective. An exception to this trend is the BSQ which examines women's cognitions and behaviours regarding feeling fat. The focus of the present study is to develop an instrument to assess women's concerns about food, dieting and appearance but to expand upon the BSQ and include the social context in which women develop attitudes and behaviours regarding the ideal female body shape. It was expected that females would receive these messages from significant others, the media, and the fashion industry. It is also time to take the ownership of eating disorders away from psychiatry and place it with women. This shift from an individualistic, medical model to a broader socio-cultural perspective should more accurately reflect the reality of women's experiences with food, dieting and body image concerns. There has been an assumption by the medical profession that bulimic women are qualitatively different from "normal" women. This assumption has been based on scant empirical evidence. In fact, there has been an overlap in the literature between bulimic women and "normal" women in terms of their eating behaviour and attitudes towards food; it was difficult to distinguish between the two in some studies (for example, Cooper et al., 1987; Greenfield et al., 1987; Klemchuk et al., 1990). The aim of this study is to develop a self-report questionnaire based upon an exploration of the experiences of "normal" women and their relationship with food, dieting and appearance.

Sample

The present study involved the use of two school based samples of women, an item generation sample and an item analysis sample. A description of the two samples used in the study is as follows:

(1) The item generation sample was comprised of 16 subjects. Ten of these were female high school students (5 in grade 11 and 5 in grade 12) attending Memorial High School in Sydney Mines, Nova Scotia. Their ages ranged from 15–19 years. The other six were Mount St. Vincent University (MSVU) summer school students enrolled in an undergraduate psychology course. Their ages ranged from 19 to 29 years of age. (Eight students were interviewed, however, the data collected from two of the subjects interviewed was not used as these women were in their 40's and their concerns were very different from those of the younger subjects.)

(2) The item analysis sample was comprised of a total of 131 subjects who were attending summer school at MSVU, St. Francis Xavier University (St. FX) and St. Mary's University (SMU). There were 124 undergraduate subjects and seven graduate students. The St. FX sample included a total of 55 subjects. Twenty one were enrolled in a developmental psychology course, 2 in a business course, 23 in a nursing course, 1 in a graduate education course and 8 in an history course. The MSVU sample included a total of 51 subjects, 2 of whom were enrolled in an introductory psychology course, 16 in two first year English courses, 8 in an introductory business course, 4 in a first year political science course and 15 in

an introductory economics course. Six graduate students in the school psychology program at MSVU volunteered to complete a questionnaire. The SMU sample was comprised of a total of 25 subjects, 20 of whom were from 2 different introductory psychology courses and 3 from an introductory sociology course.

Procedure

Item Generation (High School Students)

Contact was made with the Head of Special Services, Northside–Victoria School Board, North Sydney, Nova Scotia (see Appendix F). Verbal permission was granted to conduct the study at Memorial High School, in Sydney Mines. A guidance counsellor at Memorial High School was contacted and agreed to be a liaison at the school (see Appendix G).

The guidance counsellor supplied the names of all female grade 11 and 12 students attending Memorial High School. Birthdates and home phone numbers also were included. Five students from grade 11 and 5 students from grade 12 were randomly selected from the list (i.e., every 20th name on the list was contacted until there were 10 subjects willing to participate). Potential subjects were contacted at home by telephone. (See Appendix H for the telephone script used.) Interested students who were under 18 years of age were asked to pick up parental consent forms (see Appendix I) and student consent forms (see Appendix J) from the school secretary. They were asked to bring both signed forms when they came to the interview. Students 18 years of age and over were asked

to pick up a consent form prior to the interview (see Appendix J). Two subjects did not show up for the interview. The guidance counsellor contacted one grade 11 student and one grade 12 student to make up for the two who were absent. Interview times were scheduled over the telephone and were held in a private office at the high school.

Item Generation (University Students)

A professor teaching an undergraduate psychology course at MSVU was contacted by telephone and informed of the nature of the study. The professor expressed an interest in the study and gave permission to seek out subjects from her class. Consent forms (see Appendix L) were distributed during a class. Interested participants were asked to write their name and phone number on the second page of the form, leave it in an envelope posted outside of the professor's office and place their initials next to a convenient time on a sheet also posted on the office door (see Appendix L). Those willing to participate were contacted by telephone to confirm interview times. A total of eight students were interviewed. The professor volunteered to offer one bonus point for those who participated. Interviews were held in a private seminar room at MSVU.

Interview Procedure

The individual semi-structured interviews were tape recorded and took approximately 20–30 minutes to complete. The list of interview questions used is presented in Appendix D. At the beginning of the interview, subjects were told that they would be asked questions about their experiences with food and dieting and would be asked to comment on a series of pictures of models and an excerpt of a popular music video. Subjects were asked to answer the questions honestly and were assured that there was no way of identifying their answers. Questions asked at the beginning of the interview dealt with issues regarding clothes and fashion, as these were believed to be the least threatening and a way to establish rapport. The next section of the interview examined pressures from family and friends to diet and be slim. There were also questions dealing with how friends and family dealt with dieting themselves. Subjects were asked to comment on weight loss methods of other people they knew who were dieting. The final phase of the interview was more personal in nature. Questions asked dealt with the importance of being thin, the social and personal consequences of being thin or overweight and how satisfied they were with their bodies at the present time. Lastly, subjects were asked to comment on pictures of models and on an excerpt of a music video. The six pictures of models used with the high school students were obtained from the magazines People, Mademoiselle, and National Enquirer. The pictures showed four typical models, one heavier model and one actress who was anorexic at the time the picture was taken. Participants were asked to give their reaction to the models' appearance (see Appendix D). Five extra pictures from a "Victoria's Secret" lingerie catalogue were

used with the university sample. These pictures were considered to be more suitable for older subjects. The music video "My Love (You're Never Gonna Get It)" by En Vogue showed five women singing with male dancers in the background. The women were dressed in identical, low-cut mini-dresses. Approximately one minute of the video was shown. Subjects were asked to watch the video and give their reaction to the women's appearance in the video (see Appendix D). A tape recorder, television and VCR were supplied by Memorial High School and MSVU for the interviews. Blank audio-cassettes for recording the interviews, pictures of models and the music video taped from "Much Music" were supplied by the interviewer.

At the end of the interview, each subject completed a "feedback form" (see Appendix E). Subjects were informed that the forms would not be read until all interviews had been completed and they would be randomly read to ensure anonymity. At the end of the interviews, high school subjects were informed that the Sydney Mental Health Centre treats women with eating disorders should they know someone with an eating disorder or suspect that they have one. (The Sydney Mental Health was contacted by telephone prior to conducting the interviews and informed of this study. A representative at the clinic said they had an experienced psychologist on staff who treats adolescents with eating disorders.) The university students were informed that student affairs at MSVU offers a counselling service and has an experienced counsellor on staff who treats women with eating disorders (see Appendix K). One subject from the university sample did indicate on the feedback form that she believed she had an eating disorder.

Generation of Items

The 16 tape-recorded interviews were transcribed verbatim for later analysis. Interview 11 had approximately 5 minutes of inaudible conversation due to audio-tape malfunction. Categories common to each interview were identified and colour coded. Questionnaire items were generated from the categories which contained information gathered in the semi-structured interviews. The items were based on comments (or were paraphrased comments) made during interviews so as to accurately and comprehensively reflect the content of the interviews. This method of generating items from categories is similar to the procedure used in developing the BSQ, in that items were generated from each "conceptual category to reflect their content" (Cooper et al., 1987, p. 487) (see Appendix N).

The resulting items were placed on a 5 point scale (e.g., 1=strongly disagree, 2=disagree, 3=neither agree or disagree, 4=agree and 5=strongly agree) and the questionnaire was entitled "Women's Experiences With Body Shape" (see Appendix O).

Item Analysis

A list of summer school courses was obtained from the MSVU registrar's office. This list contained course titles and instructor names for summer courses being offered in Halifax at MSVU and SMU. First and second year undergraduate courses were selected as they were thought to have the highest enrollment. Instructors of the courses selected

were contacted, informed of the nature of the study and asked if she/he would allow the researcher to recruit female students for possible participation in the study. Where and when data collection was to take place was arranged over the telephone with interested instructors.

A letter was written to a psychology faculty member at St. FX (see Appendix R) explaining the nature of the study and asking for information regarding what procedure to follow in trying to gain permission to collect data at that university. The professor responded by telephone, supplying the names of several summer school instructors and their office phone numbers. The instructors were telephoned and all agreed to co-operate.

In all cases, the classes were visited by the researcher (with exception of 1 which was visited by the thesis advisor), the nature of the study explained and interested participants were asked to complete a questionnaire. A consent form was attached to the questionnaire (see Appendix M). One class at St. FX took the questionnaires home to complete and brought them back the following class to be picked up. These subjects were asked to complete the questionnaires independently and informed that it would require approximately 15 minutes to complete. All other instructors offered to let the subjects complete the questionnaire during class time or during break time. After completing the questionnaires, the subjects were debriefed (see Appendix S) and ask to sign a mailing list if they wanted a copy of the results forwarded to them. One instructor at SMU had

male students in the class fill out a questionnaire to make the bonus point available to everyone. (In all cases, bonus points for participation were at the discretion of the professor/instructor.) The males were asked to answer the questionnaire by role playing from a female perspective. This class was asked to indicate their sex by writing "M" or "F" at the top of the questionnaire; the male questionnaires were omitted during data analysis.

Ethical Considerations

Informed consent was obtained from university and high school students, and from their parents if under 18 years of age. Students and parents were informed that interview sessions would be tape recorded but that anonymity would be maintained as students did not have to identify themselves on tape.

There was a possibility that subjects would disclose that they were eating disordered; therefore, all subjects in the item generation sample were informed of counselling services available in their area. Prior to commencing the study, contact was made with counselling services at Mount St. Vincent University and the Sydney Mental Health Clinic to alert them to this possibility. Literature regarding eating disorders and treatment would be made available to subjects who expressed an interest or need for such material (see Appendix P for list of books recommended for adolescents and Appendix Q for addresses of Eating Disorder Agencies in Canada).

CHAPTER IV

RESULTS

Category and Item Development from Item Generation Interviews

The 16 interviews were transcribed and analyzed. There appeared to be 7 common themes or categories that emerged from this data. These themes were as follows:

(1) perfect body shape (**PB**): very specific ideas regarding the perfect female body shape;

(2) societal messages (**SM**): societal messages to be thin from the media, family and friends;

(3) comparing body size (**CB**): comparison of self to other women regarding body size and shape;

(4) thinness equals self–confidence (**TS**): thinness equated with self–confidence and happiness;

(5) exercise (**EX**): exercise viewed as an effective weight loss method;

(6) off hand comments (**OH**): off hand comments by males regarding weight; and

(7) healthy diets (**HD**): "healthy" diets considered a good weight loss method (i.e., more fruit and vegetables).

One hundred and one items were generated from the information contained in these categories. This 101 initial item pool was administered to 131 female university students who comprised the item analysis sample. Several criteria were employed to select the best items from this item pool and to empirically identify underlying dimensions of the reduced data set. It was necessary to eliminate items before conducting a factor analysis as there was not enough subjects in the item analysis sample. Ideally, there should be 3 subjects per item. In this case there were 101 items and only 131 subjects.

Criteria for item elimination analysis included discarding items that did not contain a personal referent, as well as items that had means greater than 4.0. A total of 25 items were discarded using these two criteria. Based on a preliminary factor analysis, 17 of the remaining 76 items with final communality estimates 0.1 or less were eliminated. The remaining 59 items were factor analyzed using a 1, 2, 4 and 5 factor solution. A five factor solution appeared to be the most suitable solution. Eleven items were eliminated as they did not show simple structure (i.e., did not load clearly on any one of the 5 factors); an additional 5 items also were eliminated as two did not load highly on a particular factor and three did not conceptually fit their defining factor. The final questionnaire contained 43 items.

Initial Item Elimination

Eighteen items (see Table 1) that did not contain a personal referent (i.e., the words "I", "me", or "my") were the first items to be discarded during the item elimination process. It was believed that these items were more factual in nature compared to the remaining items that assessed women's personal attitudes and experiences regarding body shape and dieting. An exception to this was item 61 ("A person's attractiveness depends more on their body shape than the style of clothes they are wearing"). Although it did not contain a personal referent, it was retained as it appeared to be personal and reflective in nature.

Next, means were calculated for each item and those with means greater than 4.0 were eliminated. Items with such high means had limited variability and seemed to reflect a social desirability component. Seven items were discarded using this criterion (see Table 2). Thus, a total of 25 items were eliminated through these criteria, now leaving a total of 76 items.

The third criterion for item elimination was to discard items with low communalities. Communality refers to the variance of an "observed variable accounted for by the common factors" (Kim & Mueller, 1978, p. 75). A preliminary factor analysis was conducted on the remaining 76 items using a one factor solution and estimated through unweighted least squares to examine their communality estimates. A one–factor solution was deemed to be a reasonable initial model, as the first eigenvalue (eigenvalue=20.74) was much larger the second (eigenvalue=2.94) so captured most of the variance in the common factor space. In this and subsequent factor analyses, the prior or starting communality estimate for each variable was set to the square of its multiple correlation with all other variables. Seventeen items with communality estimated below 0.1 were eliminated (see Table 3) as this indicated that these items were not part of the common factor space. This left a total of 59 remaining items.

Factor Analysis

The purpose of conducting a factor analysis on the remaining 59 items was to identify the underlying dimensions of the item pool. A decision regarding the number of factors to retain was based on inspection of the eigenvalues (see Table 4) and a scree plot of the eigenvalues (see Figure 1). An eigenvalue not only helps to determine the number of factors to extract but also acts as a "measure of variance accounted for by a given dimension" (Kim & Mueller, 1978, p.76). Eigenvalues less than one explain less variance than a single variable; therefore, it is desirable to have eigenvalues at least equal to one. Examination of the eigenvalues indicate that the first eigenvalue is much larger than the others (as is typical) and that beyond eigenvalue 5, the differences between successive eigenvalues is very small. That is, the amount of variance associated with a component drops off substantially after the 5th component is extracted. In fact, the sixth and seventh eigenvalues are very close to one. The first 10 eigenvalues and the differences between successive eigenvalues are presented in Table 4. Thus, a 5-factor solution seemed most reasonable.

A 4–factor solution also was computed to balance parsimonious data reduction with interpretability of factors. Four and five factor solutions were estimated using an oblique rotation (i.e., permitting factors to be correlated, as it was expected that the dimension would be related). A five factor solution had the most interpretable factors. Eleven items that did not show simple structure (i.e., did not load clearly on any one of the five factors) were eliminated (see Table 5).

The remaining five factors contained a total of 48 items. Factor I contained 18 items, factor II, 10 items, Factor III, 9 items, Factor IV, 9 items, and Factor V, 2 items (see Table 6). The five factors were identified and labelled the following:

Factor I: Body Dissatisfaction and Dieting (**BDD**);

Factor II: Comparing Self to Others and Being Evaluated by Others (**CSE**);

Factor III:Pressure to be Thin from Significant Others and the Media (**PTS**);

Factor IV: Comments Made about Appearance and Self–consciousness (**CAS**); and,

Factor V: Valuing Thinness (**VT**).

Two items with loadings on their defining factor less than 0.5 were eliminated. Specifically, item 43, "I would rather diet than exercise to lose weight" loaded 0.39 on Factor I and item 29, "Diet and exercise articles in magazines are inspirational to me", loaded 0.49 on Factor II. Three items that did not appear to fit conceptually with their defining factor were also eliminated (i.e., item 44, "I feel content with my life when I am slim" was eliminated from Factor II; item 48, "I feel intimidated by slim attractive

women" was eliminated from Factor III; and item 70, "I think most models should gain a few pounds" was eliminated from Factor IV). Items 44, 48 and 70 loaded quite highly on all the 5 factors.

Item Analysis

Cronbach's alphas were calculated along with the corresponding item-to-total correlations (see Table 7) to check the homogeneity of subscales identified in the factor analysis. Examination of item-to-total correlations indicated that deleting items would not improve the homogeneity of the subscales. The five subscales also were intercorrelated and found to be moderately related (see Table 8).

The remaining 43 items are contained in the final version of "Women's Experiences With Body Shape" contained in Appendix T.

TABLE 1

18 Items Without a Personal Referent

Item	
11	Most of the sizes in clothing stores are for slim women with no hips.
16	Often people who are overweight have little will power.
18	Losing weight is easy–stop eating!!!
20	One healthy way to lose weight is to cut out snacking between meals.
22	Good looking, slim women tend to be stuck up.
39	It would be easier for women to live in a culture where thinness is looked down upon.
56	A good way to lose weight is to skip one meal a day.
59	Advertisements on TV and in magazines show "perfect" women.
66	Fasting occasionally is OK.
69	Exercise is the key to looking good.
73	Exercising is the best way top lose weight.
76	Being slim has physical and mental benefits.
81	Guys definitely prefer slim women.
85	Diets that are nutritious but low in calories are OK.
90	A lot of people who lose weight, keep it off.
97	Liquid diets are OK if you don't stay on them too long.
98	In high school, it was the slim girls who had boyfriends.
101	Men have the right to comment on their partner's weight.

TABLE 2

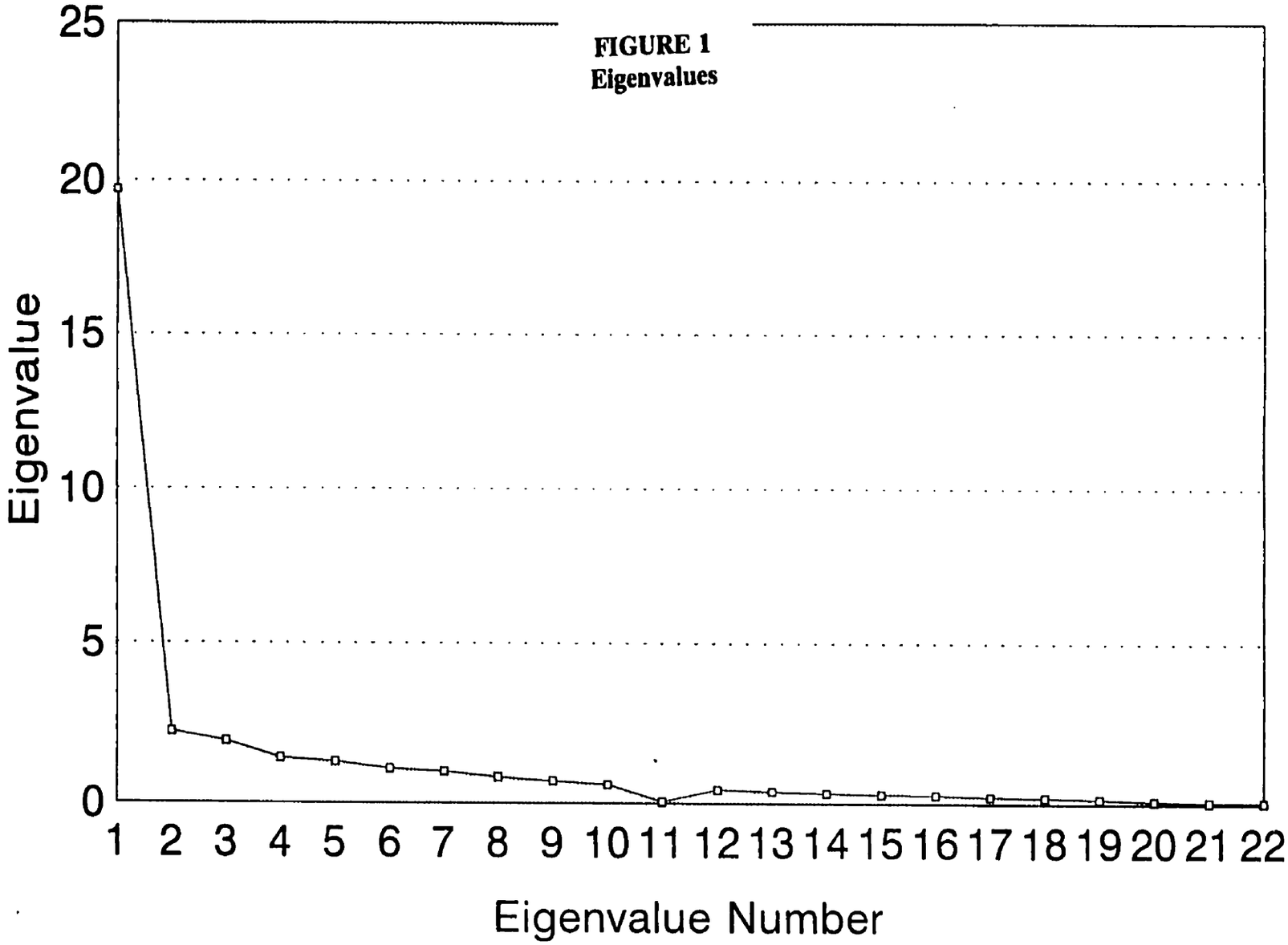
7 Items With Means Greater than 4.0

Item		Mean
6	I would like to be slimmer.	4.07
8	I wish I had more muscle tone.	4.14
9	I believe all the media attention on thinness is promoting eating disorders such as bulimia and anorexia.	4.19
19	I would like to slim down certain body parts.	4.09
31	I hate it when my jeans feel tight.	4.07
72	I wish advertisements would show women of all different shapes and sizes.	4.16
99	I admire people who have the self-discipline to exercise regularly.	4.26

TABLE 3

Final Communality Estimates Below 0.1

Item		Final Communality Estimate
1	I feel happy when long skirts or baggy pants come in style.	0.091
2	My friends and I compare what we've eaten in a day, to see who has eaten the least.	0.050
3	I could look like a model if only I the will power to exercise and diet.	0.049
10	Occasional crash diets are OK if you are in a panic to lose weight for special occasions such as graduations or weddings.	0.001
23	When I overeat, I exercise to burn off the extra calories.	0.006
25	I would like to be taller.	0.096
34	I can lose weight if I put my mind to it.	0.085
38	If I lost weight, I'd never gain it back.	0.001
45	I think the majority of models are anorexic.	0.023
51	I can see why some guys break off their relationships when their partners gain weight.	0.071
53	I am average in size for my height.	0.058
54	I try to exercise regularly.	0.053
62	I smoke to help curb my appetite.	0.085
63	My life would not change if I were slim.	0.076
86	I don't diet to lose weight, I exercise.	0.016
91	Most of the food I eat is low in fat.	0.002
96	When I'm trying to lose weight, I just make sure I eat smaller portions of my usual meals.	0.003



23 to 59 less than 0

TABLE 4

First 10 Eigenvalues and their Successive Differences

Eigenvalue Number	Eigenvalue	Difference
1	19.69	17.42
2	2.27	0.29
3	1.97	0.52
4	1.45	0.12
5	1.33	0.22
6	1.11	0.09
7	1.02	0.17
8	0.85	0.12
9	0.73	0.10
10	0.62	0.07

TABLE 5

11 Items Not Showing Simple Structure

Item	
14	The thought of gaining 5 or 10 pounds upsets me.
17	One good thing about being sick is that you lose weight.
30	When I picture a successful woman, I tend to think of someone who is slim.
32	If I gained weight, I would feel obligated to comment on it.
47	I look and feel my best when I am slim.
52	When I gain weight, I feel self-conscious.
57	I feel depressed when I see models on TV and in magazines.
67	I feel like socializing more when I am slim.
77	I avoid wearing short skirts.
83	I worry about my weight and appearance daily.
95	I often compare my size to women who are smaller than me.

TABLE 6
5 Factors and their Loadings

Factor I–Body Dissatisfaction and Dieting

Item		Factor Loadings
7	I can change my appearance and body shape if I work hard enough.	0.61
15	If I were my ideal weight and body shape, I'd be more self–confident.	0.62
24	I would like to slim down all over.	0.68
26	My behind is not firm enough.	0.62
28	I feel fat most of the time.	0.81
33	I admire people who can stick to a diet.	0.52
35	If I lost weight, I'd be healthier.	0.73
36	My thighs are too flabby.	0.53
37	It bothers me people say they eat everything they want and don't gain weight.	0.67
40	I would like to fit into smaller size clothes.	0.78
42	I have difficulty finding the style of clothes that suit my body.	0.62
43	**I would rather diet than exercise to lose weight.**	**0.39**
46	When I sit down, I fold my arms in front of me to hide my stomach.	0.75
49	When I am slim, I feel anything is possible.	0.52
50	I envy my slimmer friends.	0.77
78	I feel more positive about myself when I am dieting.	0.62
82	When people make negative comments about my weight, it makes me want to lose weight.	0.68
88	People that know me, know that commenting on my weight is a definite no–no.	0.56

***Item 43 was eliminated as its factor loading was only 0.39**

Factor II–Comparing Self to Others and Being Evaluated by Others

Item		Factor Loadings
29	**Diet and exercise articles in magazines are inspirational to me.**	**0.49**
41	Sometimes when I walk by a group of guys, I worry that they are sizing me up and evaluating how I look.	0.63
44	**I feel content with my life when I am slim.**	**0.60**
58	Nothing beats the feeling of putting on your smallest pair of jeans and going out.	0.55
64	I can attain the "perfect" look if I diet and exercise faithfully.	0.53
68	I often compare myself to models I see in advertisements on TV and in magazines.	0.70
74	I think I'd become a recluse if I gained a lot of weight.	0.65
75	I feel relieved when I see women who are heavier than me.	0.59
80	If I was overweight, I wouldn't be caught dead in a bathing suit.	0.49
89	If I gained weight, I would try to avoid being around acquaintances who knew me when I was smaller.	0.64

***Item 29 was eliminated as its factor loading was only 0.49. Item 44 was eliminated as it did not appear to conceptually fit with factor II.**

Factor III–Pressure to be Slim From Significant Others and the Media

Item		Factor Loadings
4	I feel embarrassed asking for help from a sales clerk in a clothing store who is smaller than me.	0.67
5	I'm either on a strict diet or I'm pigging out; there is no in between for me.	0.60
13	When I hear negative comments about my weight, it makes me want to "pig out".	0.60
27	Sometimes it seems my family is more concerned with my weight and appearance than my accomplishments.	0.66
48	**I feel intimidated by slim attractive women.**	**0.58**
65	I get depressed watching women in music videos and in exercise shows.	0.62
79	I feel uncomfortable watching music videos and movies with my male friends because I think they are comparing me to the women in them.	0.63
93	I sometimes ask my friends how my size compares to other women I see in public.	0.52
94	My mother wants me to look good and be slim.	0.63

***Item 48 was eliminated as it did not appear to conceptually fit with factor III.**

Factor IV–Comments Regarding Weight and Appearance

Item		Factor Loadings
12	It really bothers me when male relative and friends make comments about my weight.	0.75
55	I hate it when guys talk about other women's bodies in front of me.	0.63
60	I hate it people I haven't seen for a while immediately comment on my weight.	0.68
70	**I think most models should gain a few pounds.**	**0.55**
71	I often size up other women's size and body shape.	0.63
84	I find people really notice it when women gain weight.	0.58
87	I feel self-conscious at the beach.	0.64
92	I would rather live in a society where being thin is not considered so attractive.	0.55
100	I don't like getting changed in locker rooms.	0.55

***Item 70 was eliminated as it did not appear to conceptually fit with factor IV.**

Factor V–Valuing Thinness

Item		Factor Loadings
21	It is more important for me to be slim than physically fit.	0.68
61	A person's attractiveness depends more on their body shape than the style of clothes they are wearing.	0.60

TABLE 7
Correlational Analyses

Factor I: Body Dissatisfaction and Dieting
(Cronbach's Alpha for Raw Variables=0.93)

Item	Item–to–Total
7	0.58
15	0.66
24	0.65
26	0.56
28	0.77
33	0.50
35	0.69
36	0.54
37	0.71
40	0.75
42	0.61
46	0.74
49	0.60
50	0.80
78	0.65
82	0.67
88	0.49

Factor II: Comparing Self to Others/Being Evaluated by Others
(Cronbach's Alpha for Raw Variables=0.85)

Item	Item–to–Total
41	0.57
44	0.58
58	0.52
64	0.51
68	0.61
74	0.65
75	0.60
80	0.43
89	0.64

Factor III: Pressure to be Thin From Significant Others and The Media (Cronbach's Alpha for Raw Variables=0.85)

Item	Item-to-Total
4	0.63
5	0.59
13	0.52
27	0.63
65	0.59
79	0.69
93	0.48
94	0.56

Factor IV: Comments Made About Appearance and Self-Consciousness (Cronbach's Alpha for Raw Variables=0.83

Item	Item-to-Total
12	0.74
55	0.48
60	0.64
71	0.39
84	0.57
87	0.65
92	0.38
10	0.59

Factor V: Valuing Thinness (Cronbach's Alpha for Raw Variables=0.58)

Items 21 and 61 correlated at 0.41 (p less than 0.001). Item-to-total correlations not applicable as there are only two items in this subscale.

TABLE 8

Pearson Correlation Coefficients for the Five Subscales

	Fact1	Fact2	Fact3	Fact4	Fact5
Fact1	1.00	0.726	0.696	0.687	0.433
Fact2		1.00	0.706	0.573	0.471
Fact3			1.00	0.652	0.467
Fact4				1.000	0.315
Fact5					1.000

(p less than 0.001)

CHAPTER V

DISCUSSION

The newly developed questionnaire, "Women's Experiences with Body Shape" (WEBS) fills a glaring gap in the extant literature on eating disorders and body image, as it examines "normal" women's experiences with appearance, body image, food and dieting by asking women themselves. This feminist methodology is in sharp contrast with the medical model's perspective which focuses solely on overt eating behaviour at the exclusion of symbolic meaning. The present measure attempts to focus on the individual by incorporating contextual elements into the conceptual model of women's feelings and experiences regarding body image and body shape. Instead of relying on clinical samples of eating disordered women, clinical literature and treatment providers, items were generated from semi-structured interviews with "normal" women aged 15 to 29. Items generated from these interviews reflect the content of these interviews and comprise the foundation for the questionnaire. This questionnaire should be something that women can relate to as it was developed out of real women's daily experiences.

One existing self-report measure that is similar to WEBS's methodology is the BSQ which examines global body shape. However, WEBS refines global body image even further by breaking it down into subcomponents, set in a social context. The subcomponents include self-consciousness, pressures from others to be slim and the perceived personal and social benefits of achieving the "thin ideal".

A factor analysis of the reduced set of items revealed five underlying dimensions, "Body Dissatisfaction and Dieting", "Comparing Self to Others and Being Evaluated by Others", "Pressure to be Thin from Significant Others and the Media", "Comments Made about Appearance and Self-consciousness" and "Valuing Thinness". Factor I, body dissatisfaction and dieting, was not surprising as this has been found in numerous other studies. This factor seems to emerge when the focus in on individual women who are viewed in isolation. However, Factors II, III, IV and V were dimensions that seem to be neglected in other research in this area. Wolf (1991) discusses the phenomena of women comparing themselves to other women and constantly feeling they are being evaluated by other women and men, thus causing self-consciousness. The present study supports this observation. The women interviewed had very strong opinions regarding this and felt that their weight and appearance were under constant scrutiny.

These five underlying dimensions appear different, yet related. They seem to reflect different components of body image placed in a socio-cultural context. "Valuing Thinness" had only two items; however, this subscale was retained as the items loaded quite highly with the factor (e.g., item 21 loaded 0.68 and item 61 loaded 0.60) and showed simple structure. The item analysis sample was smaller than the ideal situation of three subjects per variable; therefore, factors derived may not have been as clearly defined had a larger sample been used. Three items had to be eliminated from the final five factor solution as they did not appear to conceptually fit their defining factor. This may have been the result of using a small sample. Despite using three universities for

data collection, only 131 students volunteered to participate. Summer school classes tend to be smaller, with a wider range of ages. As a result, women of varying ages comprised the item analysis sample.

Social desirability played a role in face–to–face interviews and in responses to the large item pool. When asked to describe the perfect body shape during the item generation interviews, the majority of women stressed that they did not consider the thin "waif" look attractive. However, when describing their reactions to pictures of very thin (and at least one anorexic) models, these models were described as having "average" body sizes and were considered to have bodies that the women would like to emulate. This phenomena was difficult to capture in the questionnaire items. The item analysis sample also exhibited social desirability; seven items had to be eliminated as their means were greater than 4.0 (see Table 2). Such high means indicate low variability among women answering these particular questions. However, some degree of social desirability should be expected in such a questionnaire as the issues are closely tied societal pressures women experience.

Comments made to the researcher after interviews and questionnaire completion were very positive. Several subjects said that the questions/items made them reflect on issues they had never examined before, such as pressure from significant others and off hand comments from males regarding weight and appearance. Several subjects mentioned having a friend or relative with an eating disorder. Feedback forms which were used with

only the item generation sample, revealed that one subject believed that she had an eating disorder. All subjects in the item generation sample were informed of eating disorder specialists in their area.

The questionnaire items reflect the content of the item generation interviews. However there were behaviours such as body language and facial expressions that were difficult to capture. The use of qualitative research methodology enabled these behaviours to be observed and described (see Appendix U).

It appears that the initial item pool questionnaire format was difficult to follow. For some analyses, up to 36 subject responses could not be used due to missing values. This was primarily due to some items being answered twice on one line. It may have been more "user friendly" if spaces were placed between items so as to not appear so cluttered.

The underlying dimensions of the questionnaire reflect areas of concern for "normal" women. These areas do not seem that different from concerns of eating disordered women. In order to quantify this observation, it would be necessary to administer the questionnaire to eating disordered women and see if their responses are qualitatively distinct from those of "normal" women.

Further Research

The newly developed instrument lends itself to further research beyond the scope of this study. It would be valuable to administer the item pool to a much larger sample of women, preferably ages 15–29, to match the item generation sample. A factor analysis based on a larger sample would address whether the current five dimensions are particular to this small sample. It also would be advantageous to develop more items for Factor V, "Valuing Thinness" as it appears to be under–identified in the questionnaire.

The present study could be used in cross–cultural research and also could be extended be extended downwards and upwards with regards to age. It would be ideal if item generation interviews were conducted for the different groups, and the items generated administered to a similar aged sample. The current items were derived from women aged 15 to 29; however, the questionnaire was administered to women ranging from 20 years of age to middle age due to the composition of university summer school classes.

The newly developed questionnaire could be used to gather data in order to establish norms for "normal" women. This would eventually allow for scoring of the instrument. The next step would be to administer the questionnaire to a group of bulimic women. Based on the current medical model perspective, one would expect the instrument to clearly discriminate between the bulimic and "normals"; however, if it did not discriminate between the two groups, this would support the argument that eating

disorders are an expression of behaviours already normative for women.

It would be interesting to re-factor analyze the questionnaire including the 7 items with means over 4.0 in the analysis. These items have the potential to discriminate between eating disordered women and "normal" women; eating disordered women in denial may not answer these questions truthfully. These items could also be useful if used with a more diverse item analysis sample. They could provide information regarding cross-cultural differences in body image.

Limitations of the Study

A limitation of the study is the relatively small item analysis sample. This had implications in the interpretation of the five subscales. Re-factor analyzing the questionnaire using a larger sample size would reveal whether or not the dimensions derived were an artifact of the sample.

It also was difficult to quantify and eliminate social desirability. Attempts in controlling for this were the elimination of items with high means and the use of pictures to compare what subjects said abstractly versus what they actually saw concretely. The format of the initial item pool could also be improved.

Conclusion

The present study found "normal" women to be very dissatisfied with their bodies, they wish to be thinner and view thinness as a goal to attain. The "thin ideal" appears to be very evident in the samples of women used in this study. Preoccupation with weight and appearance are not concerns reserved for eating disordered women, but appear to be concerns of women in general.

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APPENDIX A

DSM–IIIR CRITERIA

The diagnostic criteria for bulimia in the DSM–IIIR are as follows:

A. Recurrent episodes of binge eating (rapid consumption of a large amount of food in a discrete period of time).

B. A feeling of lack of control over eating behaviour during the eating binges.

C. The person regularly engages in either self–induced vomiting, use of laxatives or diuretics, strict dieting or fasting, or rigorous exercise in order to prevent weight gain.

D. A minimum average of two binge eating episodes a week for at least three months.

E. Persistent overconcern with body shape and weight (APA, 1987 pp. 68–69).

APPENDIX B

DSM-IV Criteria

The DSM-IV criteria are as follows:

A. Recurrent episodes of binge eating. An episode of binge eating is characterized by both of the following:

(1) eating, in a discrete period of time (e.g., within any two hour period), an amount of food that is definitely larger than most people would eat during a similar period of time and under similar circumstances

(2) a sense of lack of control over eating during the episode (e.g., a feeling that one cannot stop eating or control how much one is eating)

B. Recurrent inappropriate compensatory behavior in order to prevent weight gain, such as self-induced vomiting; misuse of laxatives, diuretics, enemas, or other medications; fasting; or excessive exercise.

C. The binge eating and inappropriate compensatory behaviors both occur, on average, at least twice a week for 3 months.

D. Self-evaluation is unduly influenced by body shape and weight.

E. The disturbance does not occur exclusively during episodes Anorexia Nervosa.

Specify type:

Purging Type: during the current episode of Bulimia Nervosa, the person has regularly engaged in self-induced vomiting or the misuse of laxatives, diuretics or, enemas.

Nonpurging Type: during the current episode of Bulimia Nervosa, the person has used other inappropriate compensatory behaviors, such as fasting, or excessive exercise, but has not regularly engaged in self-induced vomiting or the misuse of laxatives, diuretics, or enemas. (APA, 1994, pp. 549-540).

APPENDIX C

EDI Subscales

(1) **Drive for Thinness**: preoccupation with weight and dieting, which is considered a central feature of anorexia nervosa; (e.g., "I am terrified of gaining weight".)

(2) **Bulimia**: engagement in bulimic behaviours such as uncontrollable binge eating followed by self-induced purging; (e.g., "I have thought of trying to vomit in order to lose weight".)

(3) **Body Dissatisfaction**: dissatisfaction with various body parts, especially those that change with puberty such as, thighs, buttocks and hips; (e.g., "I think that my stomach is too big".)

(4) **Ineffectiveness**: feelings of low self esteem; (e.g.,"I feel alone in the world".)

(5) **Perfectionism**: drive for excellence in all areas of life, such as academically and athletically; (e.g., "I hate being less than best at things".)

(6) **Interpersonal Distrust**: inability to form close, meaningful relationships; (e.g., "I have trouble expressing my emotions to others".)

(7) **Interoceptive Awareness**: inability to recognize one's feelings and emotions, including the sensations of hunger and satiety; (e.g., "I get confused as to whether or not I am hungry".)

(8) **Maturity Fears**: desire to retreat back to the pre-pubertal years in the hope of avoiding the demands of adulthood; (e.g., "I wish that I could be younger".) (Garner et al., 1983).

APPENDIX D

Interview Questions

I'd like to start by asking you your age.

What kind of clothes do you typically wear?

Is there any reason why?

What kind of clothes do you avoid wearing?

Is there any reason why?

Do other people close to you such as your parents, mother, father, brothers, sisters or friends have ways of keeping their weight down?

What do your think of their weight loss methods?

Do you feel pressure from important people in your life to lose weight?

Why do you think they are concerned? Is it for health or appearance reasons?

How does this make you feel?

Are there any foods you avoid eating?

Why do you avoid these foods?

Is there anything frustrating about your own eating habits?

If you could change one thing about your eating habits, what would you change?

What do you think about diets in general?

What type of diet is good?

What are some popular diets people sometimes follow?

Do you monitor your daily food intake? Do you keep a running tab of the calories you eat in the run of a day? If yes, how?

If you had to lose a few pounds, how would you go about doing it?

How important is it for you to be thin in your life?

How important is it for you to be physically fit?

What is more important, to be thin or physically fit?

If you were your ideal weight and body shape, how do you think your life would change or do you think your life would change?

Do you read women's magazines?

What sections do you tend to read most often?

When you get together with your friends, what topics do you usually discuss in relation to what we are talking about now?

What is your favourite television show?

Who is your favourite female character on that show?

Any reason why she is your favourite?

If you could look like anyone, who would you chose?

Can you describe for me, the perfect female body shape?

If you could change one thing about your body, what would it be?

Does anything make you feel bad about your size and weight?

Does anything make you feel good about your size and weight?

If you gained 50 lbs., how would it affect your life?

If you lost 20 lbs., how would if affect your life?

Where do you get messages to be thin in society?

I have some pictures to show you of models. Each picture has a number on top of it. When you describe the model, refer to the number at the top.

Now I have a video I want to show you. I want you to look at the women in the video and afterwards I want to describe your reaction to their appearance.

PAUSE TO WATCH VIDEO

After watching a segment of the video, how did you react to the women in it?

I want to thank you for your time. I really appreciate it.

APPENDIX E

Feedback Form (Item Generation Sample)

Mount Saint Vincent University
Halifax, Nova Scotia, Canada B3M 2J6
Phone 902 457-6341 FAX 902 445-3960

Department of Education
Graduate Studies

Feedback Form

(1) What did you think of the interview? Did you feel comfortable answering the questions? W ere there any you felt uncomfortable answering?

_____

_____

_____

_____

_____

(2) Did the interview address important issues regarding weight and appearance? Do you think other issues could have been addressed? If yes, which ones?

_____

_____

_____

_____

_____

(3) Do you know anyone with an eating disorder?

YES_____ NO_____

(4) Do you believe you have an eating disorder?

YES_____ NO_____

DO NOT SIGN YOUR NAME. THIS WILL ENSURE ANONYMITY.

APPENDIX F

Letter to Head of Special Services

Northside-Victoria School Board

North Sydney, Nova Scotia

Mount Saint Vincent University
Halifax, Nova Scotia. Canada B3M 2J6
Phone 902 457-6341 FAX 902 445-3960

Department of Education
Graduate Studies

Lisa O'Keefe
PO Box 28,
Christmas Island,
Nova Scotia.
BOA-1CO

Special Services,
Northside-Victoria School Board,
Brook Street, North Sydney,
Nova Scotia.

Attention: Helen MacDonald

June 15, 1994

Dear Ms. MacDonald:

Further to our conversation of June 14th, 1994, I have contacted Beth McIssac, Guidance Counsellor, at Memorial High School, in Sydney Mines, as you suggested.

Ms. McIssac has agreed to be a contact person at Memorial High School. She has forwarded a computer list of the names and home phone numbers of all the grade 11 and grade 12 female students at the school. She has also given me permission to use an office adjacent to hers for interviewing students. I will be telephoning students in the near future to see if they are interested in participating in the study.

Enclosed are copies of the parental consent form and student consent forms I will be using. These forms have been approved by my thesis committee at Mount Saint Vincent University.

Should you require additional information, please contact me at my home number, 871-2211. Thank you for allowing me the opportunity to conduct this part of my study in your school district.

Sincerely,

Lisa O'Keefe

Lisa O'Keefe

APPENDIX G

Letter to Guidance Counsellor

Memorial High School

Sydney Mines, Nova Scotia

Mount Saint Vincent University
Halifax, Nova Scotia. Canada B3M 2J6
Phone 902 457-6341 FAX 902 445-3960

Department of Education
Graduate Studies

Lisa O'Keefe
PO Box 28,
Christmas Island,
Nova Scotia.
BOA-1CO

Memorial High School,
Sydney Mines,
Nova Scotia.

Attention: Beth McIssac

June 15, 1994

Dear Ms. McIssac:

I wish to thank you for offering to be a contact person at Memorial High School. I will telephoning grade 11 and 12 students from the computer list you forwarded to me, June 14th, 1994.

I also wish to thank you for allowing me to conduct the interviews in the room adjacent to your office. As previously discussed, I will inform you of my interviewing schedule as soon as possible.

Enclosed are copies of the parental consent form and student consent forms I will be using. These forms have been approved by my thesis committee at Mount Saint Vincent University.

Should you require additional information, please contact me at my home number, 871-2211. Thank you for allowing me the opportunity to carry out this part of my study in your school.

Sincerely,

Lisa O'Keefe

Lisa O'Keefe

APPENDIX H

TELEPHONE SCRIPT

Hi. My name is Lisa O'Keefe and I am a graduate student at Mount St. Vincent University, in Halifax. I got your name from a student list that Beth McIssac, the Guidance Counsellor at Memorial, gave me.

The reason I am calling is to see if you would like to involved in a study I am conducting for my master's thesis, about teenagers' experiences with weight and food. Participation would involve me interviewing you for about 30–40 minutes at Memorial, in an office next to Mrs. McIssac's. The interview would be tape–recorded to help me analyze the information afterwards, but it would be anonymous because you do not have to give your name at any point during the interview.

Would you like to participate?

IF NO: Thank you for your time. Hang up.

IF YES: I will be starting the interviews next week, which is the week of June 20th. Is there a time that is more convenient for you?

SET UP TIME FOR INTERVIEW

ASK THE STUDENT HER AGE

FOR STUDENTS UNDER 18 YEARS OF AGE: Because you are under 18 years of age, I will need your parents to sign a consent form. I will leave consent forms with Sherry, the secretary, at Memorial. Would you please pick up the form, have your parent read it and sign it. I also have a form for you to read and sign. Would you please bring the signed forms to the interview when you come.

FOR STUDENTS OVER 18 YEARS OF AGE: I will leave a form with Sherry, the secretary, at Memorial, that I'll need you to read and sign. Would you please pick the form up and bring it the interview when you come.

CLOSING REMARKS FOR EVERYONE: My home phone number is 871–2211 in case you or your parents have any questions about the study. If you are unable to come to the interview or change your mind about participating, I would appreciate it if you would call me so I can get another student to take your place. Thanks and I look forward to meeting you next week.

APPENDIX I

Parental Consent Form

Item Generation Sample

(high school students under 18 years of age)

Mount Saint Vincent University
Halifax, Nova Scotia, Canada B3M 2J6
Phone 902 457-6341 FAX 902 445-3960

Department of Education
Graduate Studies

Parental Consent Form

My name is Lisa O'Keefe and I am a graduate student at Mount Saint Vincent University, in Halifax. I am currently working on my thesis and would like permission to have your daughter participate in a study of young women's experiences with food and dieting. The study calls for me to interview your child individually at Memorial High School, in Sydney Mines. Helen MacDonald, head of Special Services with the Northside-Victoria School Board, and Beth McIssac, Guidance Counsellor, at Memorial High School, are aware of this study.

In the interview, I will be asking your daughter questions regarding her experiences with food and dieting. Sessions will be tape recorded but no record will be kept of which students participated in which interview. Therefore, there will be no way of identifying your daughter's answers. I am interested in gathering information regarding teenagers' feelings toward their appearance and the pressures they may feel to be slim.

Sessions will be informal and take approximately 30-40 minutes. Your child is free to withdraw from the study at any time. If you have any questions or wish more information regarding this study, please feel free to contact myself at 871-2211 or my thesis advisor, Dr. Mary Delaney, Psychology Department, Mount St. Vincent University, at 457-6559. If you would like to speak to someone not directly involved in the study, please contact Rilda van Feggelen, School Psychology Supervisor, at 457-6329.

Envelopes are included with the permission forms. If you would like a copy of the results, please address the envelope and return it with the permission form. The results of the study will be forwarded to you as soon as they are available.

If you are willing to have your child participate in this study, please sign the enclosed form and have your daughter bring it to the interview. Please be assured that tape recorded sessions will be strictly confidential and will be used for the purposes of this study only. Thank you for your consideration.

Sincerely,

Lisa O'Keefe

Lisa O'Keefe, B.Sp.Ed., B.Ed.

After having read the above description of the study, I give permission for my daughter_____ to participate. I also consent to the reporting of the results of this study, with the understanding that information will be anonymous so that no identification of particular children can be made.

Signature of parent:_____

Date:_____

APPENDIX J

Item Generation Sample

Student Consent Form

(high school students under 18 years of age/

18 years of age and over)

Mount Saint Vincent University
Halifax. Nova Scotia. Canada B3M 2J6
Phone 902 457-6341 FAX 902 445-3960

Department of Education
Graduate Studies

Student Consent Form

You have expressed interest in participating in a study I am conducting on teenage girls' experiences with food, appearance and dieting. As previously discussed during our telephone conversation, participation would involve being interviewed at Memorial High School, during a time that was convenient for you. Questions asked would address the above issues and take approximately 30-40 minutes. All information will be strictly confidential. If you have any questions regarding the study or must cancel the interview, please contact me at 871-2211. Thank you for your consideration.

Sincerely,

Lisa O'Keefe

Lisa O'Keefe

Yes, I am interested in being in your study.

Name (Please print):_____

Mount Saint Vincent University
Halifax, Nova Scotia, Canada B3M 2J6
Phone 902 457-6341 FAX 902 445-3960

Department of Education
Graduate Studies

Student Consent Form
(18 years of age or older)

You have expressed interest in participating in a study I am conducting on young women's experiences with food and dieting. Helen MacDonald, head of Special Services with the Northside-Victoria School Board and Beth McIssac, Guidance Counsellor at Memorial High School, are both aware of this study. As discussed in our previous telephone conversation, participation would involve being individually interviewed by me, at Memorial High School, in Sydney Mines.

In the interview, I will be asking you questions about your experiences with food and dieting. Sessions will be tape recorded but no record will be kept of which students participated in which interviews. Therefore, there will be no way of identifying your answers. I am interested in gathering information regarding young women's feelings toward their appearance and pressures they may feel to be slim.

Sessions will be informal and take approximately 30-40 minutes. I will be conducting the interviews in an office next to Beth McIssac's office at Memorial High School. You

1/..2

may withdraw from the study at any time. If you have any questions or wish more information regarding this study please feel free to contact my thesis advisor, Dr. Mary Delaney, Psychology Department, Mount St. Vincent University, at 457-6559. If you would like to speak to someone not directly involved in the study, please contact Rilda van Feggelen, School Psychology Supervisor, at 457-6329.

An envelope is included with this consent form. If you would like a copy of the results, please address the envelope and include it with this form. The results of the study will be forwarded to you as soon as they are available.

If you are willing to participate in this study, please sign the enclosed form and bring it with you to the interview. The time of the interview has already been scheduled over the telephone. If you are unable to attend the interview or have any additional questions, please contact me at my home number, 871-2211. Thank you for your consideration and I look forward to meeting you next week.

Sincerely,

Lisa O'Keefe

Lisa O'Keefe, B.Sp.Ed., B.Ed.

Yes, I am interested in being in your study.

Name (Please print) _____

APPENDIX K

Letter to Student Affairs

Mt. St. Vincent University

Halifax, Nova Scotia

Mount Saint Vincent University
Halifax, Nova Scotia, Canada B3M 2J6
Phone 902 457-6341 FAX 902 445-3960

Department of Education
Graduate Studies

Lisa O'Keefe
PO Box 28
Christmas Island
Nova Scotia
BOA-1CO

Dean of Student Services
Mount St. Vincent University
Halifax, Nova Scotia

Attention: Dr. Carol Hill

June 28, 1994

Dear Dr. Hill:

Further to a telephone discussion with a representative at Student Services, I am writing to inform you of a study I am conducting on campus.

I am a graduate student in the school psychology program here at Mount St. Vincent University. I am presently collecting data for my thesis. This involves me interviewing female undergraduate students enrolled in a summer psychology course. I am asking these women to describe their experiences with food and dieting and any societal pressures they may feel to be slim.

Ethical considerations involve the possibility of disclosure of an eating disorder. I understand that Norma Wadden is working as a counsellor on campus over the summer and she has experience dealing with women who are eating disordered.

I wish to alert you of the fact that I am informing the participants in the study that there is a counsellor available to help them if they suspect they may have an eating disorder.

Should you require more information about this study, please contact me at 871-2211 or my thesis advisor, Dr. Mary Delaney at 457-6559.

Thank you for your attention to this matter.

Sincerely,

Lisa O'Keefe

Lisa O'Keefe

APPENDIX L

Student Consent Form

Item Generation Sample

(University Students)

Mount Saint Vincent University
Halifax, Nova Scotia, Canada B3M 2J6
Phone 902 457-6341 FAX 902 445-3960

Department of Education
Graduate Studies

Consent Form

My name is Lisa O'Keefe and I am a graduate student at Mount Saint Vincent University. I am currently working on my thesis and am seeking university students to participate in a study of women's experiences with food and dieting. If interested, the study calls for you to participate in an individual interview session with me. You will be asked questions regarding your experiences with food and dieting. Sessions will be tape recorded but no record will be kept of which students participated in which discussions, therefore, there will be no way of identifying your answers. I am interested in gathering information regarding women's feelings toward their appearance and the pressures they may feel to be slim.

Sessions will be informal and take approximately 20-30 minutes. You are free to withdraw from the study at any time. If you have any questions or wish more information regarding this study, please feel free to contact myself at 871-2211 or my thesis adivsor, Dr. Mary Delaney, Psychology Deptartment, Mount St. Vincent University, 457-6559. If you would like to speak to someone not directly involved in the study, please contact Rilda van Feggelen, School Psychology Supervisor, at 457-6329.

Envelopes will be provided at the interview. If you would like a copy of the results, you will be asked to address an envelope. The results of the study would be forwarded to you as soon as they are available.

If you are willing to participate in this study, please sign the enclosed form. Please be advised that tape recorded sessions will be strictly confidential and will be used for the purposes of this study only. Thank you for your consideration.

Sincerely,

Lisa O'Keefe

Lisa O'Keefe

Yes, I am interested in being in your study.

Name (Please print): _____

Phone Number: _____

PLEASE DETACH AND SIGN THIS PAGE OF THE CONSENT FORM AND PLACE IT IN THE ENVELOPE OUTSIDE DR. CRONIN'S OFFICE (SETON 441).

THE NEXT STEP IS TO SIGN UP FOR AN INTERVIEW TIME ON JUNE 27TH OR 28TH. THIS SHEET IS ALSO POSTED OUTSIDE DR. CRONIN'S OFFICE. YOU WILL BE CONTACTED OVER THE PHONE FOR CONFIRMATION OF THIS TIME.

SIGN UP SHEET FOR INTERIVEWS

INTERVIEWS FOR STUDY ARE BEING HELD IN SAC 403

INTERVIEWS ARE SCHEDULED FOR MONDAY, JUNE 27TH OR TUESDAY, JUNE 28TH.

PLEASE PUT YOUR INITIALS BY A TIME THAT IS CONVENIENT FOR YOU.

MONDAY, JUNE 27TH	TUESDAY, JUNE 28TH
9:O0-9:45 _____	9:00-9:45 _____
9:45-10:30 _____	9:45-10:30 _____
10:30-11:15 _____	
11:15-12:00 _____	

PLEASE SIGN PAGE TWO OF THE CONSENT FORM AND PLACE IT IN THE ENVELOPE PROVIDED.

THE NEXT STEP IS TO SIGN UP FOR AN INTERVIEW TIME ON THIS SHEET. YOU WILL BE CONTACTED OVER THE PHONE FOR CONFIRMATION OF YOUR INTERIVEW TIME.

THANK YOU!!!

APPENDIX M

Student Consent Form

(Item Analysis Sample)

Mount Saint Vincent University
Halifax, Nova Scotia, Canada B3M 2J6
Phone 902 457-6341 FAX 902 445-3960

Department of Education
Graduate Studies

Consent Form

My name is Lisa O'Keefe and I am a graduate student at Mount Saint Vincent University in Halifax. I am currently working on my master's thesis and am seeking university students to participate in a study of women's experiences with food and dieting. If interested, the study calls for you to participate by completing the enclosed questionnaire. You will be asked about your experiences with food and dieting. All questionnaires will be anonymous. You will not be asked to put your name on the questionnaire. I am interested in gathering information regarding womens' feelings toward their appearance and pressures they may feel to be slim.

It will take approximately 10-15 minutes to complete the questionnaire. You may withdraw from the study at any time. If you have any questions or wish more information regarding this study, please feel free to contact myself at 863-8328 or my thesis advisor, Dr. Mary Delaney, Psychology Department, Mount St. Vincent University, 457-6559. If you would like to speak to someone not directly involved in the study, please contact Rilda van Feggelen, school psychology supervisor, at 457-6329.

If you are willing to participate in this study, please detach this form and begin the questionnaire. Please keep the consent form for your own information.

Thank you for your cooperation. It is very much appreciated!

Sincerely,

Lisa O'Keefe

Lisa O'Keefe

APPENDIX N

Categories and Items Generated from Transcribed Interviews

(1) VERY SPECIFIC "IDEAL" FEMALE BODY SHAPE

-THIN (BUT NOT TOO SKINNY/BONY)
-TALL
-MUSCULAR (BUT NOT TOO MUSCULAR/MUSCLE DEFINITION);
-TONED/FIRM; "CURVY" SHAPE

ALL INTERVIEWEES WANTED TO BE SMALLER THAN THEIR CURRENT SIZE. (THOSE WHO WERE VERY SMALL WISHED TO MAINTAIN THIS SIZE.)

PROPOSED ITEMS FROM CATEGORY #1:

(1) I would like to be taller.
(2) I would like to be slimmer.
(3) I wish I had more muscle tone.
(4) It is more important for me to be slim than to be physically fit.
(5) I would like to slim down all over.
(6) I would like to slim down certain body parts.
(7) I feel fat most of the time.
(8) The thought of gaining 5 or 10 pounds upsets me.
(9) Often people who are overweight have little will power.
(10) I hate it when my jeans feel tight.
(11) My thighs are too flabby.
(12) My behind is not firm enough.
(13) If I lost weight, I'd never gain it back.
(14) I can lose weight if I put my mind to it.
(15) I would like to fit into a smaller size clothes.
(16) I have difficulty finding the style of clothes that suit my body shape.
(17) When I sit down, I fold my arms in front of me to hide my stomach.
(18) A person's attractiveness depends more on their body shape than the style of clothes they are wearing.

(2) MESSAGES TO BE THIN AND PRESSURES TO BE THIN FROM: (i) TV; (ii) FASHION INDUSTRY; (iii) MUSIC VIDEOS; (iv) EXERCISE SHOWS; (v) MAGAZINES; (vi) FRIENDS; (vii) PEER PRESSURE AT SCHOOL; AND (viii) FAMILY

PROPOSED ITEMS FROM CATEGORY #2:

(19) Advertisements on TV and in magazines show "perfect" women.
(20) I can attain the "perfect" look if I diet and exercise faithfully.
(21) I can change my appearance and body shape if I work hard enough.
(22) I often compare myself to the models I see in advertisements on TV and in magazines.
(23) I get depressed watching the women on music videos and in exercise shows.
(24) I wish advertisements would show women of all different shapes and sizes.
(25) I believe all the media attention on thinness is promoting eating disorders such as bulimia and anorexia.
(26) I would rather live in a society where being thin is not considered so attractive.
(27) I worry about my weight and appearance daily.
(28) I could look like a model if only I had the will power to exercise and diet.
(29) I think the majority of models are anorexic.
(30) It bothers me when people say they eat everything they want and don't gain weight.
(31) I feel uncomfortable watching music videos and movies with male friends because I think they are comparing me to the women in them.
(32) I envy my slimmer friends.
(33) My mother wants me to look good and be slim.
(34) My friends and I compare what we've eaten in a day to see who has eaten the least.
(35) I admire people who can stick to a diet.
(36) In high school, it was the slim girls who had boyfriends.
(37) I don't like getting changed in locker rooms.
(38) I avoid wearing short skirts.
(39) Most of the sizes in clothing stores are for slim women with narrow hips.
(40) I feel happy when long skirts or baggy pants come in style.
(41) It would be easier for women to live in a culture where thinness is looked down upon.
(42) I find people really notice it when women gain weight.
(43) Diet and exercise articles in magazines are inspirational to me.
(44) I think most models should gain a few pounds.
(45) I admire people who have the self-discipline to exercise regularly.
(46) Sometimes it seems that my family is more concerned with my weight and appearance than my accomplishments.
(47) I hate it when people I haven't seen for a while immediately comment on my weight.
(48) If I gained weight, I would try to avoid being around acquaintances who knew me when I was smaller.
(49) If I gained weight, I would feel obligated to comment on it when I am out.

(3) COMPARING SELF TO OTHERS WITH REGARDS TO SIZE

PROPOSED ITEMS FOR CATEGORY #3:

(50) I often compare my size to women who are smaller than me.
(51) I sometimes ask my friends how my size compares to other women I see in public.
(52) I feel relieved when I see women who are heavier than me.
(53) I often size up other women's size and body shape.
(54) Good looking, slim women tend to be stuck up.
(55) I feel embarrassed asking for help from a sales clerk in a clothing store who is smaller than me.
(56) I am average in size for my height.
(57) I feel intimidated by slim, attractive women.
(58) I feel depressed when I see models in magazines and on T.V.

(4) THINNESS IS EQUATED WITH SELF-CONFIDENCE AND HAS SOCIAL AND PERSONAL BENEFITS.

PROPOSED ITEMS FROM CATEGORY #4:

(59) If I were my ideal weight and body shape, I'd be more self-confident.
(60) When I gain weight, I feel self-conscious.
(61) When I am slim, I feel anything is possible.
(62) I feel content with my life when I am slim.
(63) My life would not change if I were slim.
(64) When I picture a successful woman, I tend to think of someone who is slim.
(65) Being slim has physical and mental benefits.
(66) I feel self-conscious at the beach.
(67) I feel like socializing more when I am slim.
(68) I think I'd become a recluse if I gained a lot of weight.
(69) Guys definitely prefer slim women.
(70) If I was overweight, I wouldn't be caught dead in a bathing suit.
(71) I look and feel my best when I am slim.
(72) I can see why some guys break off relationships when their partners gain weight.
(73) Nothing beats the feeling of putting on your smallest pair of jeans and going out.
(74) I feel more positive about myself when I am dieting.

(5) EXERCISE AS A HEALTHY AND EFFECTIVE WAY TO LOSE/MAINTAIN WEIGHT.

PROPOSED ITEMS FROM CATEGORY 5:

(75) Exercising is the best way to lose weight.
(76) I try to exercise regularly.
(77) When I overeat, I exercise to burn off the extra calories.
(78) Exercise is the key to looking good.
(79) I don't diet to lose weight, I exercise.

(6) OFF HAND COMMENTS FROM MALES (FATHER, PARTNER, BROTHER, MALE PEERS) REGARDING WEIGHT.

PROPOSED ITEMS FROM CATEGORY #6:

(80) It really bothers me when male relatives or friends make comments about my weight.
(81) When people make negative comments about my size, it makes me want to be lose weight.
(82) When I hear negative comments about my weight, it makes me want to "pig out".
(83) People who know me, know that commenting on my weight is a definite no–no.
(84) I hate it when guys talk about other women's bodies in front of me.
(85) Sometimes when I walk by a group of guys, I worry that they are sizing me up and evaluating how I look.
(86) Men have the right to comment on their partner's weight.

(7) "HEALTHY" DIETS ARE A GOOD WAY TO LOSE WEIGHT.
-i.e., eat more fruit, vegetables and cut out "junk" food

(SOCIAL DESIRABILITY WAS EVIDENT IN THE COMMENTS MADE BY THE INTERVIEWEES)

PROPOSED ITEMS FROM CATEGORY #7:

(87) I would rather diet than exercise to lose weight.
(88) Fasting occasionally is O.K.
(89) Occasional crash diets are O.K. if you are in a panic to lose weight for a very special occasion such as graduations or weddings.
(90) I smoke to help curb my appetite.
(91) I'm either on a strict diet or I'm pigging out; there is no in between for me.
(92) Losing weight is easy--stop eating!!
(93) Liquid diets are O.K.if you don't stay on them long.
(94) A good way to lose weight is to skip one meal a day.
(95) One good thing about being sick is that you lose weight.
(96) Most of the food I eat is low in fat.
(97) One healthy way to lose weight is to cut out snacking between meals.
(98) Diets that are nutritious but low in calories are O.K..
(99) A lot of people who lose weight, keep it off.
(100) When I'm trying to lose weight, I just make sure I eat smaller portions of my usual meals.
(101) If I lost weight, I'd be healthier.

APPENDIX O

Initial Item Pool for Questionnaire

"Women's Experiences with Body Shape"

THE MARGINS HAVE BEEN ALTERED FROM THE ORIGINAL TO FIT THIS DOCUMENT

WOMEN'S EXPERIENCES WITH BODY SHAPE

PLEASE DO NOT SIGN YOUR NAME. THIS WILL ENSURE ANONYMITY.

This questionnaire contains statements regarding societal pressures placed on women to be thin. Please read each statement carefully and answer honestly how each one applies to you by circling the appropriate number. **There are no right or wrong answers.** (The term "partner" refers to a person with whom one is romantically involved.)

1 = strongly disagree
2 = disagree
3 = neither agree nor disagree
4 = agree
5 = strongly agree

(1) I feel happy when long skirts or baggy pants come in style.
1 2 3 4 5

(2) My friends and I compare what we've eaten in a day to see who has eaten the least.
1 2 3 4 5

(3) I could look like a model if only I had the will power to exercise and diet.
1 2 3 4 5

(4) I feel embarrassed asking for help from a sales clerk in a clothing store who is smaller than me.
1 2 3 4 5

(5) I'm either on a strict diet or I'm pigging out; there is no in between for me.
1 2 3 4 5

(6) I would like to be slimmer.
1 2 3 4 5

(7) I can change my appearance and body shape if I work hard enough.
1 2 3 4 5

(8) I wish I had more muscle tone.
1 2 3 4 5

(9) I believe all the media attention on thinness is promoting eating disorders such as bulimia and anorexia.
1 2 3 4 5

(10) Occasional crash diets are O.K. if you are in a panic to lose weight for very special occasions such as graduations or weddings.
1 2 3 4 5

(11) Most of the sizes in clothing stores are for slim women with narrow hips.
1 2 3 4 5

1 = strongly disagree
2 = disagree
3 = neither agree nor disagree
4 = agree
5 = strongly agree

(12) It really bothers me when male relatives or friends make comments about my weight.
1 2 3 4 5

(13) When I hear negative comments about my weight, it makes me want to "pig out".
1 2 3 4 5

(14) The thought of gaining 5 or 10 pounds upsets me.
1 2 3 4 5

(15) If I were my ideal weight and body shape, I'd be more self-confident.
1 2 3 4 5

(16) Often people who are overweight have little will power.
1 2 3 4 5

(17) One good thing about being sick is that you lose weight.
1 2 3 4 5

(18) Losing weight is easy-stop eating!!
1 2 3 4 5

(19) I would like to slim down certain body parts.
1 2 3 4 5

(20) One healthy way to lose weight is to cut out snacking between meals.
1 2 3 4 5

(21) It is more important for me to be slim than to be physically fit.
1 2 3 4 5

(22) Good looking, slim women tend to be stuck up.
1 2 3 4 5

(23) When I overeat, I exercise to burn off the extra calories.
1 2 3 4 5

(24) I would like to slim down all over.
1 2 3 4 5

(25) I would like to be taller.
1 2 3 4 5

(26) My behind is not firm enough.
1 2 3 4 5

(27) Sometimes it seems that my family is more concerned with my weight and appearance than my accomplishments.
1 2 3 4 5

(28) I feel fat most of the time.
1 2 3 4 5

1 = strongly disagree
2 = disagree
3 = neither agree nor disagree
4 = agree
5 = strongly agree

(29) Diet and exercise articles in magazines are inspirational to me.
1 2 3 4 5

(30) When I picture a successful woman, I tend to think of someone who is slim.
1 2 3 4 5

(31) I hate it when my jeans feel tight.
1 2 3 4 5

(32) If I gained weight, I would feel obligated to comment on it when I was out.
1 2 3 4 5

(33) I admire people who can stick to a diet.
1 2 3 4 5

(34) I can lose weight if I put my mind to it.
1 2 3 4 5

(35) If I lost weight, I'd be healthier.
1 2 3 4 5

(36) My thighs are too flabby.
1 2 3 4 5

(37) It bothers me when people say they eat everything they want and don't gain weight.
1 2 3 4 5

(38) If I lost weight, I'd never gain it back.
1 2 3 4 5

(39) It would be easier for women to live in a culture where thinness is looked down upon.
1 2 3 4 5

(40) I would like to fit into a smaller size clothes.
1 2 3 4 5

(41) Sometimes when I walk by a group of guys, I worry that they are sizing me up and evaluating how I look.
1 2 3 4 5

(42) I have difficulty finding the style of clothes that suit my body.
1 2 3 4 5

(43) I would rather diet than exercise to lose weight.
1 2 3 4 5

1 = strongly disagree
2 = disagree
3 = neither agree nor disagree
4 = agree
5 = strongly agree

(44) I feel content with my life when I am slim.
1 2 3 4 5

(45) I think the majority of models are anorexic.
1 2 3 4 5

(46) When I sit down, I fold my arms in front of me to hide my stomach.
1 2 3 4 5

(47) I look and feel my best when I am slim.
1 2 3 4 5

(48) I feel intimidated by slim, attractive women.
1 2 3 4 5

(49) When I am slim, I feel anything is possible.
1 2 3 4 5

(50) I envy my slimmer friends.
1 2 3 4 5

(51) I can see why some guys break off relationships when their partners gain weight.
1 2 3 4 5

(52) When I gain weight, I feel self-conscious.
1 2 3 4 5

(53) I am average in size for my height.
1 2 3 4 5

(54) I try to exercise regularly.
1 2 3 4 5

(55) I hate it when guys talk about other women's bodies in front of me.
1 2 3 4 5

(56) A good way to lose weight is to skip one meal a day.
1 2 3 4 5

(57) I feel depressed when I see models in magazines and on T.V.
1 2 3 4 5

(58) Nothing beats the feeling of putting on your smallest pair of jeans and going out.
1 2 3 4 5

(59) Advertisements on TV and in magazines show "perfect" women.
1 2 3 4 5

1 = strongly disagree
2 = disagree
3 = neither agree nor disagree
4 = agree
5 = strongly agree

(60) I hate it when people I haven't seen for a while immediately comment on my weight.
1 2 3 4 5

(61) A person's attractiveness depends more on their body shape than the style of clothes they are wearing.
1 2 3 4 5

(62) I smoke to help curb my appetite.
1 2 3 4 5

(63) My life would not change if I were slim.
1 2 3 4 5

(64) I can attain the "perfect" look if I diet and exercise faithfully.
1 2 3 4 5

(65) I get depressed watching the women on music videos and in exercise shows.
1 2 3 4 5

(66) Fasting occasionally is O.K.
1 2 3 4 5

(67) I feel like socializing more when I am slim.
1 2 3 4 5

(68) I often compare myself to the models I see in advertisements on TV and in magazines.
1 2 3 4 5

(69) Exercise is the key to looking good.
1 2 3 4 5

(70) I think most models should gain a few pounds.
1 2 3 4 5

(71) I often size up other women's size and body shape.
1 2 3 4 5

(72) I wish advertisements would show women of all different shapes and sizes.
1 2 3 4 5

(73) Exercising is the best way to lose weight.
1 2 3 4 5

(74) I think I'd become a recluse if I gained a lot of weight.
1 2 3 4 5

1 = strongly disagree
2 = disagree
3 = neither agree nor disagree
4 = agree
5 = strongly agree

(75) I feel relieved when I see women who are heavier than me.
1 2 3 4 5

(76) Being slim has physical and mental benefits.
1 2 3 4 5

(77) I avoid wearing short skirts.
1 2 3 4 5

(78) I feel more positive about myself when I am dieting.
1 2 3 4 5

(79) I feel uncomfortable watching music videos and movies with male friends because I think they are comparing me to the women in them.
1 2 3 4 5

(80) If I was overweight, I wouldn't be caught dead in a bathing suit.
1 2 3 4 5

(81) Guys definitely prefer slim women.
1 2 3 4 5

(82) When people make negative comments about my size, it makes me want to be lose weight.
1 2 3 4 5

(83) I worry about my weight and appearance daily.
1 2 3 4 5

(84) I find people really notice it when women gain weight.
1 2 3 4 5

(85) Diets that are nutritious but low in calories are O.K..
1 2 3 4 5

(86) I don't diet to lose weight, I exercise.
1 2 3 4 5

(87) I feel self–conscious at the beach.
1 2 3 4 5

(88) People who know me, know that commenting on my weight is a definite no–no.
1 2 3 4 5

(89) If I gained weight, I would try to avoid being around acquaintances who knew me when I was smaller.
1 2 3 4 5

1 = strongly disagree
2 = disagree
3 = neither agree nor disagree
4 = agree
5 = strongly agree

(90) A lot of people who lose weight, keep it off.
1 2 3 4 5

(91) Most of the food I eat is low in fat.
1 2 3 4 5

(92) I would rather live in a society where being thin is not considered so attractive.
1 2 3 4 5

(93) I sometimes ask my friends how my size compares to other women I see in public.
1 2 3 4 5

(94) My mother wants me to look good and be slim.
1 2 3 4 5

(95) I often compare my size to women who are smaller than me.
1 2 3 4 5

(96) When I'm trying to lose weight, I just make sure I eat smaller portions of my usual meals.
1 2 3 4 5

(97) Liquid diets are O.K.if you don't stay on them long.
1 2 3 4 5

(98) In high school, it was the slim girls who had boyfriends.
1 2 3 4 5

(99) I admire people who have the self-discipline to exercise regularly.
1 2 3 4 5

(100) I don't like getting changed in locker rooms.
1 2 3 4 5

(101) Men have the right to comment on their partner's weight.
1 2 3 4 5

APPENDIX P

Books Recommended for Adolescents

Arnold, C. (1984). Too fat? Too thin? Do you have a choice?. New York: William Morrow & Company.

Bruch,H. (1978). The golden cage. Cambridge, Mass.: Harvard University Press.

Carney, B. (1986). A preventative curriculum for anorexia and bulimia. Windsor, Ontario: University of Windsor–Bulimia Anorexia Nervosa Association.

Landau, E. (1979). Why are they starving themselves? Understanding anorexia and bulimia. New York: Julian Messner.

Levenkron, S. (1979). The best little girl in the world. New York: Warner Books.

O'Neill, C. (1983). Starving for attention. New York: Dell Publishing.

APPENDIX Q

Canadian Eating Disorders Agencies

National Association of Anorexia Nervosa and Associated Eating Disorders

c/o 291 Nigel Avenue,
Vancouver, BC.
(604) 783-6787

National Eating Disorder Information Centre

c/o Toronto General Hospital
200 Elizabeth Street
CCRW 2nd Floor room 332
Toronto, ONT. M5G-2C4
(416) 595-4156

Women's Health Clinic

304-414 Graham Avenue
Winnipeg, MAN. R3C-O98
(204) 947-1517

Bulimia/Anorexia Association (BANA)

University of Windsor
Windsor, ONT. N9B-3P4
(519) 253-4232 ext 2429
BANA hotline- (519) 253-7421

APPENDIX R

Letter to Psychology Faculty Member

St. Francis Xavier University

Antigonish, Nova Scotia

Mount Saint Vincent University
Halifax, Nova Scotia, Canada B3M 2J6
Phone 902 457-6341 FAX 902 445-3960

Department of Education
Graduate Studies

Lisa O'Keefe
134 Main Street,
Antigonish, Nova Scotia
B2G-2B7
Phone #:863-8328

Dr. Zoe Hayes
St. Francis Xavier University,
Antigonish, Nova Scotia

July 7, 1994

Dear Dr. Hayes:

My name is Lisa O'Keefe and I am a graduate student in school psychology at Mt. St. Vincent University. My thesis advisor, Mary Delaney, gave me your name as a possible contact person at St. Francis Xavier University.

I am presently collecting data for my thesis. I am developing a self-report instrument which examines societal pressures placed on women to be thin. As part of the questionnaire's development, I would like to administer the initial item pool to female undergraduate students at St. Francis Xavier.

I am writing in hopes that you may inform me of the proper procedure to follow or person to contact regarding this matter.

Thank you for your attention and I look forward to hearing from you.

Sincerely,

Lisa O'Keefe

Lisa O'Keefe
Phone #: 863-8328

APPENDIX S

Debriefing Script

The statements found in the "Women's Experiences with Body Shape" questionnaire came from interviews recently conducted with females aged 15–29 years of age who were asked questions regarding their experiences with food and dieting and to comment on societal pressures they may feel to be slim.

The 101 statements in the questionnaire form the initial item pool for the final version of the questionnaire. The purpose of this phase of the data collection is to statistically analyze your reaction to these statements in order to eliminate ones that are unsuitable. The end result will be a much shorter, more concise final questionnaire.

If you'd like a summary of the results of this study mailed to you, please sign the mailing list I have here. I'll forward them to you as soon as they are available.

Thank you for your interest and co–operation.

MAILING LIST

IF YOU WOULD LIKE THE RESULTS OF THIS STUDY TO BE MAILED TO YOU, PLEASE PUT YOUR NAME AND ADDRESS ON THIS SHEET. THEY WILL BE FORWARDED TO YOU AS SOON AS THEY ARE AVAILABLE.

THANK YOU FOR PARTICIPATING IN THIS STUDY.

APPENDIX T

THE MARGINS HAVE BEEN ALTERED FROM THE ORIGINAL TO FIT THIS DOCUMENT

"WOMEN'S EXPERIENCES WITH BODY SHAPE"

PLEASE DO NOT SIGN YOUR NAME. THIS WILL ENSURE ANONYMITY.

This questionnaire contains statements regarding societal pressures placed on women to be thin. Please read each statement carefully and answer honestly how each one applies to you by circling the appropriate number. **There are no right or wrong answers.** (The term "partner" refers to a person with whom one is romantically involved.)

1 = strongly disagree
2 = disagree
3 = neither agree nor disagree
4 = agree
5 = strongly agree

(1) I feel embarrassed asking for help from a sales clerk in a clothing store who is smaller than me.
1 2 3 4 5

(2) I'm either on a strict diet or I'm pigging out; there is no in between for me.
1 2 3 4 5

(3) I can change my appearance and body shape if I work hard enough.
1 2 3 4 5

(4) It really bothers me when male relatives or friends make comments about my weight.
1 2 3 4 5

(5) When I hear negative comments about my weight, it makes me want to "pig out".
1 2 3 4 5

(6) If I were my ideal weight and body shape, I'd be more self-confident.
1 2 3 4 5

(7) It is more important for me to be slim than to be physically fit.
1 2 3 4 5

(8) I would like to slim down all over.
1 2 3 4 5

(9) My behind is not firm enough.
1 2 3 4 5

(10) Sometimes it seems that my family is more concerned with my weight and appearance than my accomplishments.
1 2 3 4 5

1 = strongly disagree
2 = disagree
3 = neither agree nor disagree
4 = agree
5 = strongly agree

(11) I feel fat most of the time.
1 2 3 4 5

(12) I admire people who can stick to a diet.
1 2 3 4 5

(13) If I lost weight, I'd be healthier.
1 2 3 4 5

(14) My thighs are too flabby.
1 2 3 4 5

(15) It bothers me when people say they eat everything they want and don't gain weight.
1 2 3 4 5

(16) I would like to fit into a smaller size clothes.
1 2 3 4 5

(17) Sometimes when I walk by a group of guys, I worry that they are sizing me up and evaluating how I look.
1 2 3 4 5

(18) I have difficulty finding the style of clothes that suit my body.
1 2 3 4 5

(19) When I sit down, I fold my arms in front of me to hide my stomach.
1 2 3 4 5

(20) When I am slim, I feel anything is possible.
1 2 3 4 5

(21) I envy my slimmer friends.
1 2 3 4 5

(22) I hate it when guys talk about other women's bodies in front of me.
1 2 3 4 5

(23) Nothing beats the feeling of putting on your smallest pair of jeans and going out.
1 2 3 4 5

(24) I hate it when people I haven't seen for a while immediately comment on my weight.
1 2 3 4 5

(25) A person's attractiveness depends more on their body shape than the style of clothes they are wearing.
1 2 3 4 5

(26) I can attain the "perfect" look if I diet and exercise faithfully.
1 2 3 4 5

1 = strongly disagree
2 = disagree
3 = neither agree nor disagree
4 = agree
5 = strongly agree

(27) I get depressed watching the women on music videos and in exercise shows.
1 2 3 4 5

(28) I often compare myself to the models I see in advertisements on TV and in magazines.
1 2 3 4 5

(29) I often size up other women's size and body shape.
1 2 3 4 5

(30) I think I'd become a recluse if I gained a lot of weight.
1 2 3 4 5

(31) I feel relieved when I see women who are heavier than me.
1 2 3 4 5

(32) I feel more positive about myself when I am dieting.
1 2 3 4 5

(33) I feel uncomfortable watching music videos and movies with male friends because I think they are comparing me to the women in them.
1 2 3 4 5

(34) If I was overweight, I wouldn't be caught dead in a bathing suit.
1 2 3 4 5

(35) When people make negative comments about my size, it makes me want to be lose weight.
1 2 3 4 5

(36) I find people really notice it when women gain weight.
1 2 3 4 5

(37) I feel self-conscious at the beach.
1 2 3 4 5

(38) People who know me, know that commenting on my weight is a definite no-no.
1 2 3 4 5

(39) If I gained weight, I would try to avoid being around acquaintances who knew me when I was smaller.
1 2 3 4 5

(40) I would rather live in a society where being thin is not considered so attractive.
1 2 3 4 5

(41) I sometimes ask my friends how my size compares to other women I see in public.
1 2 3 4 5

1 = strongly disagree
2 = disagree
3 = neither agree nor disagree
4 = agree
5 = strongly agree

(42) My mother wants me to look good and be slim.
1 2 3 4 5

(43) I don't like getting changed in locker rooms.
1 2 3 4 5

APPENDIX U

Additional Observations

The questionnaire items are a reflection of the comments made during item generation interviews. However, there were behaviours such as body language and facial expressions that were difficult to capture in the questionnaire. The fact that this was recognized at all is one strength of qualitative research.

During the interviews, it was not uncommon for the adolescents/women to look at their bodies and make facial grimaces. This was especially evident when asked if they would like to change anything about their own bodies. Many of the subjects grabbed their legs or stomachs in anger and said that they wished they could remove these body parts. There were also comments regarding how their lives would improve if they could attain the thin ideal. One 29 year old subject said that if she was slim, she would be finished university, have travelled the world and be married by now.

It was interesting to note the contrasting comments made in the item generation interviews regarding two pictures. One model, anorexic at the time the photograph was taken (see Figure 2) was described as being "average" in size even though her neck and knee bones were clearly visible. Another model (see Figure 3) was described as being fat. This picture was often greeted with laughter and comments such as "Oh my God, she's disgusting" or "She's gross".

Subjects in the item analysis sample also made comments worth noting. For example, one woman stated after completing the questionnaire, "I hated your questionnaire, it was so true!".

It was evident during the course of this study that these issues are tapping into an area that is very emotional and personal for women.

Figure 3