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Planting the seeds of hope: Research and action on body image of university students

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PLANTING THE SEEDS OF HOPE:
RESEARCH AND ACTION ON BODY IMAGE OF UNIVERSITY STUDENTS

by

Michelle Poechman Fisher

Bachelor of Arts Honours in Psychology

University of Waterloo, 1992

THESIS

Submitted to the Department of Psychology

in partial fulfilment for the requirements

for the Masters of Arts Degree

Wilfrid Laurier University

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ABSTRACT

A number of researchers have expressed concern regarding the growing prevalence of body dissatisfaction, especially among North American women. Such body dissatisfaction is often linked to dieting, weight concerns, excessive exercise, poor nutrition, and eating disorders.

In order to expand our awareness and understanding of university students' needs with regards to issues concerning body image, a needs assessment was conducted in two universities located in southwestern Ontario. In focus groups and individual interviews, students were asked directly about the issues they find most troublesome, their experiences in the recovery process, and their needs for supportive and preventive interventions. In order to facilitate the utilization of the results of the needs assessment, participants were invited to join a student advisory committee (H.O.P.E.) which reviewed the suggestions, planned, and implemented interventions. Apart from encouraging utilization of the results, H.O.P.E. also provides a supportive network for members and an empowering opportunity for them to choose their own courses of action, and to make changes in their community.

The thesis process was guided by a combination of community psychology and feminist research values such as a recognition of the relationship between individuals and their social context; validation of personal experience; appreciation for a two-way researcher-participant

relationship; and incorporation of action research, social change, and empowerment within the research process. This thesis provides a model of an action-research project in which the momentum created during a needs assessment generated action.

Specific recommendations are discussed for advertising and implementing supportive and preventive interventions, developing action research projects, and for future research.

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"And to all those voices of wisdom that have whispered to me along the way." -- Dhyani Ywahoo

INTRODUCTION

Introduction to the Study

Body dissatisfaction has become a North American norm, especially among women. This norm is consuming lives, since dissatisfaction with one's body often leads to dieting, weight concerns, excessive exercise, poor nutrition, steroid use, and eating disorders (Garner & Garfinkel, 1980; Rodin, Striegel-Moore, & Silberstein, 1990; Rucker & Cash, 1992). The present study examines the needs of university students with regards to these issues. Since students are the experts in terms of their experiences and needs, a needs assessment was conducted in which students were asked directly about how they are affected by these issues and what types of interventions they feel would be most useful and practical for them. The ideas suggested in the needs assessment were then reviewed by a group of students who came together to plan and implement some of the intervention suggestions.

Introduction to the Researcher and Writer

I strongly believe that in order for readers to fully understand a piece of writing, they need to know the writer, who s/he is and where s/he is coming from. Therefore, I have chosen to share with you a little about my background and values.

My Background

I chose to do my thesis in the area of body image and related issues due to a personal struggle with bulimia. I have decided to break

the silence because I feel that by keeping my struggle a secret, I have reinforced the myth that bulimia (and eating disorders in general) are something to be ashamed of. In my opinion, eating disorders are no more than a coping mechanism, a way to deal with overwhelming feelings, pressures, and situations. An attempt to take control of something in our crazy, spinning world.

I learned the lesson of our society well. I learned to seek the "ideal" body above all else. I learned that my world would not accept me as I was, and therefore I worked to change. But in the process, I lost four years of my life. Bulimia took my passion for all else but food. It robbed me of my emotions. I forgot the way music makes my heart dance. I forgot how much I love to feel the wind whip through my hair. I forgot how to relate to people, how to share real feelings, how to live.

I count myself among the "fortunate". People helped me to recognize my need for help early enough that I was able to get support to end my painful, self-destructing behaviours. I am thankful to all of the people in my life who stood by me patiently during my recovery process, and continued to love and respect me as a whole person. Many others are not so lucky. Five to nineteen percent of people diagnosed and hospitalized with anorexia die from related complications (Brumberg, 1988; Hsu, 1980; Seid, 1989). Many others continue to live, but only as a shell of who they really are.

People with eating disorders are not "crazy", but people struggling

to survive in a world of confusing messages: Students of a society which judges people by appearance rather than their unique skills, personalities, and gifts. I have asked people to describe their journeys in order to help others better understand what people go through, what types of support people have found helpful, and how we can work together to prevent others from travelling this frightening, devastating path.

My Values

In my journey of recovery I have stumbled upon Community Psychology and Feminist Research, both of which have had a strong influence on my personal values, as well as on my values as a researcher and writer. I was elated to discover two disciplines which recognize the relationship between individuals and their social context, advocate action research and social change, validate the personal experience of both the researcher and the participants, respect human diversity, value a two-way researcher-participant relationship, and encourage empowerment in the research process. Mulvey (1988) describes community psychology and feminism as a "natural fit" (p.80). While community psychology provides a variety of models for implementing these values within the research process, feminism contributes specific insights for applying these values to issues which predominately affect women. I have chosen to discuss each of these core values briefly while highlighting their implementation within my research.

Both community psychology and feminist research have aided me

in my own healing, due to their focus on the relationship between individuals and their social context. Community psychology and feminist research recognize the fundamental, powerful relationships between personal reality and structural conditions (Mulvey, 1988). Rather than blaming and pathologizing individuals with body image and eating problems, these disciplines look at how society contributes to the development and maintenance of these problems. Feminism in particular advocates the need to address eating disorders as a community problem rather than blaming women (Mulvey, 1988). Individuals are not treated in isolation from their socio-cultural environments. Likewise, in the present study students were encouraged to consider society's role in the development and maintenance of body image problems when suggesting supportive and preventive interventions.

In learning that I was not to blame for my eating disorder, I became less ashamed and more angry. I decided that I wanted to make some changes, but I was not sure how to begin. Community psychology and feminist research provided me with examples of action research and social change. They both recognize that research alone cannot change the conditions under which the oppressed live, but that research needs to include demystification, education, consciousness-raising, community mobilization, and empowerment (Rappaport, 1990; Reinharz, 1992). The very act of obtaining knowledge from people who are affected by body image issues creates the potential for change because it demystifies the

topic by expanding the scarce body of research which talks directly with the affected individuals (Reinharz, 1992). Opportunities for education and consciousness-raising were incorporated within the data collection process, as participants were invited to reflect upon and share their views regarding the sources and development of body image issues. The research process facilitated community mobilization and empowerment by involving people directly affected by body image issues in the needs assessment, and in the planning and implementation of interventions.

My previous experience with mainstream research left me doubtful of my ability to be an objective researcher due to my personal struggle with an eating disorder. Both community psychology and feminist research critique research methodologies based on distancing, neutrality, and objectivity and they have taught me to consider my personal experience as a valuable asset (Reinharz, 1992). Rather than hiding my background, I have been encouraged to acknowledge it from the beginning since it affects my entire thesis. I was excited to discover the tradition of "identification" in feminist research, which encourages the writer to share her story and invite the reader to identify with her (Reinharz, 1992). I want you, the reader, to feel like you can identify with me and therefore I have integrated my personal process throughout my thesis and I have written in my own voice rather than third person.

Both community psychology and feminist research have also validated my belief that individuals who are experiencing difficulties are

the experts regarding their experiences and needs, and therefore these individuals are a wonderful source of information (Mulvey, 1988). The majority of the literature describes people with body image issues from professionals' perspectives, but I have decided to focus on individuals' direct experiences. I believe that to fully understand how people are affected by body image issues, we need to listen to people's experiences.

Community psychology and feminist research both advocate a true respect for human diversity (Watts, 1992; Reinharz, 1992). While I recognize and value human diversity, in choosing to focus my research on university students I have limited the representation of diverse populations since people of different backgrounds and experiences are scarcely represented in our universities. I was also limited by the self-selection sampling method, since I depended upon volunteers to share their stories with me. While I really wanted to include men's perspectives on these issues, only one man chose to participate. I apologize for my lack of inclusion of diverse populations.

I also want to remind you, the readers, that I am limited by my own experience and background (white, young, female, middle-class, able-bodied, North American, and heterosexual) and therefore, there are a variety of people for whom I cannot speak. I acknowledge these limitations, and I invite both your criticism of my interpretations, and your creativity in translating this research to make it as useful for you as possible.

My deep respect for all people led me to reject the traditional scientific relationship between researchers and participants and urged me to pursue other models. Within the fields of community psychology and feminist research, I found models which recognize the interconnection between researcher and participants and value relations of respect, shared information, mutual disclosures, and openness. Rather than treating the participants as merely "data providers", my research has incorporated a two-way relationship of sharing and learning.

Respect for my participants also led me to use a "competency framework" which assumes that the participants are skilled, competent individuals with valuable ideas and experiences (Walsh, 1982). Instead of assuming students are deficient and attempting to "fix" them, the present study gave students the opportunity to express their unique ideas and to share their capacities by contributing to the planning and implementation of interventions. Student participation enhances the entire process of social intervention by decentralizing decision making, increasing students' support for an intervention, reducing communication problems, increasing understanding of the problem, and improving the quantity and quality of alternative approaches to the problem (Kahn, 1982). Involving students also offers them an opportunity to rediscover themselves and find self-respect, dignity and confidence in their skills and abilities.

REVIEW OF THE LITERATURE

Prevalence of Body Dissatisfaction and Eating Disorders

The Canadian National Eating Disorder Information Centre (1994) estimates that ninety percent of Canadian women are dissatisfied with some aspect of their body. In 1984, 33 000 North American women told researchers that they wanted to lose weight more than any other goal (Wolf, 1991). Rodin, Striegel-Moore, and Silberstein (1990) dub this widespread weight concern and dieting behaviour as "women's normative discontent". Why are North American women so preoccupied with their bodies? Aldebaran (1975) suggests that, "the current standards of beauty are set so thin that there is hardly any woman who does not consider herself overweight" (p.6). Sociocultural pressures to attain an "ideal" are no longer limited to women. Recent research suggests that men are also becoming increasingly more dissatisfied with their body sizes and shapes (Silberstein, Striegel-Moore, Timko, and Rodin, 1988; Andersen, Woodward, Spalder & Koss, 1993; King, 1989). The workout body type appears to have become a more widely aspired ideal (Striegel-Moore, Silberstein, and Rodin, 1986; Rice, 1993).

The degree to which people are satisfied with their bodies has profound implications for their self-perceptions and behaviours (Silberstein, Striegel-Moore, Timko, & Rodin, 1988). Body dissatisfaction is often linked to poor self-esteem, weight concerns, dieting, poor

nutrition, steroid use, excessive exercise, and eating disorders (Garner & Garfinkel, 1980; Rodin, Striegel-Moore, & Silberstein, 1990; Rucker & Cash, 1992).

A Canadian Health Promotion Survey (1990) revealed that 88% of Canadians were presently trying to lose weight, or wanted to lose weight. Berman (1975) found that 90% of dieters were motivated by a desire to change their appearance, rather than by health reasons. Research suggests that dieting is not only an ineffective long-term weight reduction technique, but it may also contribute to subsequent weight gain and binge eating (Polivy & Herman, 1983; Rodin et al., 1985; Brown & Jasper,1993). Ninety-five to ninety-eight percent of people who diet will gain back all of the weight they lose (Bennett & Gurin, 1982; Chernin, 1981; Wooley & Wooley, 1979). As well, undernutrition creates biological and emotional distress. Side effects of chronic dieting and being underweight include decreased energy levels, fatigue, apathy, dizziness, intolerance to cold, slower metabolism, lowered heart rate, general preoccupation with food, intense hunger and cravings, general irritability and depression (Keys, Brosek, Henschel, Meckelsen, & Taylor, 1950; Garner, D.M. et al, 1985).

Excessive exercise, often associated with dieting, also presents risks. Recent studies suggest that 20 percent of women who exercise to stay in shape and 50 percent of endurance athletes have menstrual irregularities, including cessation of menstruation. The hormonal

imbalances which result increase risks of osteoporosis, and ovarian and endometrial cancers (Mennell, 1985).

Further along the continuum of weight and shape preoccupation are eating disorders. A number of researchers have speculated that the dieting process is a major factor leading to the development of an eating disorder (Striegel-Moore et al., 1986; Brown & Jasper, 1993). Ninety to ninety-five percent of people diagnosed with eating disorders are women (DSM-III-R, 1987; Striegel-Moore, Silberstein, & Rodin, 1986; Crisp, 1988; Wolf, 1991). The lack of substantive data on eating disorders in males, as well as the reliance on amenorrhea (loss of menstruation) as a critical diagnostic sign, has probably lead to the under or misdiagnosing of eating disorders among men (King, 1989; Vandereycken & Meermann, 1984).

Pope, Hudson, Yurgelun-Todd, and Hudson (1984) reported an incidence of anorexia among college females between 1 and 4.2 percent and an incidence of bulimia between 12.8 and 18.6 percent, using DSM-III criteria. Anorexia is characterized by a drastic weight loss resulting from dieting, an intense fear of gaining weight or becoming fat, a distorted body image, and a loss of one's menstrual cycle. Bulimia is typified by recurrent episodes of binge eating accompanied by the sense of lack of control over eating behaviour; purging through self-induced vomiting, use of laxatives or diuretics, strict dieting or fasting, and/or vigorous exercise;

and persistent overconcern with body shape and weight (DSM-III-R, 1987; Rodin, Striegel-Moore, & Silberstein, 1990; Lewis & Blair, 1991). Another fifteen to twenty percent of women engage in many of the above behaviours on an occasional basis (Halmi, Falk, & Schwartz, 1981; Pope, Hudson, Yurgelun-Todd & Hudson, 1984; Bennett, Spoth & Borgen, 1991; Pyle, Mitchell, Eckert, Halvorson, Neuman & Goff, 1983). Along with the side effects due to dieting, people with eating disorders may suffer additional problems such as menstrual irregularity, chronic constipation, permanently damaged colons, dehydration, lacerations of the esophagus, stomach ulcers, corrosion of teeth enamel and gums, kidney and liver damage, electrolyte imbalances, heart irregularities, and severe depression (Seid, 1989; Valette, 1988). Five to nineteen percent of people diagnosed and hospitalized with anorexia die from related complications (Brumberg, 1988; Hsu, 1980; Seid, 1989). Beglin and Fairburn (1992) suggest that the prevalence of eating disorders may be underestimated since they found that a large proportion of women who did not choose to participate in surveys related to eating disorders had a high rate of eating problems. There is also evidence that eating disorders are becoming increasingly common (Bruch, 1978; Garner & Garfinkel, 1980; Striegel-Moore, Silberstein, & Rodin, 1986).

Boarding schools and colleges have been described as "breeding grounds" for eating disorders (Squire, 1983). A number of factors have

been suggested to account for this observation. Striegel-Moore, Silberstein, and Rodin (1986) suggest that campuses are stressful, semi-closed environments which may intensify both the sociocultural pressures to be thin and the competition to achieve the "ideal" body. Attractiveness is also emphasized during this developmental period because of its role in dating (Rodin, Striegel-Moore, & Silberstein, 1990). Furthermore, university is a transitional period when many young people leave their familiar environments (ie. high school, friends, family) and must develop new coping mechanisms to deal with intensifying stressors.

Primary Prevention, Social Action, and Eating Disorders

Blair (1992) suggests that the majority of resources available for mental health are allocated to treatment or rehabilitation, while few resources are used for the promotion of mental health and the prevention of mental illness. Edwards (1989) proposes that this is especially true in the area of eating disorders, where individuals are pathologised while the social contexts of their experiences are ignored. Although the impact of sociocultural issues on eating disorders is well-documented by many researchers (Rodin, Striegel-Moore, & Silberstein, 1990; Seid, 1989; Brown & Jasper, 1993; Chernin, 1981; Garner & Garfinkel, 1980; Garner, Garfinkel, Schwartz & Thompson, 1980; Wiseman, Gray, Mosimann & Ahrens, 1992; Silverstein, Peterson, & Perdue, 1986; Wolf, 1991), treatment of eating disorders focuses on "fixing" pathologized individuals while

ignoring their social context. Sociocultural pressures include the bombardment by the media of an "ultra thin beauty ideal"; the stereotype that attractive individuals are more successful and happier than less attractive people; the stigma of obesity; and the prescriptions for attaining the "ideal" from money making industries such as diet, fitness, cosmetic surgery, fashion, and cosmetics (Rothblum, 1992; Seid, 1989; Wolf, 1991). The combination of these pressures promote body dissatisfaction and increase individuals' vulnerability for developing destructive coping behaviours.

The classification of eating disorders in the American Psychiatric Association's Diagnostic Statistical Manual (DSM-III-R) reflects the powerful and dominant medical paradigm. These labels and diagnostic criteria contribute to victim-blaming by encouraging society to view the pursuit of thinness as a selected set of women's experiences rather than a potential experience of all North American women due to our social context. Women's investment in thinness is completely rational given that a woman's identity, social value, and self-esteem depend upon her appearance (Brown & Jasper, 1993). The psychiatric criteria for eating disorders reflect a poor understanding of the degree of desperation and anxiety that the average woman in our society experiences around eating and her body shape and size. Rodin, Striegel-Moore, and Silberstein (1990) propose that all women lie on the continuum of body

dissatisfaction and eating disorders and that they are moved along the continuum by individual, familial, and sociocultural risk and protective factors. In its recognition of the variety of risk and protective factors involved, the continuum framework promotes multiple levels of intervention, including social interventions.

Most of the prevention interventions suggested in the literature are secondary prevention interventions aimed at identifying and treating at the earliest possible moment in order to reduce the duration and severity of the disorder. Suggestions include earlier recognition of eating disorders through improved screening instruments and more educated health professionals (Vandereycken & Meermann, 1984; Frankenburg, Garfinkel, & Garner, 1982); workshops to assist coaches, roommates, teaching assistants, families and friends in identifying and dealing with people with eating disorders (Christiansen, Payne & Van Valkenburg, 1986; Shisslak, Crago, Neal & Swain, 1987); minimization of childhood obesity through persuading mothers to eat less during and between pregnancies, and reducing binge-eating in childhood and adolescence through behavioural approaches (Crisp, 1988).

A few authors have suggested primary prevention interventions that aim to reduce the incidence of the disorder within the community. The most popular primary prevention interventions for eating disorders are prevention curricula to be implemented into schools or used in group

settings (Moriarty, Shore, & Maxim, 1990; Shisslak, Crago, Neal & Swain, 1987; Killen et al., 1993; Polivy & Herman, 1992; Rockett & McMinn, 1990). While a number of these curricula acknowledge society's role in eating disorders, most of them focus exclusively on changing the "affected" individuals by increasing their protective factors (i.e. teaching anxiety management skills, promoting healthful weight regulation, teaching individuals about the dangers of dieting and eating disorders, increasing self-awareness, and teaching assertiveness techniques). Such curricula may increase students' critical awareness and offer them coping mechanisms, but they do not address the need to work towards changing the sociocultural environment. While reactive interventions are successful in helping individuals build resistances to the environmental factors which help to create or maintain illnesses, whenever possible, proactive preventive interventions should be implemented since they aim to remove or decrease the environmental stressors which place individuals at risk for developing an illness in the first place. Such proactive (social action) interventions would not only work to expand the range of body types that are deemed attractive and acceptable in our culture, but more importantly to reduce the importance of physical appearance when assessing or valuing people.

The supportive and preventive interventions suggested and discussed in the literature have been developed by professionals without

consultation with the people that they most affect. Cochran (1986) states that people understand their own needs better than anyone else and therefore they should have the power to both define and act upon their needs. People who are or have struggled with issues of body image, weight concerns, nutrition, exercise, dieting, and/or eating disorders are the experts with regards to their experiences and needs, and therefore it is vital to ask them directly about their needs and to include them in the planning, development, and implementation of supportive and preventive interventions.

THESIS CONTEXT

In the Fall of 1992, I began searching for a practicum placement in order to fulfil one of my course requirements for my Masters in Community Psychology at Wilfrid Laurier University. I really wanted to do something in the area of prevention of eating disorders, so I contacted a few local agencies and community groups to find out what they were doing and if I could become involved. I was disappointed to discover that there was little happening with regards to primary prevention. While all of the people with whom I spoke recognized the need for primary prevention, they felt that the few existing resources needed to be spent on people already identified as having an eating disorder. I agree that it is important to serve people who are identified as struggling with an eating disorder, but I also believe that this population is going to continue to grow unless some type of primary prevention is put into action.

My practicum advisor suggested that I contact a counsellor at the University of Waterloo's Counselling Services whom he thought may be interested in this area. To my excitement, she expressed enthusiasm regarding my ideas for a possible placement and she agreed to meet with me to discuss the possibilities. The first few months of my practicum placement were spent consulting with this counsellor around what she felt would be most useful for Counselling Services and what I could provide. We narrowed our options down to either an evaluation of the

existing services offered through Counselling Services or a needs assessment, and then we called in three other counsellors who support people with body image issues for their ideas. I presented them with information about program evaluations and needs assessments (i.e. purpose, pros and cons), and they decided that a needs assessment would be the most useful at that time. They expressed their concern that a large number of the students on campus are affected by these issues but relatively few students use the services offered. Therefore they wanted to know more about what students want and need in terms of issues related to poor body image.

Next we discussed possible sources of information and information-gathering techniques. The counsellors felt that they had a variety of resources regarding professionals' ideas and suggestions of what students with body image concerns need, but they wished to hear more from students themselves about what they want and need. We decided to talk with both students from the general student body, and students experiencing difficulty with issues related to body dissatisfaction and eating disorders. By talking with both of these groups, we hoped to include people within all stages of concerns with body image. Focus groups were chosen as the main tool for gaining information about students' needs due to their efficiency in gaining high quality information. We discussed the possibility of supplementing this information with a few

follow-up interviews in order to gain more detailed information about students' experiences.

Two major factors contributed to my decision to expand my practicum project into my thesis. First of all, one of the counsellors at the University of Waterloo also works for Wilfrid Laurier University and she asked me if I could include Wilfrid Laurier students in my needs assessment. Secondly, I decided that I really wanted to go beyond simply assessing students' needs, and facilitate the implementation of students' suggested interventions.

In September 1993, my thesis proposal was approved for ethics by the Office of Human Research and Animal Care at the University of Waterloo, and it was also reviewed by Wilfrid Laurier University's Department of Psychology Ethics Committee. The recommendations made by both of these committees were implemented.

The needs assessment was conducted during the Fall of 1993. A student Advisory Committee came together in December 1993 to review the results of the needs assessment and to decide on how to implement some of the intervention suggestions. This committee continues to meet regularly.

RATIONALE AND PURPOSE OF THE STUDY

Rationale

In 1988, in her Community Psychology Masters thesis project, Tammy Morrell estimated that there were between 932 and 2986 high school, college, and university women in the Waterloo Region who were suffering from an eating disorder. Counsellors at both of the local universities have expressed concern regarding the growing number of students seeking support for body image issues. Due to a high prevalence of body dissatisfaction and eating disorders among university students, there is a great need for supports, prevention, and social action interventions.

In order for interventions to be useful and practical, we need to expand our understanding of which issues students find most troublesome, what is their experience in the recovery process, and what students want and need in terms of support, prevention, and social action. Involving students in the planning, development, and implementation of interventions empowers students to play a vital role in their own healing by offering them an opportunity to develop interventions which are both supportive, and practical for people struggling with these issues.

Purpose

The purpose of this thesis was two-fold: to conduct a needs

assessment, and to facilitate the implementation of the interventions suggested in the needs assessment. Following is a brief description of each of these objectives.

Needs Assessment

In order to expand our awareness and understanding of university students' needs with regards to issues concerning body image, a needs assessment was conducted in which students were asked directly about issues they find troublesome. Needs assessments fulfil the following functions: (a) check out assumptions about people's needs in order to build an intervention on an accurate assessment of needs, (b) indicate how to best use resources, (c) raise public awareness, (d) allow for effective consumerism by involving the consumer in the process and (e) encourage social action (Edmonton Social Planning Council, 1988; Posavac & Carey, 1992; Reinharz, 1992).

Action

The present study not only asked students about the difficulties they are facing and the types of support they need, but students were also encouraged to join an Advisory Committee which reviewed the results of the needs assessment and decided how to develop and implement the intervention suggestions. The main goal of the action component of this research was empowerment, and therefore it realized Prilleltensky's values of empowerment (1994) by providing students with

people affected by the interventions in the decision making and implementation processes.

THE ORGANIZATION OF THE REMAINDER OF THE THESIS

In an attempt to make my thesis clear and understandable, the main portion of this document is divided into the following two components:

1. The research component - The needs assessment
2. The action component - The development of a Student Advisory Group and the implementation of the recommendations made in the needs assessment.

The discussion, limitations, recommendations, and concluding comments have been combined for these two components and follow the findings of the action component.

THE NEEDS ASSESSMENT

Method for the Needs Assessment

Participants

All interested students (females and males) at the University of Waterloo and Wilfrid Laurier University were invited to take part in this needs assessment. Participants were recruited through advertisements posted on the two campuses (in Counselling Services, on bulletin boards, in stair wells, above water fountains, and on washroom doors); messages written on classroom black boards; flyers distributed in lounges, cafeterias and libraries; and announcements made by myself in classes. This variety of advertising methods was used in order to provide opportunities for students to collect the essential information while maintaining their privacy. Posters were continually monitored and those which disappeared were replaced. A copy of the advertisement is shown in Appendix A. In addition, participants who were recovering or who had recovered from an eating disorder were specifically recruited through a letter which Counsellors at Counselling Services mailed out to their clients with eating disorders. In this letter, I disclosed my personal struggle with an eating disorder and I described the purpose of my study, and how the information was to be collected and used. Interested individuals were asked to complete and return a consent form which gave Counselling Services permission to release their name and phone

number. I also included my phone number in case individuals wanted to contact me personally. A copy of the letter and the consent form to release the client's name are shown in Appendix B.

A total of twenty-five people, twenty-four women and one man, participated in the needs assessment. Nineteen individuals took part in focus groups and eight people were interviewed individually. Two individuals participated in both a focus group and a follow-up individual interview. Another twelve people contacted me for more information about the study but chose not to participate. Participants ranged in ages from 19 to 34, with a mean age of 22.8 years. All of the participants were undergraduates, with the majority being in their third (55.6%) and fourth year (29.6%). The following faculties were represented: Arts (81.5%), Applied Health Studies (11.1%), Science (3.7%), and Math (3.7%). The two universities were equally represented with 51% of the participants from the University of Waterloo and 49% of the participants from Wilfrid Laurier University. In terms of participants' experiences, 81.5% reported that they were directly affected by issues related to body dissatisfaction.

Procedure

Two data collection techniques were employed in the present study, focus groups and personal interviews. Each of these procedures will be described in detail here.

Focus Groups

Focus groups were chosen as the primary data collection tool due to their efficiency in gathering high quality information in a social context where individuals can consider their own views while listening to and reflecting upon other people's perspectives (Patton, 1990). Focus groups are simply interviews with a small group of people on a specific topic. Participants are asked to reflect on questions, share their ideas, listen to others' responses, and then expand on their original responses with additional comments. This technique provides its own quality control mechanism since participants weed out each other's false or extreme views. The focus group may also act as an intervention since the group format is conducive to consciousness-raising (Reinharz, 1992). One drawback of focus groups is that more time is needed for each question than in an individual interview, and therefore the number of questions one is able to ask in a focus group is limited.

Eleven focus groups were scheduled in total. Eight focus groups were originally scheduled (four on each of the two campuses), but they were not well attended. A number of people phoned me to express interest and an inability to attend any of the scheduled times. Three additional focus groups were organized around people's schedules. Only four focus groups were actually held. The number of participants in each focus group ranged from three to nine, with a mean of five. The average

duration was one and a half to two hours. Four scheduled focus groups became individual interviews since only one person attended.

The interview guide which provided a framework for the focus groups is shown in Appendix C. After welcoming participants, I introduced myself and explained that I was not there to judge anyone, but to listen and to learn. Because of the shame associated with body image difficulties, I wanted people to know that I understood the sensitivity of these issues and some of the emotions involved, therefore I disclosed my personal struggle with bulimia. I hoped that by sharing my background I would foster openness. A number of people commented after the focus groups that hearing that I had personally experienced an eating disorder put them at ease, since they knew that I could relate to them and their experiences.

I then explained that the purpose of the study was to expand university professionals' understanding of how students are affected by body image issues and what students need in terms of support and prevention. I shared my belief that students are the experts on their needs and therefore I felt that their input is crucial in order to develop practical, needed resources. An information letter which explained the purpose and process of the study was then distributed and read aloud. A copy of the letter is shown in Appendix D. I stressed that participation was voluntary and that if anyone felt uncomfortable participating at any

time I wanted them to feel free to leave. Everyone who came to the focus groups chose to participate. After everyone's questions were answered, I asked participants to sign the consent form shown in Appendix E. Participants were then asked to complete a short demographic questionnaire in order to provide an indication of which types of students were represented in the focus groups (ie. age, gender, year, faculty). A copy of the questionnaire is shown in
Appendix F.

Before beginning the focus groups, I asked participants for their permission to tape record the focus group. I explained that I would be the only one listening to the tape and that it would be destroyed as soon as my thesis was complete. All of the members in each of the focus groups agreed to being tape recorded.

Finally, I acknowledged that everyone took a risk in coming to the focus group to talk about such sensitive and personal issues, and I assured people that I would respect their confidentiality. I then asked participants to raise their hands if they promised to respect each of the group members by keeping each others' conversations and identities confidential.

In order to focus the group discussions, the focus groups began with a reiteration of the purpose of the group, "to discuss services, supports, and prevention ideas, for students who are affected by issues

of body image, dieting, nutrition, exercise, weight, and/or eating disorders." The group was then asked, "There are a number of issues related to concerns with body image, such as dieting, nutrition, exercise, weight concerns, and eating disorders. Which issues are of greatest concern for you, or other people you know?" Responses were recorded on a flip chart and participants were asked if what was written was an accurate reflection of their point. Participants were then asked, "What do you see as the source of these issues or problems?" The purpose of these first two questions was to help people warm up and feel comfortable in the group, as well as to raise the levels of consciousness around the roots of body image problems. All of the groups listed individual, familial, and sociocultural factors.

The nominal group technique was used to structure the remaining two questions. Participants were given five minutes to individually brainstorm and record their responses to the question, "What services do you feel are needed with regards to these issues? Ideas may include existing and/or new services." When people finished writing their individual notes, I asked participants to take turns going around the circle, sharing one idea from their list at a time. At this time I emphasized that everyone's opinions and ideas were important since everyone came from different backgrounds and experiences. All of the ideas were recorded on a flip chart at the front of the room. An average of fifteen

ideas were generated in each group. Once the group exhausted its ideas, a discussion period followed during which ideas were clarified and re-organized. Members were then asked to individually think about which ideas they felt were important and needed, and which ideas they thought they would actually use. Participants were then given six red stickers and six green stickers and they were told that they may use as many or as few of the stickers as they would like. The red stickers represented, "I feel that this service idea is important" and the green stickers represented, "I would use this service idea". People were then asked to put the appropriate sticker beside their priorities.

The nominal group technique has a number of specific advantages since it: (a) offers an opportunity for private reflection and thought, (b) encourages the sharing of individual ideas and concerns, (c) maximizes the amount, diversity, and quality of the problems and alternatives proposed, (d) provides a structure which promotes equality among members since no one person or point of view can dominate the meeting, and (e) facilitates creativity (Siegel, Attkisson, & Carson, 1978). The main disadvantage of the nominal group technique is that the process may lack in precision since little time can be given for participants to carefully sort out all of the ideas before voting. Careful planning and thoughtful preparation of participants can minimize this disadvantage (Siegel, Attkisson, & Carson, 1978).

The same process was used for the following question, "What types of primary prevention or social action do you feel are needed with regards to these issues?" Primary prevention was defined as, "interventions which reduce the incidence of disorders and promote individuals' overall well being" and social action was defined as, "interventions which aim to make changes in the sociocultural environment". An example for each of these definitions was also given.

After the two nominal group questions, I asked participants how they felt about the information collected; if it was an accurate reflection of their needs. I also asked for their comments on the focus group structure and how they felt about the process. I explained that I wanted to improve the process and invited their criticisms and suggestions for change.

Since I feel that it is very important for participants to receive feedback about the findings of a study, I offered a number of choices for feedback. The options included: a) a printed copy of feedback mailed to participants who provided their address, b) printed copies available to be picked up at Counselling Services for those who wished to remain anonymous, c) an individual meeting or phone call with participants who provided their phone number, and/or d) a follow-up forum for participants and any other interested students, in which the results would be presented to the students and they would be asked for their suggestions and insights. Participants were asked to choose the type of feedback

they would like and to indicate their choice on a Feedback Form, as shown in Appendix G. At this time, participants were also invited to provide their name and phone number if they were interested in participating in a follow-up interview. It was stressed that if they provided their name and number that I may contact them about a follow-up interview, but they were in no way obligated to participate. Participants were also asked to provide their name and number if they were interested in becoming involved in an Advisory Committee which would offer suggestions and insights with regards to the information collected, as well as design and implement some of the suggested interventions. Finally, I thanked all of the participants for sharing their time, experiences, and creative ideas. I also provided participants with a list of resources and services, and a list of relevant readings, as shown in Appendices H and I.

Individual Interviews

Qualitative individual interviews were chosen as a secondary data collection technique in order to enrich the data with students' feelings, thoughts, and perceptions. Interviews were semi-structured with a general interview guide which outlined the set of issues to be explored. Open-ended questions were used since they encourage an unlimited number of responses and in doing so, allow significant themes to emerge (Patton, 1990). This approach provides a framework which ensures that

all of the basic information is gathered, while allowing for flexibility to explore, probe and ask questions as individuals' perspectives emerge. It is important to note that this technique depends upon the development of a thoughtful interview guide in order to avoid inadvertently omitting salient topics. As well, the quality of the interview depends upon the interviewer (Patton, 1990).

Feminist values were also incorporated into the interview process. Oakley (1981) challenges the traditional guidelines which value objectivity, detachment, hierarchy, and "science" by promoting openness, interaction, and engagement in individual interviews. Feminist values encourage the researcher to recognize the commonality between her experiences and those of the participants, to accept that a shared feeling and emotion exists, and to understand that emotional and sentimental perceptions are as valid as intellectual and rational ones (Smith, 1987). Rather than treating the participants as merely data providers, the feminist approach strives for intimacy, includes self-disclosure, and provides an opportunity for the development of a potentially long-lasting relationship (Oakley, 1981; Reinharz, 1992).

A total of eight individual interviews were conducted. Four of the scheduled focus groups turned into individual interviews when only one person showed up for each of these groups. Another two interviews were scheduled at individuals' requests because they were too embarrassed to

attend a focus group. Finally, two interviews were conducted as follow-ups to focus groups. All of the individual interviews took place on the university campuses and lasted between one and a half to three hours. The interviews were allowed to flow as the discussion directed, depending on the personal accounts of the people involved.

The individual interviews followed basically the same format as that for the focus group. The interview guide is shown in Appendix J. The only main difference between the focus groups and the individual interviews was that a few extra questions were asked in the interviews. Additional questions included how the person was affected by issues related to body dissatisfaction, what helped the person recognize her need for support, what barriers were encountered when seeking support, and what and/or who were helpful in the recovery process. Two of the participants requested to not be tape recorded, therefore their comments were recorded in written form only.

Process Notes (Reflective Journal)

After each focus group and individual interview, I recorded my observations, thoughts, feelings, and insights, as recommended by Patton (1990) and Lincoln and Guba (1985). My main purpose for keeping these process notes was to encourage reflection during the data collection process, and to provide myself with a place to vent my emotions since the focus groups and interviews triggered some of my personal issues.

After many of the focus groups and interviews my stomach knotted in turmoil and my heart ached. I felt a part of the women's anguish, grief, anger, guilt, and shame, and all of these feelings blended with my own mixed emotions. Some days I could not put an interview out of my mind. I was haunted by the pained faces of women describing their struggles and their words of despair which replayed themselves over and over again in my head.

After other interviews, my spirits soared and I was filled with an indescribable hope. I was overwhelmed by the courage and gentle strength of people who had experienced incredible violation, desperation, and devastation and yet struggled through it to find true love for themselves and life. These women reminded me of the gift which so often accompanies painful journeys, that of unimaginable growth.

Analysis of the Information Collected

All of the focus groups and interviews were transcribed and the flip chart notes from the focus groups were typed. A list of the interventions suggested in the focus groups was compiled. Votes for each of the suggested interventions were tallied.

Open coding was used to break down, examine, compare and categorize the data (Straus & Corbin, 1990). The properties and dimensions of each category were then considered in order to form subcategories. Finally, patterns were uncovered through the use of axial

coding which helped put the data back together in new ways by making connections between categories (Straus & Corbin, 1990).

In order to verify my qualitative analysis, I used the strategy of triangulation (Patton, 1990; Lincoln & Guba, 1985). Triangulation is an approach which combines multiple observers, theories, methods, and/or sources in order to improve credibility (Denzin, 1970). Methods-triangulation was used to check out the consistency of findings generated by two different data-collection methods (i.e. focus groups and interviews). Credibility was also improved through the use of member checks which involves checking with stakeholders from whom the data was originally collected, the participants, if the information gained represents their realities (Lincoln & Guba, 1985). The following member checks were implemented: a) after each of the focus groups participants were asked how they felt about the information collected (ie. "Is this an accurate reflection of your needs and ideas?"); b) focus group and interview participants were mailed a summary of the findings and were asked to call or write if they wanted to make any changes, additions, or deletions; c) interview participants were also mailed a transcript of their interview so that they could verify if their responses were accurately recorded; and d) the Advisory Group was asked to review the findings and comment on their credibility.

Feedback

Feedback to Participants

A summary of the findings were provided to all participants who indicated a wish for this feedback, and verbatim transcripts were included for all of the interview participants. Participants were asked to reflect upon the summary and contact me (by telephone or in writing) if they wanted to make any additional comments, deletions, or changes. A copy of the summary letter is seen in Appendix K. A number of participants (eight) also chose the option of joining the Advisory Committee in order to review the results of the needs assessment.

Feedback to Counselling Services

A number of the Advisory Committee members joined me in presenting the findings of the needs assessment at a joint staff meeting of University of Waterloo's professionals in Counselling Services and Health and Safety. Wilfrid Laurier's Counselling Services also sponsored a presentation which was open to anyone, and drew university health professionals, support staff, professors, students, and community health professionals. During these informal presentations, we shared our findings, personal experiences, and recommendations, and we invited questions and feedback. Written information was also provided.

A copy of my completed thesis will also be provided to each of the universities.

Findings and Discussion of the Needs Assessment

Out of respect for my participants, I have decided to include direct quotes wherever possible in order to allow the interviewees to speak for themselves, and to encourage the reader to form some of her/his own analysis. Participants' descriptions of their journeys have been divided into the following sections: a) sources of participants' body image issues, b) how and when participants recognized their need for support, c) barriers participants encountered when seeking support, d) what was helpful in recovery, and e) the types of support students want and need in terms of body image issues.

Sources of Difficulties / Contributors to body image issues

Difficulties with issues of body image, weight, nutrition, dieting, exercise, and eating disorders, were attributed to a number of sources; socio-cultural, environmental, familial, and individual. Participants proposed that Western societies in general tend to base social acceptance on physical appearance. Thinness is equated with beauty, health, success, femininity and romance; It is promoted as the prescription to a "wonderful life". People are constantly bombarded with images of the "ideal body" through television shows, commercials, movies, magazines, advertisements and fairy tales. As one participant said, "They [media] portray images that young people and even adults model themselves after. They provide the social ideals." One woman

asked a very poignant question, "Who are the models in the media supposed to represent?" The title "model" suggests that they are trying to imitate someone, but they certainly do not represent the average woman. In fact the average model weighs twenty-three percent less than the ordinary woman (Seid, 1989; Wolf, 1991). A few participants suggested that models portray people with eating disorders. "Most of these women are anorexic, but that's not what they tell you about, that they can barely walk because they don't have any energy, they have been starving themselves so much." Participants expressed concern that the media glamorizes eating disorders and the models suffering from them rather than educating people regarding the health risks.

Although few people can actually attain the ultra thin ideal, participants noted that the media portray it as a realistic goal for everyone. "The media demand perfection, it's either perfection or imperfection, there's no in between. And yet everything is falsified and touched up so we can't actually realize that we're not seeing reality, we're seeing a manufactured image." Unfortunately, the media "kind of give a legitimacy to that, to that struggle to try and achieve something that is unachievable."

One woman spoke of how magazines played a vital role in her eating disorder. "That encouraged my behaviour. That was one of my major habits. Reading those magazines while eating, that was a

compulsion."

The money making industries, such as cosmetics, fashion, weight-loss, and cosmetic surgery, were also mentioned as contributing to the myth that the thin ideal is possible, desirable for all people, and can be attained by buying specific products. As one woman explained:

> People wanting to lose weight makes tons and tons of money. Like how many weight-loss clinics are there? Like there's tons of them. And then people go out and buy clothes and then they gain weight, so they buy more clothes, and then they lose weight because they went to Weight Watchers and they need money for that...it's a vicious cycle that keeps women as fabulous consumers of products that make them sick....It seems to me that there's this huge money making machine that revolves around people losing weight, people thinking they're too fat, people eating too much, people exercising, people buying new clothes, people getting plastic surgery.... everybody is making money off of people with low self-esteem and body image problems.'

The actual money made by the diet industries alone is staggering. Diet items are a $74 billion-a-year industry in the United States, totalling one-third of the nations' annual food bill (Wolf, 1991). In 1986 there were 313 diet books in print and sales of diet books outranked sales of all other books on the market except the Bible (Seid, 1989). Weight Watchers has attracted thirteen million people over the last twenty years and 500 000 people attend the 16 000 classes held weekly across the United States (Seid, 1989).

Unfortunately the diet industry's successful marketing schemes have popularized dieting and portrayed it as an ordinary behaviour. The

effect of this normalization is very clear in the following woman's experience.

> My four best friends have some kind of an eating disorder. Those are the people I grew up with, so I didn't know that it wasn't normal to be so obsessed with everything I ate. We weighed ourselves six times a day, and that's all we talked about.

The women I spoke with were very disturbed by our culture's emphasis on dieting. Many of them felt that dieting was the first step in developing their eating disorder since it fosters an obsession with weight and appearance. One participant remarked on the appropriateness of the word "diet" since, "diet is a four letter word that has the word DIE in it."

The media's message about the ideal body is often reinforced through the comments of others. Peers help to spread our culture's message, both through their specific comments to people, as well as through sharing their judgements about others.

> The way people judge you or the types of things people say I think impact on you. Like in terms of my memory, there's a lot of things that I can't remember, but um, sometimes if there's just one thing that someone's said to me that's negative, I remember it. And it's always the negative things that I think people remember, or that impact on them the most. Just for instance, if someone were to hold up an article of clothing and say, 'Oh my goodness, that fits you?' or 'You actually fit into that?'. I think that impacts on the way people see themselves and their level of self-esteem.

One woman explained that indirect comments also convey strong messages, for example, "We'll be watching t.v. and he'll be going, 'Oh, that girl's so beautiful....and we'll go to a movie and he'll be like, 'Oh,

she's so hot' and 'Look at her'. " This environment of comparison leads to competition, especially among women since our societal value depends upon our appearance. "Everyone compares themselves to everyone else". One woman described this competition with disgust:

> Like I would like it, to see a woman who either had not lost weight or had gained weight to say to me how great I looked because I had lost weight, because it gives you that upper hand right off the bat. You're succeeding, they're not.

A number of specific environments or subcultures were also suggested as possible breeding grounds for body image difficulties due to their focus on ideal weights and appearances. Some of the participants felt that their involvement in competitive sports, such as running and swimming, contributed to their pursuit of thinness. One woman explained, "I was also a runner and I had this notion that, you know, the thinner I was, the faster I would go. Just ridiculous." Another participant described the pressures from coaches to attain and maintain a certain weight:

> The memo that was put out for the track team had a special notice on the bottom for girls, and that was to make sure that they didn't eat any sweet foods or any junk foods, and to cut down on sugar intake because they'd all have to lose weight.

Researchers have also found individuals involved in dance, figure skating, gymnastics, middle distance and marathon running, swimming, rowing, riding, and wrestling are at risk of developing eating disorders (Garner & Garfinkel, 1980; Hamilton et al., 1986; Black & Burkes-Miller, 1988;

Holliman, 1991).

A number of the participants were affected by the subculture of modelling.

> In modelling they pushed me to lose weight. They told me I needed hollows in my cheeks, that I had a full face. When I came in fourth in a competition, they told me I would have won if only I had lost some weight.

Another woman was told, "You have to watch it because, not right now, but you might have a tendency to get a fat bum and a fat stomach." Again and again, these women were told that they were not okay as they were. "Modelling reduced me to my parts; 'You have a great this, but you really need to work on that'."

University was a third subculture participants identified as having a negative impact on their self-esteem and body image.

> It's a certain, like it's a subclass, subculture... like it's the survival of the fittest, you know what I mean, like there's a lot of competition between all these, you know, intellectually, physically fit, socially fit people...Coming to university, I think it made it a lot harder in terms of feeling very unimportant, insignificant. There are so many people that all seem to know what they're doing, and you don't.

A number of participants commented on the transition to university as being a time when underlying stressors were intensified. "I don't adapt to change very well and coming to a new university and meeting new friends and everything was really really hard for me and really traumatic, and I uh, just started doing strange things." One woman explained:

> I left my home environment, the role I was playing, and all of

> the unwritten rules of my dysfunctional family. I think that is why it comes out a lot at university. You don't know that something is wrong until you leave your familiar environment.

Another transitional time suggested as difficult was puberty. "Your body starts to change from being a little girl to being a woman and those changes you aren't used to. I can remember being a little bit uncomfortable with it and in high school thinking, 'I want my old body back.'"

Repeatedly I was told that eating disorders go much deeper than difficulties with food.

> I don't think that the real issue behind the eating disorder is actually food....It really is from, it's the emotional, the psychological aspects of this that make it so horrible because you're trying to, after your recovery, you're trying not only to deal with the food but also what actually got you there in the first place. And I think that is an important part that a lot of people don't realize, that it's not just, you know, it's not just this disease with food.

Participants described eating disorders as symptoms of deeper issues. Destructive eating behaviours were used to cope with stressors such as poor self-esteem, a feeling of lack of control over one's life, depression, abuse (emotional, physical, sexual), parental separation, and other traumatic experiences. One woman explained:

> I think, although I didn't know it at the time, family issues around abuse and things like that really, really affected me strongly and so I developed an eating disorder...So I think that the real stressor was with the family, but then it got played out, like sexism and the media images, ended up getting played out in my body image. You know, feeling like I didn't have a lot of control in other areas of my life, so I

> couldn't control anything else. I could control my body, and I could force it to be what I thought it should be, or what somebody else thought it should be."

Lack of self-esteem was commonly suggested as a predisposing factor which lead to difficulty dealing with other stressors.

> I think my main source of difficulties was not having a good hold on me. You know, like who I am outside of how I look. Like, this is just me, you know, take it or leave it, like it or lump it...like not believing in myself and liking myself, and thinking I was valuable no matter what.

Poor body image contributes to self-depreciation and withdrawal from life as is illustrated in the following woman's description.

> I always thought I was fat. It got so [bad] that I was afraid to slow dance because the guy would feel my fat. I was afraid to hug, afraid to go to the beach in a bathing suit. I thought people were always looking at me and thinking about how fat and ugly I was. I had really bad self-esteem.

Most of the participants remarked how the development of their eating disorder could not be traced to one sole source, but a combination of factors.

> I just think that none of it happens in isolation. Like, you get hit by the media, you get hit by your own feelings, you get hit by a lack of control, you get hit by exercise, you know, it's just all one combined bomb kind of thing. And I mean all of those things come into play, in my experience.

How and when people recognized their need for support

When asked how they recognized their need for help, participants discussed two separate stages of realization) personal identification and acknowledgement of their behaviours as destructive and out of the

"normal realm", and b) after a failing attempt(s) to stop their behaviours on their own, the realization that their behaviours were out of their control and therefore they needed support. During the first stage participants admitted to themselves that they were struggling with an eating disorder. One woman described this stage:

> I don't think I was aware of being bulimic for maybe a year because I just you know, did the old, 'Well, I only do it once in a while', and then when I started doing it every day, then I couldn't really deny it anymore, you know, to myself, and I started to panic....like from there I didn't actually stop the behaviour, but from there on I was aware that what I was doing was pretty out there - like it wasn't a normal thing to be doing.

Once participants realized that their behaviour was destructive, most of them attempted to stop the behaviours themselves. One woman's response to the question, "When did you seek support?" describes this stage quite vividly:

> It was probably almost another year, a half a year to a year after that, after trying to do it on my own. You know, that was the year where every day it wasn't so great to be thin anymore, it was more like, it was just a struggle, like of trying not to throw up, trying not to eat and then throw up, you know, the battle. I'd go a day where I'd manage not to eat or throw up and I'd feel happy and say I was fine, and then the next day it would all come crashing down again....You get up in the morning and say, 'Okay, I'm not going to do it today', but you also say, 'I'm not going to eat either.' So it's impossible. It's an impossible situation. So you naturally end up eating and then you end up throwing up. And all the time you've got that terror or panic going, you know, 'I'm losing my control'.

Another woman said:

> I can remember spending so much time over top of this damn thing [toilet], thinking to myself, you know, this is the last time, this is the last time, I swear, this is the last time, I'll never do it again. But you know, you make these empty promises to yourself that you never keep. It's horrible.

After struggling on their own for varying lengths of time, participants described a point where they realized that they were unable to deal with the problem on their own, that it was out of their control.

> I tried to get help, because it was an obsession, ya, and I felt out of control, very much so, very out of control, and you know, I was a control freak. I mean I wanted to control my body but here I was doing something and I was out of control.

Most of the participants described a trigger that forced them to address their problem and seek the support of others. Fear regarding one's health, and ultimately for one's life was a common motivator. One woman explained, "I think my health was the main concern, because I realized I was affecting, that I was doing something to jeopardize my health." A few participants became frightened when they learned the risks of their behaviours, while others were not struck by the reality of the risks until they saw other people struggling with eating disorders and recognized themselves as progressing towards that severity on the body dissatisfaction continuum. Unfortunately, a number of participants did not recognize the danger they were in until they began suffering physical side effects themselves. Participants described symptoms of fainting,

continuous headaches, blue hands, constant diarrhea, lack of energy, inability to concentrate, and burning throats. One woman described a day which was her turning point:

> I had eaten and thrown up, like binged and thrown up maybe a couple of times, quite a few times that day for me, and I'd also been, uh, that's when I started using the laxatives too, and I uh, didn't do them for very long because of this actually, because it just, like I felt so, I was so ill and so sick, and I could hardly, I was just you know, throwing up and it was just like one of the worst days of my life. I remember standing there in the bathroom going, 'What am I doing to myself? Like I don't have control of my bodily functions.'

Other people became worried after those around them began to express their concerns and fears. One woman said that the beginning of her realization that there was something wrong happened in her first year of University when a roommate pointed out her obsession with food and weight.

> She said that she had never met anyone before who was so concerned about her weight and talked constantly about it. Before that, I never thought of my behaviour as being abnormal because my friends did it too. I was still in denial for a while, but I think it was the beginning of realization.

Other participants sought help when a close friend or parent expressed concern and suggested a place to go for support. In a few of these instances, the friend or parent actually took the person to a doctor or hospital.

Finally, a couple of women came into help through a "back door". These participants sought counselling for other issues (i.e. support during

parent's divorce, help during a friend's recovery from abuse), and in the process they discovered that they needed support for issues related to body image.

Barriers to getting support

Fifty-two percent of the participants who indicated that they were directly affected by issues related to body image, weight concerns, dieting, exercise, nutrition, and/or eating disorders had not sought professional support. Forty percent of this group reported that they were directly affected by an eating disorder. While alarming, these statistics are not surprising since a number of barriers to getting support were mentioned by participants.

Participants spoke about their inability to identify that they had a problem. "I thought everybody was like this, so I didn't see it as a problem for a long time." Since eating disorders often serve to numb one's emotions, in the middle of the eating disorder many of the participants were too numb to recognize their pain. One woman recounted her reaction when a friend read her a description of someone struggling with anorexia:

> It never clicked in, that's how far gone I was. 'I can't believe someone would actually starve themselves, you say that they would...Oh my God, I couldn't understand that.' You know, this is me, saying that to her. I was so far gone from reality....I was just totally blind to what I was doing.

Distorted thinking also played a role. One woman explained:

> I don't know what would have gotten through to me at that time. I twisted everything. I remember seeing Karen Carpenter's story on t.v. and instead of taking, wow, she died from this, I saw that she used laxatives, that's how she got so thin. I tried them after that.

A lack of support from family and friends was also reported to be a barrier to getting support. Others' denial of the problem made individuals who were struggling doubt or belittle their own experience. A number of participants felt that they had to deal with their problems on their own because no one around them acknowledged or believed the pain they were going through. Participants attributed this denial to fear and discomfort. As one woman described:

> They were really, I think, frightened. They didn't know how to react and so I think because they didn't know how to react they thought the best way was just not to react. So it ended up being very much a closeted thing.

Other people clearly did not understand the eating disorder, as illustrated by the comment a friend made to a woman fighting for her life in the hospital, "I wish I had your problem." This comment is an obvious example of how desperate people are to attain the thin "ideal", and the pressures and ignorance that people trying to heal body image issues have to face and overcome among friends, family, and society in general.

As well, a few of the participants reported a lack of support networks due to the severity of their eating disorder. As eating disorders progress, people tend to withdraw from society.

Once one identifies the problem, participants described a number of

other barriers that come into play. First of all, individuals find themselves in a double bind where they need to decide which is more important, to get better or to be thin.

> I still wanted to be thin, so it was, do I give up being bulimic or do I give up being thin?....You have to take the chance that you're not going to be thin anymore. And that's a pretty hard cost, for someone in that situation. A big cost. You're giving up what your perceptions are of glamour, success, you know, all those things."

After one decides to seek help, she needs to deal with the shame and stigma which unfortunately in our culture, surround both eating disorders and getting support. Although I can remember those feelings vividly, I had forgotten how paralyzing they could be. Embarrassment and guilt were mentioned by almost everyone as an obstacle to getting help. One woman explained, "There's a whole stigma that surrounds seeking help, especially counselling help. I mean, you think you must be some kind of a fuck-up. We don't live in a culture that promotes relying on other people." One woman got as far as Counselling Services but when she did not find any reading material on eating disorders she left empty handed. When I asked her why she didn't ask someone there for information, she replied:

> Embarrassment I guess. You know what I mean? Everyone talks about it as, you know, 'Yes this happens, yes this is an issue, it happens to young women and blah blah blah.' But who's going to say, 'Ya'? I wasn't going to be the first one. You know, that's how it felt, very much. I wasn't that committed to getting over it that I would stand up and say, 'I need help. Somebod, help me.'

Another woman admitted that she still finds it difficult to walk in and out of Counselling Services. She shared that she always looks around to see if anyone she knows is watching, and she is always prepared with an "acceptable" excuse for being there.

Poor advertising of available resources and services was mentioned by a number of the participants. People said that when they overcame the shame and stigma of seeking help, they didn't know where to go. In terms of posters at the universities, one participant noted:

> Unless you spend an outrageous amount of time at school and look at every bulletin board and every hallway, then you don't get the full benefit of what's going on at our school. Everything I found out about, I found out through word of mouth...You know I don't see these things posted and if I didn't have friends or teachers that I talked with, I wouldn't know about it...Bulletin boards are jam packed with stuff so you have to sift through everything.

Participants suggested that information be made available in residences, campus kits, university newspapers, student calendars, lounges, cafeterias, the Physical Activities building and in washrooms.

A few of those who did find information about resources and services were disappointed to discover that they were inaccessible geographically, financially, or due to a long waiting list. One woman described her experience as a young teenager:

> And so being a kid out in the [suburbs], you know, and not really wanting to, not being able to depend on my family for support, and still not wanting to tell anyone, I was so ashamed, there was no way I could get down there [to the hospital].

Other women talked about their despair when they were told that they would be put on a six month waiting list for treatment.

Even more devastating was the lack of understanding or awareness among some of the professionals approached for support. When one women reached out for help by calling a crisis line, she was shocked by the person's ignorance:

> I said, 'I have a problem, I'm bulimic.' And she said, 'Oh, what does that mean?' I said, 'Well you know', and I thought, oh no, this is not going to work, and I said, 'That means I eat a lot of food, like I eat a whole loaf of bread and I eat a pie, and stuff like that and then I throw it up.' She said, 'And why do you do that?' I thought, you just don't understand do you? You just, you don't understand. No, this is definitely not going to work. I'm really upset and I'm calling you and I don't want to hear that you don't know what the hell I'm talking about, that you can't conceive how anyone could do that.

Women also expressed anger towards their family doctors because they did not look into their repeated symptoms but blamed the problems on stress. Another woman told of how her mother begged her to go to the hospital and when she finally consented the Doctor told her to "Go home and eat". She explained, "They were like, 'See ya'. That just kind of reinforced that 'there-was-nothing-wrong-with-me' kind of attitude, which is why it took so long for me to get into recovery."

Other professionals were incompetent. One woman described her devastating experience with a counsellor who had not done her own work.

> I went for help, and um, it was horrible, the counsellor I went to was just horrendous. She spent more time discussing

> herself and her own problems, and said, 'Well you look so thin, why do you have any worries?'. You know, it was devastating. I needed someone to be there for me and she was just um, totally self-absorbed with her own life....I really started to question if I needed help after that...I never knew what good counselling was.

Another woman was told by a doctor, "I've got my own sob story and if you don't like it, go somewhere else."

Referral to a nutritionist in the early stages of recovery was a negative experience for a couple of the participants.

> It just made me more tense because I started the same things, about being so obsessive, like you have to have so many calories every day and if you're going to work out, then have this and try this, and this. And of course there was no room for things like cake, or other like, kind of normal treat foods.

Another woman said that she knew all about nutrition and healthy eating tips, but that was not the problem. She needed to change how she viewed herself.

What was helpful in recovery

When asked what was helpful during the recovery process, participants mentioned things that they did for themselves, as well as how others in their lives supported them.

A number of individuals mentioned that keeping a journal provided them with an outlet to vent their emotions and it helped them to discover links between their emotions and their destructive eating patterns. A few of the participants found that once they were able to identify triggers to

their unhealthy behaviours, a list of alternative positive options helped them to substitute their destructive habits with healthier activities (i.e. calling a friend, taking a warm bubble bath, going for a walk).

Another woman reported that she found feminism helpful since it enabled her to understand her eating disorder within a social context and it encouraged her to take political action. This participant reported that "It was empowering to participate in a protest at a beauty pageant." Many of the other participants discussed how they had opted out of many of the media which promote the myth of the "ideal body" (ie. magazines, movies, music).

A number of the participants spoke of friends, partners, and/or family who encouraged them during their recovery process. When I asked how these people were supportive, I was given a number of specific characteristics that people found helpful. First of all, participants said that they needed someone who was available twenty-four hours a day, any day, and whom they could call guilt-free. One woman explained, "Somebody you can go to right when you're in the midst of somewhere you don't want to be, who can help you get out of it." Participants said that the main thing they needed from that person, was for them to listen. The importance of having someone to talk with, who understands that eating disorders are coping mechanisms for dealing with overwhelming emotions, is clear in the following woman's account:

> I needed to talk to somebody at least once a day during that time 'cause I really, really wanted to [throw up]. I felt very compelled to throw up. So every time I felt like throwing up I would phone somebody and say, 'I'm going to throw up, like, help me now.' I had some really neat women in my life, who I could do that with, and who knew that there were other things behind the compulsion. You know what I mean? So, like if I said that I was, that I felt compelled to throw up or binge out, or whatever, you know, they would say, 'What else happened today?' or 'So, what else is going on?' You know, so I could take the focus off of my physical desire to be thin, to you know, hate myself physically or whatever, and give myself a sort of perspective outside of the body.

By focusing on the women's feelings rather than their symptoms, people provided participants with an opportunity to vent and deal with the emotions at the root of their destructive eating behaviours. One woman had a friend who actually went to the woman's counsellor to ask what she could do to support her friend. Other family members and friends helped participants seek professional support by giving them referrals (contact names and numbers), making phone calls, and visiting professionals with them.

Opportunities to meet with others in groups, was also mentioned as helpful in the recovery process. Group therapy for eating disorders, depression, and a workshop for women who wanted to take back their power and self-esteem were three types of groups mentioned as particularly helpful. Participants discussed benefits of reduced isolation, provision of a support network, and an opportunity to learn positive coping skills. One woman explained, "It's really reassuring, it's really nice

to know that you're not alone, there's other people."

Supportive counsellors, doctors, crisis line workers, and professors were also mentioned as playing key roles in participants' recoveries. When asked to define "supportiveness", participants discussed the following aspects. Participants appreciated professionals who were both aware of eating disorders and who recognized and understood the physical and emotional components involved. Helpful professionals did not focus solely on the symptoms (i.e. weight gain/stability, cessation of vomiting or use of laxatives), but they also dealt with the underlying issues (i.e. poor self-esteem, lack of control in one's life, abuse). Participants also found it helpful when professionals who did not have the resources to support the individual themselves provided contact names and numbers where the person could get appropriate support. A few of the participants expressed gratitude for professionals who made the first call to another professional and set up their initial appointment. As well, a couple of participants mentioned that it meant a lot to them when professionals expressed genuine concern for them. Finally, support which was confidential and accessible was vital to recovery.

Types of support students need

Table 1 includes a list of each of the intervention ideas suggested, the number of focus groups in which each idea was suggested, and the percentage of each of the types of votes the ideas received (i.e. "I think

this is an important idea" and "I would use this idea or participate in it"). Percentages for each idea were calculated by dividing the number of votes by the total number of focus group participants (i.e. 19). Since each focus group developed an individual list of suggestions, percentages of votes for each of the ideas are not very useful because voters were not able to consider the complete list of suggestions, only their specific group's suggestions. Please consider this limitation when reviewing the table. Suggestions have been grouped into the following categories: treatment, peer supports, education, consciousness raising, celebrations, changes in counselling services, and changes in the university. In order to gain a more accurate picture of which suggestions students are most in need of, a survey of all of the following suggestions is recommended.

Table 1

Intervention Ideas Suggested in the Focus Groups

IDEAS	NUMBER OF GROUPS IN WHICH IDEA WAS SUGGESTED	THIS IS AN IMPORTANT IDEA	I WOULD USE THIS / PARTICIPATE
TREATMENT INTERVENTIONS			
a) INDIVIDUAL COUNSELLING - Deal with the issues at the root of the eating disorder.	3	42%	30%

IDEAS	NUMBER OF GROUPS IN WHICH IDEA WAS SUGGESTED	THIS IS AN IMPORTANT IDEA	I WOULD USE THIS / PARTICIPATE
b) NUTRITIONAL COUNSELLING - Individual consultation available at the university re: nutrition, healthy eating, & risks of dieting.	2	26%	21%
c) GROUP THERAPY	2	16%	32%
d) CRISIS LINE - 24 hour availability.	2	5%	26%
e) RETREATS FOR PEOPLE WITH EATING DISORDERS	1	5%	11%
f) ALTERNATIVE / HOLISTIC TREATMENT	2	21%	16%
PEER SUPPORTS			
a) SELF HELP GROUP - Lead by someone who has experienced an eating disorder and has training in leading groups.	4	37%	53%
b) POSITIVE ROLE MODEL MATCHES - Match people who are just beginning to recover with people who are farther along in the process of recovery.	1	11%	16%
c) PEER COUNSELLING - Peers who have struggled with body image issues available to provide support.	1	32%	16%

IDEAS	NUMBER OF GROUPS IN WHICH IDEA WAS SUGGESTED	THIS IS AN IMPORTANT IDEA	I WOULD USE THIS / PARTICIPATE
d) PEN PAL PROGRAM - Match people who are struggling with eating disorders to "pen pals" who have recovered from eating disorders.	2	21%	5%
e) MATCH FIRST YEAR STUDENTS WITH UPPER YEAR STUDENTS	1	11%	11%
EDUCATION			
a) VOLUNTEER STUDENT EDUCATORS - Students who have experienced body image difficulties go into classes and increase students' awareness of eating disorders (ie. signs, symptoms, risks, & available resources).	1	11%	16%
b) INFORMATIONAL SESSIONS - People who have experienced body image issues share personal stories and information.	3	32%	37%
c) WORKSHOP / SEMINAR ON INEFFECTIVENESS OF DIETING	2	26%	37%
d) WORKSHOP ON BUILDING SELF-ESTEEM	1	5%	16%
e) WORKSHOP ON STRESS REDUCTION AND RELAXATION TECHNIQUES	1	5%	5%

IDEAS	NUMBER OF GROUPS IN WHICH IDEA WAS SUGGESTED	THIS IS AN IMPORTANT IDEA	I WOULD USE THIS / PARTICIPATE
f) INFORMATIONAL PAMPHLETS - Provide information about body image difficulties as well as a list of resources and services.	2	26%	21%
g) EDUCATE DOCTORS, PROFESSORS, TEACHING ASSISTANTS, TEACHERS, PARENTS, AND COACHES - Provide information regarding body image issues, symptoms, risks, and available resources.	3	68%	42%
h) INFORMATIONAL DISPLAYS - Display information (posters, videos, pamphlets) regarding body image issues in a central location within the university.	1	5%	5%
i) DRAMA GROUP - University students form a group which goes into primary schools to teach students about body image issues through plays.	1	5%	11%
j) INCREASE AVAILABILITY OF CANADA FOOD GUIDE WITHIN THE UNIVERSITY	1	5%	0%

IDEAS	NUMBER OF GROUPS IN WHICH IDEA WAS SUGGESTED	THIS IS AN IMPORTANT IDEA	I WOULD USE THIS / PARTICIPATE
CONSCIOUSNESS RAISING			
a) DRAMA - Present body image issues in the context of a play, followed by group discussions. (ie. During Frosh Week)	3	58%	21%
b) CONSCIOUSNESS RAISING SEMINAR - Debunk society's myth of the "ideal" body, and teach students to think critically about the media's messages.	1	63%	26%
c) MEDIA WRITING CAMPAIGNS - Write advertisers about positive and negative ads.	2	11%	26%
d) BOYCOTTS - Boycott products which use degrading advertising.	2	11%	26%
e) PETITION TO GOVERNMENT - Encourage the government to legislate the inclusion of people of all sizes and shapes in the media.	1	5%	5%
f) UNIVERSITY RECRUITMENT WATCH - Group of university students ensure that recruitment material includes people of all shapes and sizes.	2	16%	11%

IDEAS	NUMBER OF GROUPS IN WHICH IDEA WAS SUGGESTED	THIS IS AN IMPORTANT IDEA	I WOULD USE THIS / PARTICIPATE
CELEBRATIONS			
a) POSITIVE BODY IMAGE PEP RALLY - Include speakers who accept themselves, positive films, singers, and marches.	2	11%	37%
b) A HEALTHY EATING DAY - Encourage everyone to eat at least one meal that fills the criteria from the Canada Food Guide.	1	5%	16%
c) POSTER AND/OR T-SHIRT CAMPAIGN - Promote positive body images through slogans and artwork.	1	5%	5%
d) ALTERNATIVE MAGAZINE - Publish a magazine which includes women of all shapes and sizes, which focuses on women's stories and experiences rather than on their appearances.	1	5%	11%
CHANGES IN COUNSELLING SERVICES			
a) GREATER PROMOTION OF SERVICES AVAILABLE BOTH ON AND OFF CAMPUS - Advertise in classrooms, residences, cafeterias, lounges, change rooms, and washrooms.	3	26%	32%

IDEAS	NUMBER OF GROUPS IN WHICH IDEA WAS SUGGESTED	THIS IS AN IMPORTANT IDEA	I WOULD USE THIS / PARTICIPATE
CHANGES IN THE UNIVERSITY			
a) EXPAND / MODIFY UNIVERSITY ATHLETIC FACILITIES AND PROGRAMS - Expand range of fun, active programs and equipment. Advertise programs with a focus on fitness rather than thinness.	2	32%	32%
b) LIMIT AMOUNT OF JUNK FOOD AVAILABLE ON CAMPUS AND REPLACE IT WITH HEALTHIER OPTIONS	1	0%	26%
c) SELF-HELP BOOKS IN THE BOOKSTORE - Feature self-help books with short descriptions of their focus.	1	11%	0%

ACTION COMPONENT

Method for the Action Component

Participants

All interested focus group and interview participants (females and males) were invited to provide their name and phone number if they were interested in joining a Student Advisory Committee which would review the suggestions made in the needs assessment, and plan how to implement some of the suggestions. All fifteen participants who indicated an interest in joining the group were called and invited to an introductory meeting in December 1993. Seven people became involved initially. New members have been invited, through word of mouth, by existing members and recruitment continues within our interventions. The Advisory Committee has grown to ten members and has named itself, "H.O.P.E.", which stands for "Helping Open People's Eyes". Committee members' experiences range across the continuum of body image issues from body dissatisfaction and yo-yo dieting to compulsive eating, bulimia, and anorexia.

The Facilitation Process

I have chosen to describe the process through which these incredible people came together to form a closely knit group. In an attempt to provide a comfortable, safe place for a group of strangers to come together, our first few meetings were quite structured. I will

describe these meetings in detail since they facilitated our development as a group.

The initial meeting in December was organized around the theme of "planting a garden". I chose this "imaginative" theme in an attempt to draw out participants' creative sides. I also hoped that by using a fun, nonthreatening focus, I could create a relaxed atmosphere which would encourage people to open up and share a bit of themselves and their dreams. The meeting began with a reflection titled "Recovery releases our Creativity" from Elizabeth L.'s "Inner Harvest: Daily Meditations for Recovery from Eating Disorders". After people introduced themselves and shared a little about why they came out and what they expected from the group, we reviewed all of the intervention ideas suggested in the needs assessment. Construction paper cut-outs shaped like seeds were prepared ahead of time, and each one had an idea printed on it. As we went over each of the ideas, the seeds were taped up on a blackboard so everyone could see them. We then clumped similar seeds together into groups such as education and information, treatment, seminars or workshops, and public rallies or protests.

In order to decide which seeds we could realistically plant and nurture as a group, we conducted a resource inventory of our gardening tools by reflecting upon our skills, energy levels, time, gifts, enthusiasm, levels of commitment, and interests. Each person was given a

construction paper cut-out shaped like a gardening tool, upon which she was asked to record her personal resources. I chose this exercise because I wanted the participants to recognize their personal strengths and share these with the group. All of our tools were taped onto a basket labelled, "Our Garden Tools" and reviewed by the group. In this way, we were able to realize the gifts among us. Some of our resources included deep commitment, high energy, a strong desire to see and make something happen, willingness to share personal experience, creativity, listening skills, empathy, excitement, and an enjoyment of public speaking. This exercise fostered sharing, enthusiasm and a high level of energy.

After reviewing our resources, we looked back at the seed ideas, and individually reflected on which seeds we felt that we, as a group, had the necessary gardening tools required to plant and nurture. Each person was asked to vote for their top six intervention priorities. Education and information interventions (i.e. informational pamphlets; educating doctors, teachers, professors, coaches, teaching assistants, and dentists about eating disorders, related issues, and available resources; informational displays; drama; volunteer student educators; documentary films; and informational sessions) received the most votes.

Finally, the group developed some terms of reference. Members decided that we would schedule a one hour meeting every two weeks on

a consistent day so that we could book that time into our calendars. Since the majority of committee members are from the University of Waterloo, we decided that U of W was the most accessible meeting place. Due to the Christmas holidays and exams, we decided to schedule our next meeting for the first week of January. Before leaving, everyone was given a "Planning our Intervention" sheet to aid them in developing ideas for the interventions they hoped to implement, and a "My Thoughts" sheet which asked them for their reflections on the meeting. These sheets are shown in Appendix L and M. People's reflections on the meeting included: "I liked meeting like-minded women and jumping right in and starting things." "I really feel like myself working with this group and I think if we are all 'ourselves' it will be very powerful and a lot of fun.", and "Let's focus on our plans and get right to it. I'm excited!".

At our second meeting, we concentrated on developing our group goals. We decided that we wanted to focus our attention on taking action, as well as provide a support network for each other. Action projects which were seen as "doable" in the 1994 winter term included organizing an information booth in the universities, writing an article for the university newspapers, sending a letter to physicians and fitness instructors about the signs and symptoms of eating disorders, trying a pilot peer support group to see if people were interested, and organizing for speakers to go into schools next year. When I mentioned that we

could tie one of these projects into the National Eating Disorder Awareness Week (February 1 - 7), the group decided that an information booth could be organized within that limited amount of time, and immediately began brainstorming on what could be included in the information booth, and dividing up tasks.

The next two meetings focused on finalizing the details for the information booths and updating each other on what we had done individually. One of these meetings was held at my apartment, where we worked together on posters and collages for the informational display. People's comments about these meetings included, "I hope that we have fun and get closer." "I hope that we will continue as a well organized group with lots of energy and creativity. I also hope we will be realistic and share our fears."

After all of the work [illegible] formation booths, a few of the members mentioned to me [illegible] ney wanted to spend some time getting to know each other better and sharing their experiences. We decided to devote our next entire meeting to sharing our stories. Since we rushed into planning so early in our group development, we had not spent much time getting to know each other. This meeting served as an excellent opportunity to step back and rediscover who we were and where we were coming from.

March 1, 1994, we reviewed our journey and all that we had

accomplished in such a short period of time. We also clarified our goals and time commitments and reviewed our intervention priorities. Two members were graduating in Spring 1994 and two members were moving out of town, but everyone said that they wanted to stay connected and remain as involved as possible.

Our biweekly meetings are much less structured than the first few meetings since they flow with the direction of the group. Agendas are based on what the group wants to accomplish and are always left open for additions, deletions, or changes. In an attempt to nurture our group process I introduced a few ideas during our initial meetings which have become traditions. First of all, we always begin our meetings with some type of a reflection (i.e. a poem, story, article of interest). This helps to create a nurturing "space". The reflection is followed by "check-in", during which each member shares how she is feeling that day or any other issues she wants to discuss. "Check-in" has become a vital component of our meetings as it allows us to share pieces of ourselves and our lives with each other, and to support one another.

My Role as Facilitator

My role within H.O.P.E. is continually changing and evolving. In the initial stages of the development of H.O.P.E., I played a very active role as the facilitator of the process. My goal was to provide an opportunity for people who have struggled with body image issues to come together to

share their experiences, gifts and insights regarding supportive and preventive interventions. I wanted to be a part of the group, but it was important to me that the group feel free enough to follow the group's vision and to take on a life of its own. My strong commitment to empowerment led me to take on the role of facilitator rather than that of leader since I did not want to lead the group but rather follow its direction and support members in making their dreams possible. As facilitator I undertook the organizational responsibilities such as inviting people to meetings (either by phone or by letter), booking meeting rooms, preparing agendas (from suggestions made at the previous meeting), finding opening reflections for meetings, and recording and distributing the minutes.

In the beginning, it was really difficult for me to convince people that I was not the leader, as they continually looked to me for direction and decisions. When someone asked a question, everyone turned to me expecting an answer. Although the group became frustrated at times because of the extra time and energy involved in making a consensual decision, I continually turned decisions back over to the group saying, "This is not my group, it is our group. How do you feel? What do you want to do? What do you think is best?" I really tried to encourage members to listen to each other, and I reminded them of the value of each of their unique experiences and insights.

Over a rather short period of time (six months), this group has transformed from a gathering of strangers looking to one person for direction, into a cohesive team of people working and growing together in an effort to reach collectively defined goals. When in need of direction, members now look to the group as a whole, rather than to me. With encouragement and many invitations, members have adopted many of the organizational responsibilities such as sharing reflections, phoning members about meetings, taking minutes, developing agendas, and coordinating social events. Now, rather than being responsible for completing all of these tasks myself, I simply ensure that someone is taking care of them.

Results and Discussion for the Action Component

H.O.P.E.'s Goals

During the initial meetings, members of H.O.P.E. expressed two main goals, action and support. These goals were further developed and defined in June 1994:

1. To work towards achieving a community which recognizes and accepts people of all shapes and sizes.
2. To increase awareness and take ongoing action with regards to body image issues and eating disorders.
3. To provide a support network and information about available resources.

Information Booths in the Universities

During a brainstorming session of possible intervention ideas, the group decided that National Eating Disorder Awareness Week (N.E.D.A.W.), February 1 to 7, would be an excellent opportunity to promote increased awareness of the issues related to body dissatisfaction and to raise consciousness regarding the effects of sociocultural pressures to attain an "ideal" body. Information booths were decided upon as the most appropriate vehicle since they can reach a large audience.

We adopted the 1994 N.E.D.A.W. theme for the information booths: "Celebrating our Natural Sizes". We liked this theme because of its

nonthreatening, positive message to accept ourselves as we are, and we appreciated its inclusiveness of people within the entire range of body image issues rather than exclusively people struggling with eating disorders. Our central poster carried this theme in bold letters which were surrounded by pictures of people of many different shapes, colours, and sizes. Other displays included life-size cut-outs of a man and a woman covered with collages of magazine models which were punctuated by the statements, "In the media, why does everyone look the same?" and "Reality Check: Only five percent of us can actually attain the 'ideal' body"; charts which listed the risks of yo-yo dieting, starvation, laxative abuse, self-induced vomiting, diuretic abuse, and excessive exercise; posters which listed simple ideas for how to celebrate our bodies such as, "Treat yourself to a massage.", "Do something active that is fun - Go dancing or tobogganning!", "Make a list of ten things you like about yourself", and "Accept the fact that you're not perfect, but you're great!"; and the "Famine Within" Video which describes the sociocultural issues related to body dissatisfaction and eating disorders. The following resources were also made available at the booth: lists of Resources and Services, pamphlets for local support groups and crisis lines, information about eating disorders from the National Eating Disorder Information Centre, reading lists and books for people to browse, copies of Canada's Food Guide, and a list of shocking facts which illustrate the prevalence of

body dissatisfaction and its destruction. Finally, at least one member of H.O.P.E. was always present to speak with people and answer questions. Pictures of the booths are shown in Appendix N.

The Information booth was displayed in the University of Waterloo's Campus Centre on February 1, 1994, from 9:00 a.m. to 4:00 p.m. and in Wilfrid Laurier University's Concourse on February 3, 1994, from 9:00 a.m. to 4:00 p.m. An article announcing N.E.D.A.W. and the Information Booths was written by one of H.O.P.E.'s members and published in each of the University Student Newspapers, the "Imprint" and "The Cord". A copy of this article is shown in Appendix O. A total of three hundred and seventy-three people took a moment to look at a poster, the video, or a resource, thirty-four people picked up information, and sixty-six people spoke with someone at the booth. The most popular time for both booths was over the lunch hour, between 11:00 a.m. and 1:00 p.m.

We noted a number of behaviours which confirmed the stigma surrounding body image issues. Visitors tended to approach the booth in clumps. Once one person moved towards the booth, a number of people followed. Perhaps the "safety in numbers" concept applied. A number of people at the University of Waterloo did not approach the booth, but took in the posters and video from a distance. The location at U of W (in the main hall of the Campus Centre) provided an opportunity for people to check out the booth from a safe distance away because the booth faced

an informal gathering place with small tables and chairs from which people could read the posters or watch the video without being obvious. Our location at Wilfrid Laurier University (in the Concourse) was more intimidating since people had to stop in front of the booth in order take in the information.

Five feedback forms asking for people's input regarding the information booths were completed and returned. A copy of the feedback form is shown in Appendix P. When asked what made them approach the booth, curiosity was the most common response, as people mentioned that the posters, video, and the life-size male and female images drew their attention. One person said that s/he was concerned by body image issues and therefore approached the booth looking for information. Another person reported that s/he saw the advertisement in the student newspaper and made a point of watching out for the booth.

In terms of what people learned or found most helpful, people commented on both the information provided and the consciousness-raising component. Information specifically mentioned as useful included the information on the various eating disorders and the clinical signs and symptoms, the resources and reading lists, and Canada's Food Guide. Respondents also expressed appreciation for the consciousness-raising regarding the diet industry, the media, and the "ideal" body. Only one person answered the question regarding what was least interesting or

helpful to people and s/he said, "It was all useful and interesting." Suggestions for improvement included: "Get a better location", "Make speeches or provide information vocally in the Concourse in order to make people listen", and "Get rid of the election posters. Your information was somewhat lost among those posters."

Public Speaking

As a member of the multidisciplinary Waterloo Region's Eating Disorder Awareness Week Committee, I was made aware of a number of needs for speakers with personal experiences with eating disorders. I shared these contacts with members of H.O.P.E., which resulted in members speaking in the following contexts: in a public forum sponsored by S.E.E.D. (Support for everyone with an eating disorder), to fitness instructors at the A.R. Kaufman Y, in a public forum at the Kitchener Public Library, and to students within St. Benedict's high school. Requests for Fall speakers in a variety of locations are already being channelled through H.O.P.E.

Information Forums

H.O.P.E. members participated in the presentation of the findings of the Needs Assessment to the University of Waterloo's Counselling Services and Health and Safety professionals on April 27, 1994. H.O.P.E. members also participated in a forum open to the entire Wilfrid Laurier University community on May 25, 1994, which was attended by university

health professionals, professors, support staff, students, and local nutritionalists. Members shared their experiences in seeking help, their insights regarding the recovery process, and their suggestions for supporting others with body image issues. As a panel, members also responded to questions.

Writing Campaigns

In June 1994, H.O.P.E. began watching specifically for media which promote the "beauty myth" and provide prescriptions for attaining the "ideal" body. Members expressed outrage upon discovering a magazine which describes itself as "the magazine for better health" and yet fifteen of the last eighteen issues featured cover stories describing how women can change their shape and/or weight. In doing so, this magazine contributes to the myth that thinness equals health. H.O.P.E. members discussed the issues involved, our concerns, and alternative suggestions. One member took our notes home and composed a letter on behalf of the group. A list of the risks of dieting, excessive exercise, and eating disorders, and a compilation of statistics which illustrate the prevalence of body dissatisfaction and eating disorders were also prepared and enclosed with the letter. This letter is now being circulated for signatures. H.O.P.E. members plan to continue writing media organizations regarding their disturbing messages.

Informational Booklet

A funding proposal was submitted to Genesis Research Foundation, June 1, 1994, to support H.O.P.E. in developing and distributing a booklet of information and resources to first year university students regarding body image issues. The proposed booklet would include: personal statements written by people who have experienced difficulty with body image issues which describe the vicious cycle and stress the importance of seeking support early, consciousness-raising regarding society's unrealistic ideal, a description of the continuum of behaviours related to body dissatisfaction, risks of destructive behaviours such as dieting and eating disorders, tips for seeking support and choosing a professional, a list of local resources and services, information about how to support someone struggling with these issues, and a reading list.

Peer Support Matches

Requests for people who have recovered from body image issues to provide peer support for people who are presently struggling have just recently begun to be channelled through H.O.P.E. Requests are brought to the group, and if there is a member who feels she has the time and energy to volunteer her support, she gives permission to have her number given to the person struggling. We hope to continue this matching component through a referral system with the University of

Waterloo's Peer Assistance Link Service (PALS). When people call into PALS with body image issues, PALS can refer them to our group and we will attempt to match the person with a peer support.

Video

University of Waterloo's Counselling Services have asked the members of H.O.P.E. to assist in the creation of a video of people's personal struggles with body image issues. A number of members have agreed to be involved in this project.

Development of a Supportive Network

Throughout the planning, organization, and implementation of the above-mentioned interventions, H.O.P.E. has provided and continues to provide a supportive network; a safe place where people can share their stories, listen to others' experiences, and be accepted. In order to describe the type of support H.O.P.E. provides, I will share my personal experience as a member of H.O.P.E.

My experience as a member of H.O.P.E.

The most challenging part of my thesis, is to describe the profound effect H.O.P.E. has had, and continues to have in my life. I had no concept of the impact this group of people would have in my personal journey of growth and healing.

Until I began my thesis, my recovery had been a very individual, private process consisting of individual therapy, journaling and reading. I

had shared my story with very few people. I had not participated in any groups, and I had never talked with anyone who had struggled with similar issues. So, when people began sharing their stories, I was overwhelmed by the instant connection I felt. It was not until I heard others describe their experiences that I truly felt that I was not alone; That others knew and understood the painful journey I had travelled. With that realization, came incredible relief. With these women I am able to be open and honest about my struggle, and know that I am understood and accepted as I am.

When the time came for me to share my story publicly, in a television interview and in a public forum, members of H.O.P.E. surrounded me with their support and encouragement. Knowing that they stood with me gave me the strength I needed to break the silence and open up my life to others in the hopes of preventing them from falling into similar destructive behaviours.

OVERALL DISCUSSION

Intervention Suggestions

In students' descriptions of their struggles with body dissatisfaction, they discussed a combination of individual, familial, environmental, and sociocultural factors which they felt contributed to the development of their difficulties with body image issues. Students addressed this range of sources by suggesting multiple levels of intervention, including professional treatment, peer support, education, and social action. Students' prioritization of the intervention ideas indicates that both supportive interventions (i.e. professional treatment and peer supports), and preventive interventions (i.e. education, consciousness-raising, and celebrations) are wanted and needed in the area of body image issues.

Participants expressed a need to increase professional supports on campus in an attempt to treat students at the earliest possible moment and therefore reduce the severity and duration of body image difficulties. Suggestions for professional treatment included individual and nutritional counselling, group therapy, crisis lines, alternative/holistic treatments, and retreats for people with eating disorders. Recognizing the high demand for support and the limited professional and financial resources available, students proposed an expansion of supportive services to include peer supports such as self-help support groups, peer counselling,

positive role model matches, a pen pal program, and matching first year students with upper year students. Students also made a variety of recommendations for improving the advertising and accessibility of supportive services.

Education was the most commonly recommended preventive intervention. At the secondary prevention level, participants recommended education of professionals (i.e. doctors, dentists, professors, teaching assistants, teachers, coaches, and residence dons), families, and friends regarding body image issues, the symptoms and risks of eating disorders, and available resources in order to help them identify difficulties and promote treatment at the earliest possible moment. Other intervention suggestions which would attempt to foster earlier recognition of problems included informational pamphlets which provide information about body image difficulties and a list of resources and services, information booths, and informational sessions led by people who have experienced eating disorders.

Participants also suggested primary prevention oriented educational interventions. These would attempt to increase students' protective factors by promoting awareness and building skills such as offering workshops on the ineffectiveness and risks of dieting, building self-esteem, and stress reduction and relaxation techniques; and increasing the availability of the Canada Food Guide. Drama and

consciousness-raising seminars were also suggested as primary prevention interventions which would foster students' critical thinking regarding society's role in promoting body dissatisfaction.

While participants recognized the need to build individuals' resistances and protective factors, they went beyond individual interventions and suggested a variety of creative social action interventions which aim to change the sociocultural environment which places individuals at risk for developing body dissatisfaction in the first place. Participants suggested a need to transform the media since it plays a vital role in promoting weight and shape preoccupation and the myth of attainable thinness for all. Media writing campaigns were advocated as an intervention which could raise students' awareness of the underlying messages and myths promoted by the media, and teach them how to write advertisers to express their opinions and demand changes. Students could be encouraged to write advertisers which perpetuate negative messages such as overconcern with appearance, as well as to congratulate advertisers which provide positive models of acceptance and self-love. In addition, participants suggested the organization of boycotts of products which prescribe destructive prescriptions for attaining the thin "ideal".

Participants also offered a variety of suggestions for how to promote a more positive, affirming sociocultural environment on campus.

Students could be encouraged to care for themselves and celebrate their natural sizes through interventions such as a positive body image pep rally which promotes self-acceptance, a healthy eating day, poster and/or t-shirt campaigns which promote positive body images through slogans and artwork, and publishing an alternative magazine which includes women of all shapes and sizes and focuses on women's stories and experiences rather than their appearances.

Development and Implementation of Interventions

While many of the supportive and preventive interventions suggested by participants have been previously suggested and discussed in the literature, they have also been developed and implemented by professionals without consultation with the people they most affect. The present research is based upon three underlying assumptions of empowerment, as described by Whitmore (1988): a) individuals are assumed to understand their own needs better than anyone else and therefore they should have the power to both define and act upon them, b) experiential knowledge is valid and useful, and c) all people possess strengths upon which they can build. The interventions described in this thesis have been defined, designed, developed, and implemented by experiential experts, people who are or have struggled with issues of body image, dieting, weight concerns, nutrition, exercise, and/or eating disorders. The insight and experiential knowledge of people who have

experienced difficulty with body image issues has been valued both in the needs assessment, and in the development and implementation of interventions. In addition, within the student advisory committee (H.O.P.E.) members have been encouraged to share and build upon their strengths.

Intervention and Empowerment within the Research Process

Serrano-Garcia (1990) defines action research or "intervention within research" as an approach which implements goals of social change and empowerment. This thesis attempted to implement these goals and therefore provides a model of action research.

Needs assessments play a vital role in the planning and development of supportive and preventive programs since they gather information about a group of people's problems and goals in order to ensure that the interventions developed will respond to the needs of the population (Marti-Costa & Serrano-Garcia, 1983). This needs assessment collected vital information about university students' experiences, needs, and suggestions in terms of body image issues. Assumptions regarding students' needs were checked out by asking students directly about their needs and experiences rather than relying on professionals' assessments. Students' experiential knowledge improves the likelihood that the services and preventive interventions suggested will be relevant, acceptable, and utilized (Morrell-Bellai & Boydell, 1994; Kopolow, 1981). Effective

consumerism was also encouraged through student involvement since students indicated how to best use the resources of Counselling Services and they suggested alternative interventions which do not require professional resources.

In addition to providing a description of students' experiences and needs, the needs assessment also initiated the consciousness-raising, mobilization, and organization of students. Demystification and consciousness-raising began within the focus groups and interviews, where students were encouraged to consider society's role in the development of body image issues and to brainstorm regarding possible prevention and social action interventions. Demystification is the change in consciousness which occurs among the relatively powerless when they consider their situation in a new light (Ferguson, 1984). By drawing students together to reflect upon and discuss the specific issues related to body image, the needs assessment played an instrumental role in mobilizing and organizing students to respond to identified needs and issues. Within the focus groups, students with a wide range of experiences with body dissatisfaction began sharing, exploring, and affirming both their positive and negative experiences. Reinharz (1992) recognizes this as an essential first stage in the development of a consciousness-raising group. Once the group discovers their common experiences, they are able to move into the advanced stage of

development. During this stage, group members work towards collective action which aims to change the conditions associated with their shared negative experiences (Reinharz, 1992). While continuing to share and value personal stories, the student advisory group which evolved out of the needs assessment (H.O.P.E.) is also dedicated to implementing both supportive and preventive interventions suggested in the needs assessment. Involvement in this type of collective action affirms participants' experiences and strengths (Reinharz, 1992) and promotes the development of leadership skills.

Isaac Prilleltensky (1994) defines empowerment as interventions which are guided by the values of self-determination, distributive justice, and collaborative and democratic participation. The needs assessment and the development of the Student Advisory Committee (H.O.P.E.) attempted to incorporate these values and therefore empower students. Self-determination was encouraged since students were invited to brainstorm together and to share their individual goals and their preferred choices of action. The intent of this process was to allow everyone to express their view, and to promote self-respect. It was a "bottom up" approach, since the students told the professionals what they felt they need.

Collaborative and democratic participation means that the people that could be affected by a social intervention should be included in the

decision making process (Prilleltensky, 1994). Since all of the students are stakeholders, all students were invited to participate and take an active role in the defining of their needs and in the goal-setting, the decision making, the organization, and the implementation of the interventions. Students' experiential knowledge and insight were respected and valued throughout the research process.

Distributive justice requires equitable distribution of power between professionals and students. The needs assessment and development of the student advisory group aimed to reallocate power to the students by asking them directly what types of supportive and preventive interventions they want and need, and by providing them with a vehicle through which they could implement these suggestions.

LIMITATIONS

Limitations of the Needs Assessment

As with all studies, this needs assessment has some drawbacks. Due to the small sample of students involved in the needs assessment, it is difficult to generalize the information gained. As well, because of my focus on university students and my use of the self-selection recruitment technique, my sample lacks diversity in terms of age, gender, ability socioeconomic status, and culture. The methods used for the needs assessment (ie. focus groups and interviews) also reduced the diversity of my sample since they lacked anonymity, therefore the needs assessment only included people who were able and willing to share their experiences, ideas, and suggestions in person. Future studies need to investigate larger, more diverse samples.

Limitations of the Action Component

H.O.P.E.'s process of development was based on the combination of the unique needs and skills of the individuals involved and therefore this study cannot be used as a specific blueprint for how to develop such a group. Rather, it provides a general model of action research which involves students in both defining their needs and creating supportive and preventive interventions. As well, the interventions which have been chosen and implemented by H.O.P.E. reflect members' specific interests and resources and therefore other groups may choose different

interventions. Intervention choices were also limited by a lack of financial resources.

In addition, no formal evaluations were completed for any of the interventions developed in the Action Component, and therefore we do not have any research regarding their effectiveness in terms of prevention or support. Future studies need to address the evaluation of supportive and preventive interventions.

RECOMMENDATIONS

Recommendations for University Health Professionals

A number of specific recommendations have been made for University Health Professionals regarding advertising techniques and the types of supportive and preventive interventions that are needed in terms of body image issues.

Participants made a number of recommendations for how to improve the advertising of services and programs offered by Counselling Services and Health and Safety. First of all, they suggested a variety of advertising techniques: posters, articles in campus newspapers, written messages on classroom blackboards, announcements by professors in classes, student calendars, frosh kits, and an information booth during Frosh Week. In terms of posters, students recommended that they be placed in a variety of locations: classroom buildings, residences, physical activities buildings, lounges, student gathering places (i.e. Campus Centre, Concourse, South Campus Hall), cafeterias, library bulletin boards, and in washrooms. When I asked participants how they found out about my study, the most common responses were through a poster in a washroom, a message written on a classroom blackboard, or my visit to their classroom. It is interesting to note that all of these methods allowed people to take in the information anonymously (i.e. people did not have to stop in front of a poster in public and write down the information.)

Participants also suggested that the wording in advertisements needs to be as inclusive and nonthreatening as possible. Avoid rigid definitions of who may become involved (i.e. avoid advertising "for people with anorexia or bulimia"). People may be affected by these issues but do not feel that they fit the rigid definitions or criteria of specific eating disorders. Also, many people do not want to be labelled and therefore they would not come to a program for "anorexics and bulimics", but they may come to a program for "people struggling with body and/or weight issues." A number of the participants commented that the range of issues used in advertising my project made them feel comfortable about coming. As well, they appreciated that people who were just curious about the issues, and those directly or indirectly affected were specifically invited.

Finally, participants suggested that when Counselling Services advertises groups, that they advertise the first meeting as an "Information Session" to which people can come in order to learn more about what the group would be about. By opening the first meeting to anyone who is interested, concerned friends could also come out and get more information about available resources and services. Participants also felt that this would be less intimidating than committing to a six week group immediately.

Participants shared some specific recommendations for health

professionals. A number of participants spoke about wanting to talk to their doctor about their problems, but needing an "open door". When asking people for their medical history, doctors may consider asking individuals about their body image (i.e. How do you feel about your body?) in order to promote early identification of difficulties with body image. Also, if doctors notice weight fluctuations, they could open the lines of communication by addressing it, (i.e. "I've noticed you've lost twenty pounds since your last visit. Should I be concerned?")

Participants also stressed that people struggling with body image issues need professionals who recognize and understand both the physical and emotional components involved. Avoid focusing solely on the symptoms (i.e. weight gain/stability, cessation of vomiting or use of laxatives). Rather, listen to how the individual feels and encourage him/her to deal with the underlying issues (i.e. poor self-esteem, lack of control in one's life, abuse). Professionals who do not have the resources to support the individual themselves should provide contact names and numbers where the person could get appropriate support. Professionals may also consider making the first call to another professional in order to set up an initial appointment.

In addition to professional supports, participants suggested that peer support systems are very important because often in the earlier stages of body image difficulties it is easier for one to go to a peer for

help rather than a professional, due to the stigma around counselling. Participants described their relief in hearing about others' similar journeys, and discovering that they were not alone. They also spoke of the deep understanding they felt when sharing their stories with peers who had experienced or were experiencing similar struggles. Suggestions for peer support included forming a peer support group on campus, developing a "buddy system" which matches people who are struggling with an eating disorder with people who have recovered, and networking with the Peer Assistance Link Service (PALS) at the University of Waterloo so that PALS could refer people struggling with body image issues to a peer support group.

Finally, participants indicated a need for more preventive or social action interventions. In order to increase awareness of the issues and promote early recognition and support, participants recommended educational seminars for students, professors, teaching assistants, residence dons, coaches, teachers, doctors, and dentists. In terms of educational seminars, participants made a number of suggestions. First of all, address the entire continuum of eating disorders rather than focusing on the extremes, otherwise a number of people who are affected cannot identify themselves as affected. Discuss how body dissatisfaction often leads to dieting or bingeing, which can lead to eating disorders. Avoid rigid definitions and "text-book" examples of eating disorders and

the "types" of people affected by them. Since fear was a motivating factor for seeking help, stress the physical and emotional risks or side effects of eating disorders. As well, explain the ineffectiveness and destructiveness of restricting and purging methods.

Participants also suggested a variety of creative social action interventions which would foster consciousness-raising and promote changes in the sociocultural environment which places individuals at risk for developing body dissatisfaction in the first place. Such proactive primary prevention interventions would attempt to reduce the need for supportive services by preventing body dissatisfaction.

Recommendations for Action Research Projects

This thesis provides a model of an action-research project in which a needs assessment was used to foster the momentum required to generate action. Action requires awareness of the issues and motivation to make changes. In drawing students together through the focus groups, the needs assessment facilitated consciousness-raising, mobilization, and organization of students. A similar process could be adapted to address a variety of issues in a number of different settings (i.e. to address violence against women in high schools, or to address the integration of people with disabilities in a work setting).

Before making recommendations for facilitating similar action-oriented groups, I want to acknowledge that H.O.P.E.'s success is due in

great part to the group of dedicated, gifted women involved, and their willingness to give of themselves through sharing their experiences and insights. When I first shared my dream of drawing students interested in body image issues together, I was warned not to build high expectations. Members of H.O.P.E. have taught me that when one dreams and believes, anything is possible. H.O.P.E. has flourished beyond my wildest imagination.

There are four additional elements that I feel have also played a vital role in H.O.P.E.'s evolution and growth. First of all, participants were invited to play an active role in developing H.O.P.E. through the needs assessment. As participants expressed their needs and brainstormed on creative ways to meet those needs, H.O.P.E.'s foundation evolved. Rather than asking people to join a previously established group with a set agenda, participants were invited to come together to build upon their own ideas. Commitment and a sense of ownership grew out of this process.

I discovered the second element quite by accident. During H.O.P.E.'s formation stage, I received insightful advice from a number of my interview and focus group participants: Take advantage and build upon the momentum created in the brainstorming sessions. The focus groups and interviews stirred up a lot of emotions and enthusiastic energy and people were really keen to get down to work as soon as

possible, so we scheduled our initial meeting as early as our schedules would permit. In this way, we were able to keep the creative energy flowing.

Thirdly, I tried to maintain constant, personal communication with H.O.P.E. members through mailing out minutes, writing personal letters, and making phone calls. A number of members have expressed appreciation for this communication as it kept them updated and feeling connected.

Finally, although it is easy to get caught up in the planning and organizing of interventions, it is vital to take time to nurture relationships in order to keep such a group alive. After completing our information booth displays, group members reminded me of our need to take time out to share our stories and learn about one another. Since that reminder, we have dedicated an entire meeting to sharing our stories, we have adopted "check-in" as a meeting tradition, and we have and continue to celebrate our friendships through fun social events such as potluck dinners, bowling, and a pool party. The connections which have resulted are one of our group's notable strengths.

Recommendations for Future Research

Participants suggested a broader diversity of students may be reached through a questionnaire since a questionnaire would allow people who are not yet ready to admit their difficulties in public to

respond anonymously. A number of the participants discussed that sharing their experiences in person was a major step for them and that in earlier stages in their recovery they would not have been able to do this. A questionnaire was developed based on the results of the needs assessment and is included in Appendix Q. This questionnaire could be used to gain more information from a larger, more diverse sample.

Unfortunately, due to time and resource constraints, this thesis does not provide an evaluation of the action component. While H.O.P.E. members have indicated that their involvement with H.O.P.E. has been empowering, we have limited information about participants' experiences of empowerment in the research process or the specific elements which promoted empowerment. A qualitative evaluation of the development of such an advisory group could identify the experiences and elements which participants feel promote increased control and participation in their lives.

Prevention programs frequently lack an adequate assessment of outcome (Shisslak, Crago, Neal, and Swain, 1987). Evaluations of the types of interventions implemented by H.O.P.E. could provide valuable insight regarding their effectiveness in supporting people with body image issues and preventing difficulties with body image.

CONTRIBUTIONS TO THE LITERATURE

I believe that this thesis offers the following three unique contributions to the literature: a) participants' suggestions expanded the list of previously recommended individual-focused primary prevention interventions to include interventions which address the sociocultural environment (i.e. social action interventions); b) interventions were defined, designed, and implemented by people who have experienced difficulty with body image issues rather than by professionals, and c) this thesis provides a model of action research which implements social change and empowerment.

Students recommended multiple levels of preventive interventions (i.e. secondary prevention, and primary prevention aimed at changing both individuals and the sociocultural environment). Education, one of the most commonly cited prevention interventions in the literature, was also a popular idea among participants. In terms of secondary preventive education, both participants and the literature propose that earlier recognition and treatment of body image problems could be fostered by education of professionals, families, and friends regarding body image issues, the symptoms and risks of eating disorders, and available resources (Vandereycken & Meermann, 1984; Frankenburg, Garfinkel & Garner, 1982; Christiansen, Payne & Van Valkenburg, 1986; and Shisslak, Crago, Neal, and Swain, 1987). Participants also reiterated the need for

primary preventive education as previously suggested in the literature (Moriarty, Shore, & Maxim, 1990; Shisslak, Crago, Neal, & Swain, 1987; Killen et al., 1993; Polivy & Herman, 1992; Rockett & McMinn, 1990). Such interventions would attempt to increase individuals' protective factors by promoting awareness of related issues and by teaching coping skills (i.e. provide workshops which teach students about the ineffectiveness of dieting, build self-esteem, and expand critical thinking skills).

While a number of the primary prevention interventions suggested in the literature acknowledge society's role in the development of body image issues, unfortunately these interventions focus exclusively on changing the "affected" individuals. In the focus groups and interviews, participants were encouraged to consider society's role in the development of body image difficulties. Once participants considered the impact of sociocultural pressures to attain an "ideal" body, they recognized a need to expand the focus of primary prevention interventions to address the sociocultural environment. Such interventions would attempt to remcve or decrease the environmental stressors which place individuals at risk for developing an illness in the first place. Participants' suggestions included interventions aimed at changing the immediate environment (i.e. the university culture) and broader sociocultural influences such as the media.

The interventions suggested and described in the literature have

been developed by professionals without consultation with the people they most affect. In this thesis, individuals' insights and experiences were valued. Rather than relying on professionals' assessments of individuals' needs, students were asked directly about the types of support and prevention they need. Interventions were defined, designed, developed, and implemented by people who have experienced difficulty with body image issues. In addition, participants made specific recommendations for university health professionals in terms of improving the advertising, accessibility, and effectiveness of both supportive and preventive interventions.

Finally, this thesis provides a model of an action-research project in which intervention and empowerment were fostered within the research process. By drawing students together to reflect upon and discuss their needs with regards to body image issues, the focus groups and interviews offered an opportunity for consciousness-raising and mobilization. The student advisory group (H.O.P.E.) provided an empowering vehicle through which students were able to organize and implement their ideas. By involving students in both the needs assessment and the implementation of interventions, a sense of ownership and empowerment has evolved which will hopefully motivate the group to continue to develop and implement needed interventions. A similar process could be adapted to address a variety of issues in a

number of different settings.

CONCLUDING COMMENTS

Seven years ago, when I was diagnosed with bulimia, my mom planted a seed of hope. She suggested that my struggle may provide me with understanding and experience that would one day enable me to make changes to prevent others from travelling a similar journey. That seed lay dormant in the back of my mind until two years ago, when it discovered fertile ground in community psychology and feminist research. The values of these two disciplines nurtured the seed to germination. Community psychology and feminist research encouraged me to value personal experience and helped me to recognize the relationship between individuals and their social context. They also provided me with a framework of social change and empowerment within the research process.

The seedling basked in the rays of enthusiasm and creativity fostered by the needs assessment. At times weeds of self-doubt have threatened to choke out the growing plant, but fortunately it had a solid system of roots and a nurturing support network. With loving care, the plant has now blossomed into H.O.P.E.. Through sharing stories and insights and working side by side, H.O.P.E. has cultivated an abundance of fertile ground for new seeds. My joy is indescribable as I watch the seeds scattered by H.O.P.E. grow into a garden.

REFERENCES

Aldebaran, J. (1975). Uptight and hungry: The contradiction in psychology of fat. Journal of Issues in Radical Therapy,5,5-6.

American Psychiatric Association (1987). Diagnostic and statistical manual of mental disorders: Third edition, Revised, Washington, D.C.

Andersen, A.E., Woodward, P.J., Spalder, A., and Koss, M. (1993). Body size and shape characteristics of personal ("In search of") ads. International Journal of Eating Disorders,14(1),111-116.

Beglin, S. J., and Fairburn, C. G. (1992). Women who choose not to participate in surveys on eating disorders. International Journal of Eating Disorders,12,(1),113-116.

Bennett, N.A., Spoth, R.L., and Borgen, F.H. (1991). Bulimic symptoms in high school females: Prevalence and relationship with multiple measures of psychological health. Journal of Community Psychology,19,(1),13-27.

Bennett, W. and Gurin, J. (1982). The dieter's dilemma: Eating less and weighing more. New York: Basic Books, 1982.

Berman, E.M. (1975). Factors influencing motivations in dieting. Journal of Nutritional Education,7,155-159.

Black, D. and Burkes-Miller, M.E. (1988). Male and female college athletes: Use of anorexia nervosa and bulimia nervosa weight loss methods. Research Quarterly,59(3),252-256.

Blair, A. (1992). The role of primary prevention in mental health services: A review and critique. Journal of Community and Applied Social Psychology,2,77-94.

Brown, C. and Jasper, K. (1993). Consuming passions: Feminist approaches to weight preoccupation and eating disorders. Toronto: Second Story Press.

Bruch, H. (1978). The golden cage: The enigma of anorexia nervosa. Washington, DC: Howard University Press.

Brumberg, J. J. (1988). Fasting girls: The emergence of anorexia nervosa as a modern disease. Cambridge: Harvard University Press.

Chernin, K. (1981). The obsession: Reflections on the tyranny of slenderness. New York: Harper and Row Publishers, Inc.

Christiansen, M.D., Payne, L.M., and Van Valkenburg, M. (1986). Talking to a young person with hang-ups about eating: A training program. Journal of College Student Personnel,September,456-457.

Cochran, M. (1986). The parental empowerment process: Building on family strengths. In J. Harris (Ed), Child psychology in action: Linking research and practice. (pp. 12-33). Brookline, M.A.: Croon Helm.

Crisp, A.H. (1988). Some possible approaches to prevention of eating and body weight/shape disorders, with particular reference to anorexia nervosa. International Journal of Eating Disorders,7(1),1-17.

Denzin, N. K. (1970). The research act in sociology. London: Butterworths.

Edmonton Social Planning Council (1988). Doing it right! : A needs assessment workbook. Edmonton.

Edwards, G. (1989). Finding that broad street pump. Changes,7,61-64.

Ferguson, K.E. (1984). The feminist case against bureaucracy. Philadelphia: Temple University Press.

Frankenburg, F., Garfinkel, P. E., and Garner, D. M. (1982). Anorexia nervosa: Issues in prevention. Journal of Preventive Psychiatry,1, 469-483.

Garner, D.M. (1985). Iatrogenesis in anorexia nervosa and bulimia nervosa. International Journal of Eating Disorders,4(4),701-726.

Garner, D. M. and Garfinkel, P.E. (1980). Socio-cultural factors in the development of anorexia nervosa. Psychological Medicine,10,647-656.

Garner, D. M., Garfinkel, P.E., Schwartz, D., and Thompson, M. (1980). Cultural expectations of thinness in women. Psychological Reports,47,483-491.

Garner, D.M. et al, (1985). Psychoeducational principles in the treatment of eating disorders. In D.M. Garner and P.E. Garfinkel, Handbook of Psychotherapy for Anorexia Nervosa and Bulimia, New York: Guilford Press, 513-572.

Halmi, K.A., Falk, J.R., and Schwartz, E. (1981). Binge-eating and vomiting: A survey of a college population. Psychological Medicine,11,697-706.

Hamilton, L.H. et. al. (1985). Sociocultural influences on eating disorders in professional female ballet dancers. International Journal of Eating Disorders,4(4),465-477.

Holliman, S.C. (Ed.) (1991). Handbook for coaches on eating disorders and athletics. Dubuque: Kendall-Hunt.

Hsu, L. K. G. (1980). Outcome of anorexia nervosa: A review of the literature. Archives of General Psychiatry,37,1041-1042.

Kahn, Si. (1982). Organizing. New York: McGraw-Hill.

Keys, A., Brosek, J., Henschel, A., Meckelsen, A., and Taylor, H.L. (1950) The biology of human starvation. Minneapolis: University of Minnesota Press.

Killen, J.D., et al. (1993). An attempt to modify unhealthful eating attitudes and weight regulation practices of young adolescent girls. International Journal of Eating Disorders,14(4),369-384.

King, M.B. (1989). Eating disorders in a general practice population. Cambridge: Cambridge University Press.

Kopolow, L.E. (1981). Client participation in mental health service delivery. Community Mental Health Journal,17,46-53.

Lewis, V.J., and Blair, A. (1991). The social context of eating disorders. In R. Cochrane & D. Carroll (Eds.), Psychology and social issues, (pp. 22-30). London: The Falmer Press.

Lincoln, Y.S. and Guba, E. G. (1985). Naturalistic inquiry. Newbury Park, CA: Sage.

Marti-Costa, S. and Serrano-Garcia, I. (1983). Needs assessment and community development: An ideological perspective. Prevention in Human Services,2,75-88.

Mennell, S. (1985). All manners of food: Eating and taste in England and France from the middle ages to the present. Oxford: Basil Blackwell.

Moriarty, D., Shore, R. and Maxim, N. (1990). Evaluation of an eating disorder curriculum. Evaluation and Program Planning,13,407-413.

Morrell, T.L. (1988). Towards the development of a resource center for individuals with anorexia nervosa and/or bulimia: A needs/resource assessment, professional networking, and program planning process. Unpublished M.A. Thesis, Wilfrid Laurier University.

Morrell-Bellai, T.L. and Boydell, K.M. (1994). The experience of mental health consumers as researchers. Canadian Journal of Community Mental Health,13(1),97-107.

Oakley, A. (1981). Interviewing women: A contradiction in terms. In H. Roberts (Ed.), Doing feminist research, (pp. 30-61). London: Routledge & Kegan Paul.

Patton, M. Q. (1990). Qualitative evaluation research methods. Newbury Park: SAGE Publications, Inc.

Polivy, J. and Herman, C.P. (1983). Breaking the diet habit. New York: Basic Books.

Polivy, J. and Herman, C.P. (1992). Undieting: a program to help people stop dieting. International Journal of Eating Disorders,11(3),261-268.

Pope, H.G., Hudson, J.I., Yurgelun-Todd, D., and Hudson, M.S. (1984). Prevalence of anorexia nervosa and bulimia in three student populations. International Journal of Eating Disorders,3(3),45-51.

Posavac, E.J. and Carey, R.G. (1992). Program evaluation: Methods and case studies. Englewood Cliffs: Prentice-Hall Inc.

Prilleltensky, I. (1994). The morals and politics of psychology: Psychological discourse and the status quo. Albany: State University of New York Press.

Pyle, R.L., Mitchell, J.E., Eckert, E.D., Halvorson, P.A., Neuman, P.A., Goff, G. M. (1983). The incidence of bulimia in freshman college students. International Journal of Eating Disorders,2,(3),75-85.

Rappaport, J. (1990). Research methods and the empowerment social agenda. In P. Tolan, C. Keys, F. Chertok, and L. Jason (Eds.), Researching Community Psychology: Issues of Theory and Methods,(pp. 51-63). Washington: American Psychological Association.

Reinharz, S. (1992). Feminist methods in social research. New York: Oxford University Press.

Rice, C. (1993). Freeing future generations: Raising our children without food and weight problems. Nutrition Quarterly,17,(3),55-68.

Rockett, G., and McMinn, K. (1990). You can never be too rich or too thin. Journal of College Student Development,31,278.

Rodin, J., Striegel-Moore, R.H., and Silberstein, L.R. (1990). Vulnerability and resilience in the age of eating disorders: risk and protective factors for bulimia nervosa. In Rolf, J., Masten, A., Cicchetti, D., Nuechterlein, K., and Weintraub, S. (Eds.), Risk and protective factors in the development of psychopathology, (pp. 361-383) Cambridge: Cambridge University Press, 361-383.

Rothblum, E.D. (1992). The stigma of women's weight: social and economic realities. Feminism and Psychology,2(1),61-73.

Rucker, C.E. and Cash, T.F. (1992). Body images, body-size perceptions, and eating behaviors among african-american and white college women. International Journal of Eating Disorders,120(3),291-299.

Seid, R.P. (1989). Never too thin: Why women are at war with their bodies. New York: Prentice Hall Press.

Serrano-Garcia, I. (1990). Implementing research: Putting our values to work. In P. Tolan, C. Keys, F. Chertok, & L. Jason (Eds.), Researching community psychology: Issues of theory and methods (pp. 171-182) Washington, D.C.: APA.

Shisslak, C.M., Crago, M., Neal, M.E., and Swain, B. (1987). Primary prevention of eating disorders. Journal of Consulting and Clinical Psychology,55(5),660-667.

Siegel, L.M., Attkisson, C.C., & Carson, L.G. (1978). Need identification and program planning in the community context. In C.C. Attkisson, W.A. Hargreaves, M.J. Horowitz & J.E. Sorensen (Eds.) Evaluation of human service programs,(pp. 215-251) New York: Academic Press.

Silberstein, L.R., Striegel-Moore, R.H., Timko, C. and Rodin, J. (1988). Behavioral and psychological implications of body dissatisfaction: Do men and women differ? Sex Roles,19(3),219-232.

Silverstein, B., Peterson, B., and Perdue, L. (1986). Some correlates of the thin standard of bodily attractiveness for women. International Journal of Eating Disorders,5(5),895-905.

Smith, D. (1987). The everyday world as problematic. Toronto: University of Toronto Press.

Striegel-Moore, R.H., Silberstein, L.R., and Rodin, J. (1986). Toward an understanding of risk factors for bulimia. American Psychologist, 41(3), 246-263.

Straus, A., and Corbin, J. (1990). Basics of qualitative research: Grounded theory procedures and techniques. Newbury Park: Sage Publications, Inc.

Squire, S. (1983). The slender balance: Causes and cures for bulimia, anorexia, and the weight-loss/weight-gain seesaw. New York: Putnam.

Valette, B. (1988). A parent's guide to eating disorders. New York: Walker Publishing Co.

Vandereycken, W., and Meermann, R. (1984). Anorexia nervosa: Is prevention possible? International Journal of Psychiatry in Medicine,14(3),191-205.

Walsh, R. T. (1982). A psychoeducational approach to community intervention with ex-mental patients. Canadian Journal of Community Mental Health,1,76-84.

Watts, R.J. (1992). Elements of a psychology of human diversity. Journal of Community Psychology,20,116-131.

Whitmore, E. (1988). Empowerment and the process of inquiry. A paper presented at the annual meeting of the Canadian Association of Schools of Social Work, Windsor, ON.

Whitmore, E. (1991). Evaluation and empowerment: It's the process that counts. Networking Bulletin: Empowerment and Family Support, 2(2),1-7.

Wiseman, C.V., Gray, J.J., Mosimann, J.E., and Ahrens, A.H. (1992). Cultural expectations of thinness in women: An update. International Journal of Eating Disorders,11,(1),85-89.

Wolf, N. (1991). The beauty myth. Toronto: Random House of Canada Ltd.

Wooley, S. and Wooley, O. (1979). Obesity and women: A closer look at the facts. Women's Studies International Quarterly,2,69-79.

APPENDIX A

STUDENTS...

What are your experiences and needs with regards to issues of:

* body image
* dieting
* nutrition
* exercise
* weight
* eating disorders

YOU ARE INVITED....

Counselling Services wants to know if you find any areas within these topics troublesome, and if so, how they can best support you, or others, with those areas.

Small focus groups will be held in order to discuss these issues and to brainstorm on ways Counselling Services can meet the needs of students.

Meetings will be held on the following dates:
Tuesday, Sept. 28, 2:00 - 4:00 p.m., Health & Safety, Rm. 127
Thursday, Sept. 30, 9:30 - 11:30 a.m., St. Jerome's, Rm. 314
Monday, Oct. 4, 10:30 - 12:30 a.m, Counselling Services, N.H.
Wednesday, Oct. 6, 3:30 - 5:30 p.m. Modern Languages, Rm. 119

Everyone is invited (men and women!); from those who are curious, to those directly or indirectly affected by any of these issues. Your experiences and ideas are vital!

If you have any questions or concerns, or none of these dates are suitable but you are interested, please contact Michelle at #_____.

Michelle Counselling Services Needs Assessment #_____

Michelle Counselling Services Needs Assessment #_____

Michelle Counselling Services Needs Assessment #_____

Michelle Counselling Services Needs Assessment #_____

Michelle Counselling Services Needs Assessment #_____

Michelle Counselling Services Needs Assessment #_____

Michelle Counselling Services Needs Assessment #_____

APPENDIX B

RECRUITMENT LETTER TO STUDENTS WHO ARE RECOVERING, OR WHO HAVE ALREADY RECOVERED FROM AN EATING DISORDER

Hello! I am writing to you on behalf of Michelle Poechman Fisher. She is a recent graduate from the University of Waterloo, and is presently in the Masters Community Psychology Program at Wilfrid Laurier University. As a part of her Master's requirements, she is completing her thesis with Marilyn Goodbrand in Wilfrid Laurier's Counselling Services. Her supervising professor at Wilfrid Laurier is Dr. Isaac Prilleltensky. Michelle is very interested in the issues of body image, dieting, exercise, nutrition, weight, and eating disorders, since she has personally struggled with many of these issues. Michelle has asked me to distribute this letter to any students who are also concerned about these issues. Your name has not been released to her and it will not be released to her unless you give your permission.

Counselling Services needs more information about students' needs in order to ensure that students receive the most beneficial, efficient support possible. As a part of her thesis, Michelle will be assessing the needs of students with regards to issues around body image, dieting, exercising, weight, nutrition, and eating disorders. Michelle feels that people who have been directly affected by the pursuit of thinness are the best resources with regards to these concerns and your insights are critical to improving the types of support available.

As a part of the Needs and Resource Assessment, Michelle will be holding focus groups with students who have been affected by issues of body image, weight concerns, nutrition, exercise, dieting, and eating disorders. During these focus groups, participants will be invited to complete a brief survey and then to discuss a few questions. Participation in a focus group would require approximately two hours of your time and focus groups will be scheduled to occur during the month of October. You will be consulted regarding the most suitable times for you. All focus groups will take place on campus. Your identity will be kept strictly confidential. You will be treated with respect and therefore given the freedom to refuse to answer any questions or to discontinue the focus group at any time.

Thank-you for reading this letter and considering Michelle's invitation. If you have any questions, or if you would like to participate, please do not hesitate to call her at # _____. If you would like Michelle to contact you, please complete the enclosed Consent form, in order to give Counselling Services permission to release your name to her. Please note that if you complete the Consent form you are not obligated to participate in a focus group. Michelle will be contacting people as soon as she receives names and phone numbers.

Sincerely,

Counsellor's Name
Wilfrid Laurier Counselling Services, ext. _____

CONSENT FORM TO RELEASE NAME

I, _____, consent to having my name and phone number forwarded to Michelle Poechman Fisher, so that she may contact me about participating in a focus group. I am aware that by giving this permission I am in no way committing to participate, it only gives my permission to share my name with Michelle so that she may contact me about participating.

Date _____ Signature _____

INFORMATION TO BE PASSED ON TO MICHELLE

Name _____

Present phone number _____

Phone number or address where you can be reached in September

_____

Please indicate your preferred times for focus groups during the month of October by placing an OK in all of the boxes that apply.

	MON.	TUES.	WED.	THURS.	FRI.	SAT.	SUN.
9:00 A.M. to 12:00 P.M							
12:00 P.M. to 6:00 P.M.							
6:00 P.M. to 9:00 P.M.							

Other Comments:

Thank-you so much for taking the time to fill this out!
Please return this form to: Attention: Marilyn Goodbrand, Counselling Services, Wilfrid Laurier University, 75 University Ave. West, Waterloo, ON., N2L 3C5, by September 30, 1993.

APPENDIX C

FOCUS GROUP INTERVIEW GUIDE

INTRODUCTION OF MYSELF

"Hello. I really appreciate that you have taken time out of your busy schedules to attend this focus group today. My name is Michelle Poechman Fisher. I did my undergrad in Psychology at the University of Waterloo and now I am a Masters student in Community Psychology at Wilfrid Laurier. I want you to know that I am not here to judge anyone, I am here to listen and to learn. I have experienced trouble with many of the issues we are discussing today and I have recovered from bulimia. I am very interested in hearing about which issues other people have found troublesome and your ideas for types of support that you feel are needed."

INTRODUCTION OF THE STUDY

"Counsellors at Counselling Services have expressed that they want to expand their awareness with regards to students' needs around issues of body image, dieting, exercise, nutrition, weight, and eating disorders. They would also like to know what types of support students are looking for with regards to these issues. Since you, the students, are the experts on your needs, I am meeting with you to discuss what troubles you most and what types of support you feel would be most beneficial. I feel that your input is crucial in order to ensure that practical, needed resources are developed."

CONSENT

Participants will then be given a copy of the Information letter and I will read it with them. I will ask if they have any questions or want clarification on any of the information. I will also stress that participation is voluntary and that if they do not feel comfortable participating, that they are free to leave. After all of their questions are answered I will ask those who would like to participate, to sign the consent form.

DEMOGRAPHIC QUESTIONNAIRE

Participants will then be asked to fill in a short demographic questionnaire, in order to give us an indication of the types of students represented in the focus group (ie. age, on campus or off campus, year, issues which brought them to the focus group).

PERMISSION TO TAPE RECORD

Participants will be asked for their permission to tape record the focus group. It will be explained that I will be the only one listening to the tape and that the tape will be erased when my thesis is completed. If participants object, the focus group will be recorded in written form only.

CONFIDENTIALITY
Confidentiality among group participants will be addressed before the discussion begins. Each member will be asked to raise his or her hand to indicate that he or she commits to keeping anything said during the focus group confidential.

INTRODUCTORY QUESTION
The following "focus statement" will be written on a flip chart, as well as given to the participants on a slip of paper.
"The purpose of this focus group is to discuss services, supports, and prevention ideas for students affected by issues of body image, dieting, nutrition, exercise, weight concerns, and eating disorders."

The group will be asked:
"There are a number of issues related to concerns with body image, such as dieting, nutrition, exercise, weight concerns, and eating disorders. Which issues are of greatest concern for you, or other people you know? What do you see as the source of these issues or problems?"

Responses will be recorded on a flip chart. Participants will be asked if what is written is an accurate reflection of their point.

The purpose of this first question is to help people warm up and feel comfortable in the group, as well as to raise the levels of consciousness around the roots of problems with these issues. (ie. "It is important to consider the individual and family factors involved, but we also need to recognize the sociocultural factors such as the media, the fashion industry, and the diet industry").

NOMINAL GROUP QUESTIONS
Participants will be asked to take five minutes to individually brainstorm and record their responses to the question:
"What services do you feel are needed with regards to these issues? Ideas may include existing services or new services."
When people are finished with their individual notes, I will ask the participants to take turns going around the circle, sharing one idea at a time. At this time I will emphasize that everyone's opinions and ideas are important. All of the ideas will be recorded on a flip chart. Once the group has exhausted its ideas, members will be asked to individually think about which ideas they feel are needed, and which ideas they think they would actually use. Participants will then be given three red stickers and three green stickers. Participants will be told that they may use as many of these stickers as they would like and that the red stickers will be used to represent "I feel that this service idea is important" and the green stickers will be used to represent "I would use this service idea" (Note: For participants who have recovered, green stickers will represent, "I would have used this service idea"). Participants will then be asked to put the appropriate stickers beside their priorities.

This same process will be used for the following question;
"What types of primary prevention or social action do you feel is needed with regards to these issues?"

"By Primary Prevention, I am referring to interventions which reduce the incidence of disorders and promote individuals' overall well being. One example of this type of intervention may be to match each first year student with a second year student to act as a supportive peer."
"By Social Action, I am referring to interventions which aim to make changes in the sociocultural environment. For example, a social action intervention may be to organize a letter writing campaign to respond to commercials, magazine ads, and newspaper articles that encourage an aesthetically-based view of people."
If some ideas came up during the previous question, I will point out these ideas and ask if people have other ideas.

PARTICIPANT FEEDBACK
After the two nominal groups, I will ask participants about how they feel about the information collected (ie. "Is it an accurate reflection of your needs and ideas?"). I will also ask for their comments on the focus group structure and how they feel about the process. During this time, I will encourage them to make suggestions for changes in the process, or types of questions asked.

FEEDBACK OPTIONS
"I feel that it is very important that participants in a study receive feedback about the findings of the study. I would like to offer you a number of choices for feedback."
I will then distribute a Feedback Form and ask participants to mark the feedback option that they would prefer and to provide the information required for me to get the feedback to them.

ADVISORY COMMITTEE
"In order to ensure that the information gained through the focus groups is used to form practical suggestions, I am asking for volunteers to sit on an Advisory Committee which will help to summarize the suggestions that will go to Counselling Services. I am also hoping that the Advisory Committee will work together to plan and implement a primary prevention intervention."
"There is a question on the feedback form that you may fill in if you are interested in volunteering for this committee".

THANK-YOU
"Thank-you so much for sharing your ideas and concerns with me today. I have learned a lot from you. I really appreciate the fact that you took the time to come and participate in this focus group. I hope that it has been a positive experience for you. Please feel free to call me at any time if you have any questions or concerns."
A list of resources and contacts will be distributed at this time.

APPENDIX D

INFORMATION-CONSENT LETTER

My name is Michelle Poechman Fisher. I am a recent graduate from the University of Waterloo, and I am presently in the Masters Community Psychology Program at Wilfrid Laurier University. As a part of my Master's requirements, I am completing my thesis with Marilyn Goodbrand in Wilfrid Laurier's Counselling Services. My supervising professor at Wilfrid Laurier is Dr. Isaac Prilleltensky.

As a part of my thesis, I am assessing the needs of students with regards to issues such as body image, nutrition, exercising, dieting, and eating disorders. In order for Counselling Services to be more effective in dealing with these issues, they need to know how students feel about these issues and what students want and need for support. Since students are the best resource for answers to these questions, you have been invited to fill in a short survey and to participate in a focus group in which you will be encouraged to discuss a few questions. Ideas and suggestions that result from the focus groups will be submitted to Counselling Services both verbally and in the form of a report.

Participation in this needs assessment is voluntary and would involve approximately two hours of your time. The focus groups will occur on campus, at a number of different times. You may choose whatever time is most convenient for you. Both in filling out the brief survey, and during the discussion, you may decline answering any questions you feel you do not wish to answer, and you may withdraw from the group at any time. You will be asked for permission to tape record the discussion. I will be the only one listening to these tapes and they will be erased as soon as my thesis is completed. If you are not comfortable with being tape recorded, you are free to refuse and the discussion will be recorded in written form only. All information you provide would be considered confidential and would be seen only by myself and my supervisors. Since I am interested in the opinions of the group as a whole rather than those of individuals, you will not be identified by name in the report. If you are interested in participating in a follow-up individual interview in the future, or in sitting on an Advisory Committee that will review the suggestions made and make decisions about how to implement the suggestions, you may provide me with your name and phone number. Please note that by providing this information you are in no way obligated to participate in a future interview or to sit on an Advisory Committee.

Thank you for your time and assistance with this project. Your insights are critical to developing a practical, effective intervention.

Sincerely,

Michelle Poechman Fisher
_____

APPENDIX E

CONSENT FORM

I agree to participate in a focus group being conducted by Michelle Poechman Fisher of the Department of Community Psychology at Wilfrid Laurier, under the supervision of Marilyn Goodbrand, and Dr. Isaac Prilleltensky. I have made this decision based on the information I have read in the information-consent letter and have had the opportunity to receive any additional details I wanted about the study. As a participant in this study, I realize that I will be asked for two hours of my time, in order to complete a brief survey and to take part in a focus group interview. I also realize that I may decline answering any of the questions, if I so choose. I understand that I will be asked for permission to tape record the discussion and that if I refuse this option, the discussion will be recorded in written form only. If I give permission for the discussion to be tape recorded, I understand that Michelle is the only one who will be listening to the tape and that it will be erased as soon as her thesis is completed. All information which I provide will be held in confidence and I will not be identified in any way in the final report. I understand that I may withdraw this consent at any time by leaving the group. Finally, I promise to keep the conversations of other group participants confidential.

Participant's Name:_____

Participant's Signature:_____

Date:_____

APPENDIX F

QUESTIONNAIRE

In order to accurately analyze the information collected, Counselling Services would like to know which groups of people were represented in the focus groups. Thank-you for your time and consideration!

1. PLEASE COMPLETE THE FOLLOWING QUESTIONS.

Age _____ Academic Year _____ Faculty _____

2. PLEASE CHECK ONE;

a. Female ____ Male ____ b. Residence: On Campus ____ Off Campus ____

3. WHICH OF THE FOLLOWING ISSUES BROUGHT YOU TO ATTEND THIS FOCUS GROUP? (PLEASE CHECK ALL THAT APPLY)

____ Body Image ____ Dieting

____ Weight Concerns ____ Nutrition

____ Exercising ____ Eating Disorders

Other(s) (please specify) _____

_____

4. WHY DID YOU COME OUT TO THIS FOCUS GROUP? (PLEASE CHECK ALL THAT APPLY)

____ I am directly affected or concerned by one of the above issues.

____ I am indirectly affected or concerned by one of the above issues.

____ I was curious about these issues.

____ Other(s) (please specify) _____

_____

5. IF YOU ARE DIRECTLY AFFECTED OR CONCERNED BY ONE OF THE ABOVE ISSUES, HAVE YOU EVER SOUGHT PROFESSIONAL SUPPORT? (PLEASE CHECK ONE)

____ Yes ____ No

6. Additional Comments:

APPENDIX G

FEEDBACK

I feel that it is very important that participants in a study receive feedback about the findings of the study. I would like to offer you a number of choices for feedback. Please mark the option(s) you would like and provide the information required for me to get the feedback to you.

_____ A one page summary of the findings available to be picked up at Counselling Services.

_____ A one page summary of the findings mailed to me.

My name and address is; _____

_____

_____ A phone call regarding the findings.

My name and phone number is; _____

_____

_____ A personal meeting.

My name and phone number is; _____

_____

_____ A forum (meeting) open to all students to discuss the results

FOLLOW-UP INTERVIEW

Please provide your name and phone number if I may contact you in the future about a Follow-up Interview (Note: This in no way commits you to participate in an interview)

_____

ADVISORY COMMITTEE

If you would be interested in sitting on an Advisory Committee which looks at the results of this study and decides what to do with the suggestions made, please provide your name and telephone number.

_____

APPENDIX H

RESOURCES AND SERVICES

PROGRAM	SERVICES AVAILABLE	CONTACT
Kitchener-Waterloo Hospital: Outpatient Psychiatry Unit	Individual, and/or family therapy: on a weekly basis; ages 14 years plus; collaboration with family physician and dietitian included. 2. Psychoeducational Group: once weekly, 7 week program; offered 3-4 times annually. Group offers educational material on causes, symptoms, complications of eating disorders; nutritional guidance; body image concerns, and coping strategies explored.	# 742-3611 Ext. 3154 Referrals from all sources.
Kitchener-Waterloo Hospital: Inpatient Program	Pediatric Unit - up to age 16 Psychiatric Unit - ages 17 +	Referred by physicians only.
Kitchener-Waterloo Hospital: Nutrition Counselling Services	Individual counselling sessions for one time assessment and instruction are available as needed; ongoing sessions are available. All participants must be receiving counselling for an eating disorder.	# 749-4212. Referrals from physicians only.
Cambridge Memorial Hospital: Community Mental Health Centre	Eating Disorder Group: meets weekly for 10 sessions to share experiences on symptoms, family dynamics, personal growth and development, and self-image.	# 621-2330 Ext. 3300. Referrals by physician.
University of Waterloo	Health and Safety - Dr. Barbara Schumacher, Ext. 3541; Dr. Debbie Roy, Ext. 3541. Counselling Services - Ext. 2655. Individual therapy by Master's level Counsellors, or Psychologists.	# 885-1211 Students only.
Wilfrid Laurier University	Health Services - Dr. Kathie Keefe, Ext. 2146. Counselling Services, Ext. 2338 - Individual therapy by Counsellor.	# 884-1970 Students only.

PROGRAM	SERVICES AVAILABLE	CONTACT
Conestoga College	Counselling Services, Ext. 360 or Ext. 337 - support and referral for counselling in the community.	# 748-5220 Students only.
Private Therapists	Karen Bailey Robinson M.S.W., C.S.W. Marie Nowak M.S.W. Dr. Eric Mulder, psychiatrist (Guelph) Margaret Notar M.S.W., Ext. 2368 Dr. Theresa Casteels-Reis, psychologist (evenings) Sunny Sundberg M.A.Sc.	# 744-2273 # 836-5992 # 742-3611 # 741-8646 # 746-1525
Nutrition Promotion Program, Community Health Department, Regional Municipality of Waterloo	Resources and information on community services provided by Public Health Nutritionist.	# 741-3820
SEED: Support for Everyone with Eating Disorders	Self-help group holds informal, confidential meetings every Monday 7:00 - 8:00 p.m. at the Y.W.C.A. on 84 Frederick St., Kitchener. No cost.	# 744-6507 Canadian Mental Health Association, Waterloo Branch.
FREED: Friends and Relatives of Everyone with Eating Disorders	Confidential, drop-in, self-help group for parents, spouses, friends or individuals with eating disorders. Meetings are at 8:00 pm. on the 2nd and 4th Thursday of each month in the Gold Room of Kitchener-Waterloo Hospital (Park St. Entrance). No cost.	# 741-3820
NEDIC: The National Eating Disorder Information Centre	A health promotion and prevention service. Mandate is to provide resources and information on eating disorders and weight preoccupation.	N.E.D.I.C. 200 Elizabeth St., CW 1-304 Toronto, ON. M5G 2C4. #(416) 340-4156

APPENDIX I

READING LIST

BODY IMAGE

Hutchison, Marcia Germaine. (1985). Transforming body image. New York: The Crossing Press.

Jasper, Karin (1989). Are you too fat, Ginny? Toronto: Is Five Press.

Millman, Marcia. (1980). Such a pretty face: Being fat in America. New York: W.W. Norton and Co.

Newman, Leslea. (1991). Somebody to Love: A guide to loving the body you have. Chicago: Third Side Press.

Pollack Seid, Roberta (1989). Never too thin: Why women are at war with their bodies. New York: Prentice Hall Press.

Szekely, Eva. (1988). Never too thin. Toronto: The Women's Press.

Wolf, Naomi. (1991). The beauty myth: How images of beauty are used against women. Toronto: Vintage.

EATING DISORDERS

Brown, Catrina, and Jasper, Karin. (1993). Consuming passions: Feminist approaches to weight preoccupation and eating disorders. Toronto: Second Story Press.

Brown, Laura & Rothblum, Esther. (1989). Overcoming fear of fat. London: Harrington Park Press.

Chernin, Kim (1981). The obsession. Harper & Row.

Kano, Susan (1989). Making peace with food: Freeing yourself from the diet/weight obsession. New York: Harper & Row Publishers.

Polivy, Janet & Herman, C. Peter. (1983) Breaking the diet habit. New York: Basic Books, Inc.

READING LIST CONTINUED....

NUTRITION

Brody, Jane. (1987). Jane Brody's nutrition book. Bantam Books: New York.

INFORMATION ABOUT EATING DISORDERS FOR FAMILY AND FRIENDS

Siegel, Michelle, Brisman, Judith & Wienshel, Margot. (1988). Surviving an eating disorder: New perspectives for family and friends. New York: Harper & Row.

Valette, Brett. (1988). A parent's guide to eating disorders: Prevention and treatment of anorexia nervosa and bulimia. New York: Walker Pub. Co.

ABUSE

Bass, Ellen & Davis, Laura. (1988). The courage to heal. New York: Harrington Park Press.

Black, Claudia. (1989). It's never too late to have a happy childhood. Toronto: Random House Inc.

RELATIONSHIPS

Goldhor Lerner, Harriet (1985). The dance of anger: A woman's guide to changing the patterns of intimate relationships. New York: Harper & Row Publishers.

Goldhor Lerner, Harriet (1989). The dance of intimacy: A woman's guide to courageous acts of change in key relationships. New York: Harper & Row Publishers.

SELF-ESTEEM

Sanford, Linda & Donovan, Mary Ellen. (1984). Women & self-esteem. New York: Viking Penguin inc.

Wegscheider-Cruse, Sharon (1987). Learning to love yourself: finding your self-worth. Deerfield Beech, Health Communications, Inc.

APPENDIX J

INDIVIDUAL INTERVIEW GUIDE

1. How have you been affected by issues of body image, nutrition, weight, exercise, dieting, and/or eating disorders?

2. Which issues trouble you most / have troubled you most?
   What do you feel you need(ed) support for most?

3. What do you think has contributed to the development of trouble with this/these issue(s)?
   What do you think is the source of your difficulties with this/these issue(s)?

4. When did you realize (admit to yourself) that you had difficulty with this/these issue(s)?
   What helped you to recognize that you needed support?

5. Were there any barriers to getting the support you needed?

6. What/Who have been helpful in your recovery process?
   What would you recommend to other people experiencing difficulty with this/these issue(s)?

7. What types of supports do you think would be most helpful for people experiencing difficulty with these issues?

8. What types of primary prevention or social action interventions do you feel would be most effective in preventing difficulty with these issues?

   "By Primary Prevention, I am referring to interventions which reduce the incidence of disorders and promote individuals' overall well being. One example of this type of intervention may be to match each first year student with a second year student to act as a supportive peer."

   "By Social Action, I am referring to interventions which aim to make changes in the sociocultural environment. For example, a social action intervention may be to organize a letter writing campaign to respond to commercials, magazine ads, and newspaper articles that encourage an aesthetically-based view of women."

9. Additional comments.

10. Feedback regarding interview process and questions asked.

APPENDIX K

FEEDBACK LETTER

Hello! Remember the focus group that you participated in? Well, I am writing to give you some feedback with regards to the common themes that were raised in the groups and to share some of the suggestions that were made. But before I share the feedback with you, I would like to thank you again for participating in one of my focus groups! I really appreciate that you took the time to come out and share your concerns, ideas, and suggestions. I hope that it was a positive experience for you!

Overall, the issues of greatest concern to people included: poor body images and self-esteem, our culture's emphasis on dieting, little knowledge about good nutrition, the prevalence and health risks of eating disorders, the larger problems that are played out through eating disorders (ie. abuse, lack of control in one's life), and the shame and stigma which surrounds eating disorders and their treatment.

Difficulties with issues of body image, weight, nutrition, dieting, exercise and eating disorders were attributed to a number of sources. One of the most commonly cited source was the media (ie. television, movies, magazines, fairy tales, and art) since these promote ultra thin, air brushed ideals which are unattainable by the majority of people. It was also noted that recently the media has glamorized eating disorders and the models suffering with them, rather than educating people regarding their health risks. Troublesome media messages include, "thin = good, successful, healthy, and feminine."

The money making industries (ie. cosmetics, fashion, weight-loss, cosmetic surgery) were also mentioned as contributing to the myth that the thin ideal is possible, desirable for all people, and can be attained by buying specific products.

A number of specific contexts (modelling and dance careers, competitive sports, and universities) were also suggested as possible breeding grounds for eating disorders due to their focus on ideal weights & appearances. It was proposed that Western societies in general tend to base social acceptance on appearance. Two types of social motivators which promote a thin ideal exist in this culture: people who lose weight or who are underweight are constantly praised and rewarded, while people who are larger are commonly stereotyped and treated as lazy, slow and unsuccessful.

Eating disorders were also discussed as symptoms of larger issues. Participants felt that some people use destructive eating behaviours to cope with stressors such as abuse, poor self-esteem, depression, lack of control over one's life, and other psychological issues. It was also pointed out that transitional times such as moving away from home in order to go to university may intensify some of these underlying stressors.

I was overwhelmed by your creativity and ingenuity in coming up with ideas for supports, prevention and social action interventions. Thank-you so much for your thoughtfulness! I have divided your ideas into the following categories: treatment, peer supports, education, consciousness awareness, celebrations, changes in counselling services, and changes in the university context / structure.

1. TREATMENT:
   a) COUNSELLING
      - Individual counselling (deal with deeper issues)
      - Nutritional consultation
   b) GROUPS
      - Group Therapy
      - A drop-in self-help group
      - A support group / network
   c) CRISIS LINES
      - 24 hour availability
   d) RETREATS FOR PEOPLE WITH EATING DISORDERS
   e) ALTERNATIVE / HOLISTIC TREATMENTS

2. PEER SUPPORTS:
   a) POSITIVE ROLE MODELS
      - Match people who are just beginning to recover with people who are farther along in the process of recovery
   b) PEER COUNSELLING
      - Match first year students with an upper year student that they can go to with questions and concerns.
   c) PEN PAL PROGRAM
      - Match people who are struggling with eating disorders to "pen pals" who have recovered from eating disorders.

3. EDUCATION:
   a) VOLUNTEER EDUCATORS WHO HAVE EXPERIENCED DIFFICULTIES WITH THESE ISSUES
      - Volunteer students visit university classes to increase students' awareness of eating disorders, the risks, and available resources.
   b) INFORMATIONAL SESSIONS LEAD BY PEOPLE WHO HAVE EXPERIENCED DIFFICULTY WITH THESE ISSUES
      - People share personal stories (including health consequences), and allow time for questions.
   c) SEMINARS / WORKSHOPS
      - self-esteem
      - nutrition
      - the ineffectiveness and dangers of dieting
      - stress reduction and relaxation.

d) INFORMATIONAL PAMPHLETS
- regarding body image, nutrition, weight, dieting, exercise, and eating disorders. Include information about each of these issues, and the names, numbers and descriptions of services. Make available at Counselling Services, Health & Safety, Residences, Athletic complex, and in student gathering areas. Also include pamphlet in campus kits for first years, and in the university calendar.

e) INCREASE AVAILABILITY OF CANADA FOOD GUIDE
- ie. make it available in supermarkets, and cafeterias

f) EDUCATE DOCTORS, PROFESSORS, TEACHING ASSISTANTS, TEACHERS, AND COACHES
- Educate re: the issues, symptoms, risks, and available resources.

g) EDUCATE PARENTS
- re: affirming children's inner beauty, encouraging children to listen to and trust their bodies, and encouraging children to eat nutritious foods.

h) INFORMATIONAL DISPLAYS IN THE CAMPUS CENTRE / CONCOURSE
- Include, posters, videos, pamphlets, and someone available to answer questions.

4. <u>CONSCIOUSNESS AWARENESS</u>:

a) DRAMA
- present the issues in a play and then follow it with discussions. (ie. Frosh Week, and in the elementary and high schools)

b) SEMINARS
- debunk society's myths about the ideal body

c) PROTESTS
- at beauty pageants, and magazine stands

d) MEDIA WRITING CAMPAIGNS
- write advertisers about positive & negative ads

e) BOYCOTTS
- boycott products which use degrading advertising

f) POSTER AND/OR T-SHIRT CAMPAIGNS
- use slogans and artwork which encourage positive body images

g) PETITION TO THE GOVERNMENT
- encourage the government to legislate the inclusion of people of all sizes and shapes in the media.

h) UNIVERSITY RECRUITMENT WATCH
- group of university students ensure that recruitment materials include people of all shapes and sizes.

5. <u>CELEBRATIONS</u>:

a) POSITIVE BODY IMAGE PEP RALLY
- Include speakers who accept themselves, positive films, singers, marches

b) A HEALTHY EATING DAY
- encourage everyone to eat at least one meal that fills the criteria from the Canada Food Guide

c) ALTERNATIVE MAGAZINE
- a magazine which includes women of all shapes and sizes, and does not focus on appearance, but on women's stories and experiences.

6. CHANGES IN COUNSELLING SERVICES:
   a) GREATER PROMOTION OF SERVICES AVAILABLE BOTH ON AND OFF CAMPUS
      - advertise in classrooms, residences, cafeterias, lounges, change rooms, weight rooms, bathrooms and lockers.
   b) BETTER SCHEDULING OF EVENTS
      - Note: two hours is a long time slot
      - "After hours" workshops may be better attended (ie. night time)

7. CHANGES TO UNIVERSITY CONTEXT / STRUCTURES:
   a) EXPAND / MODIFY UNIVERSITY ATHLETIC FACILITIES AND PROGRAMS
      - provide exercise programs other than aerobics
      - advertise exercise with a focus on fitness rather than thinness.
   b) LIMIT AMOUNT OF JUNK FOOD AVAILABLE ON CAMPUS AND REPLACE IT WITH HEALTHIER OPTIONS
   c) SELF-HELP BOOKS IN THE BOOKSTORE
      - provide descriptions of self-help books and potential target groups.

Once again, I would like to thank-you for participating in a focus group. The information and experiences that you have shared are invaluable. If you feel that I have failed to include any of your ideas or if you have any additional comments or suggestions, please feel free to call or write to me. For those who signed the Feedback Form saying you were interested in participating in an Advisory Group, I will be contacting you shortly. If anyone else is interested in joining the Advisory Group or in being involved in any other way, please do not hesitate to call me.

Sincerely,

Michelle Poechman Fisher
_____

APPENDIX L

MY THOUGHTS

I liked ....

A few thoughts...

I would like to talk more about...

I didn't like...

For the next time...

Thank-you so much for coming and sharing a bit of yourself!

APPENDIX M

PLANNING OUR INTERVENTION

What is our intervention seed?

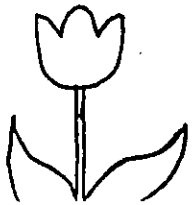
Where will we plant it? How big will the garden be?

What gardening resources do we already have?

What do we need? How will we nurture our intervention seed?

What weeds, diseases, and/or bugs could prevent our seed from thriving? How can we protect our seed from these?

What are our hopes and dreams for our intervention seed?



APPENDIX N

PHOTOGRAPHS OF THE INFORMATION BOOTHS

APPENDIX O

Article for Wilfrid Laurier's Student Newspaper

THE CORD Thursday, January 27, 1994

Focusing on eating disorders

BELINDA CLEMMENSEN
Cord Commentary

February 1 through 7, 1994 is National Eating Disorder Awareness Week, subtitled Breaking Free...Celebrating our National Body Sizes. Though this issue may seem to be relevant to only a few, a recently formed University of Waterloo/Sir Wilfrid Laurier University Advisory Committee for the enhancement of self image, body image and health will attempt to educate students on the truly epidemic prevalence of poor self image, poor body image and eating disorders.

Eating disorders are one of the most painful symptoms of low self esteem and an attempt to gain control in one's life. When they are approached from an understanding and inclusion of the whole person, they are seen as not just some unfortunate syndrome brought on by a supposed chemical imbalance or some other medical defect. They are a social and psychological issue as well as a health issue.

When people think of eating disorders they often think of extreme behaviours such as anorexia and bulimia, but the term eating disorder is far broader than this. Body image and eating disorders include dieting, excessive exercise, body and food perfection obsessions, overeating and under eating, bingeing, purging, calorie counting, laxative and diuretic use, shopping anxiety, mirror or scale fetishes, and even that ever present wish to lose just that ten extra pounds. Also included are thought patterns or behaviours about food and body which consume our valuable time and energy, and the feelings of low self esteem or not belonging which are so often at the root of these. The Advisory Committee has chosen to focus on the celebration and acknowledgement of our natural body shapes and sizes for this National Eating Disorder Awareness Week. In the face of so much contemporary fabrication of what we should be, how we should look, and how our lives should play out, we forget to give attention to who we are and what is truly important to us. Recovering this attention and this perspective is essential in the recovery of self esteem and the healing of eating disorders.

This week is for everybody: to learn something new, to discover something about ourselves, to celebrate who we are. There will be a booth set up in the University of Waterloo - Campus Centre Great Hall on Tuesday, February 1, and in the Wilfrid Laurier Concourse on Thursday February 3, 1994, both from 9:00 am to 4:00 pm. A variety of sources of information covering all aspects of the body image issue will be available. We look forward to seeing you there!

APPENDIX P

FEEDBACK: CELEBRATING OUR NATURAL SIZES INFORMATION BOOTH

1. WHAT MADE YOU APPROACH THIS BOOTH? (WHAT DREW YOUR ATTENTION TO THIS INFORMATION BOOTH?)

2. DID YOU LEARN ANYTHING NEW FROM THIS INFORMATION BOOTH? (IF SO, PLEASE EXPLAIN.)

3. WHAT WAS MOST INTERESTING OR HELPFUL TO YOU?

4. WHAT WAS LEAST INTERESTING OR LEAST HELPFUL TO YOU?

5. HOW COULD THIS INFORMATION BOOTH BE IMPROVED IN THE FUTURE? (WHAT WOULD YOU HAVE ADDED, DELETED, OR CHANGED?)

THANK-YOU SO MUCH FOR YOUR COMMENTS AND SUGGESTIONS! PLEASE RETURN COMPLETED FORMS TO SOMEONE AT THE BOOTH, OR MAIL FOR FREE THROUGH INTERUNIVERSITY MAIL TO, "MICHELLE POECHMAN FISHER, DEPARTMENT OF PSYCHOLOGY, WILFRID LAURIER UNIVERSITY".

APPENDIX Q

REVISED QUESTIONNAIRE FOR FUTURE SURVEYS

1. PLEASE COMPLETE THE FOLLOWING QUESTIONS:

Age _____ Academic Year _____ Faculty _____

2. PLEASE CHECK ONE FOR EACH OF THE FOLLOWING:

a. Female ____ Male ____ b. Residence: On Campus ____ Off Campus ____

3. PLEASE PLACE A "✓" IN ALL OF THE BOXES WHICH APPLY TO YOU, FOR EACH ISSUE.
(Please Note: "Indirectly affected" means that you know a friend, family member, classmate, co-worker, etc. who is affected by this issue.)

ISSUE	I AM DIRECTLY AFFECTED BY THIS ISSUE	I AM CONCERNED ABOUT THIS ISSUE	I AM INDIRECTLY AFFECTED BY THIS ISSUE	I AM CURIOUS ABOUT THIS ISSUE	I AM NOT AFFECTED BY THIS ISSUE
ie. STRESS	✓	✓	✓		
POOR BODY IMAGE					
WEIGHT CONCERNS					
OVER-EXERCISING					
POOR NUTRITION					
DIETING					
EATING DISORDERS					
LACK OF SELF-ESTEEM					
OTHER(S) (PLEASE SPECIFY)					

4. IF YOU ARE DIRECTLY AFFECTED OR CONCERNED BY ONE OF THE ABOVE ISSUES, HAVE YOU EVER SOUGHT PROFESSIONAL SUPPORT? (PLEASE CHECK ONE)

_____ Yes _____ No

5. THE FOLLOWING IS A LIST OF INTERVENTIONS THAT STUDENTS HAVE SUGGESTED MAY BE HELPFUL FOR PEOPLE STRUGGLING WITH ISSUES RELATED TO BODY IMAGE, WEIGHT CONCERNS, NUTRITION, EXERCISE, DIETING, AND EATING DISORDERS. PLEASE PLACE A "✓" IN ALL OF THE BOXES WHICH APPLY TO YOU, FOR EACH INTERVENTION IDEA.

INTERVENTION IDEA	I DO NOT LIKE THIS INTERVENTION IDEA	I THINK THIS IS A GOOD INTERVENTION IDEA	I WOULD USE THIS INTERVENTION	I WOULD HELP ORGANIZE THIS INTERVENTION
ie. MASSAGE THERAPY		✓	✓	
ie. ENCOURAGE PEOPLE TO STOP WATCHING T.V.	✓			
NUTRITIONAL CONSULTATION				
A DROP-IN SELF HELP GROUP				
PEER COUNSELLING				
A 24 HOUR CRISIS LINE				
INFORMATIONAL SESSIONS LEAD BY PEOPLE WHO HAVE EXPERIENCED DIFFICULTY WITH ISSUES RELATED TO BODY IMAGE, FOOD, EXERCISE AND/OR WEIGHT				
VOLUNTEERS VISIT CLASSES AND SHARE INFORMATION AND THEIR PERSONAL EXPERIENCES WITH EATING DISORDERS.				

INTERVENTION IDEA	I DO NOT LIKE THIS INTERVENTION IDEA	I THINK THIS IS A GOOD INTERVENTION IDEA	I WOULD USE THIS INTERVENTION	I WOULD HELP ORGANIZE THIS INTERVENTION
A SEMINAR OR WORKSHOP ON SELF-ESTEEM				
A SEMINAR OR WORKSHOP WHICH EXAMINES SOCIAL MYTHS AROUND BEAUTY & THE IDEAL BODY.				
A SEMINAR OR WORKSHOP ON NUTRITION				
A SEMINAR OR WORKSHOP ON THE DANGERS & INEFFECTIVENESS OF DIETING				
PAMPHLETS WITH INFORMATION ABOUT BODY IMAGE ISSUES & AVAILABLE RESOURCES & SERVICES.				
INCREASE THE AVAILABILITY OF THE CANADA FOOD GUIDE				
INFORMATIONAL DISPLAY IN THE CAMPUS CENTRE / CONCOURSE				
A PLAY THAT PRESENTS ISSUES AROUND BODY DISSATISFACTION & WEIGHT PREOCCUPATION, FOLLOWED BY A DISCUSSION.				

INTERVENTION IDEA	I DO NOT LIKE THIS INTERVENTION IDEA	I THINK THIS IS A GOOD INTERVENTION IDEA	I WOULD USE THIS INTERVENTION	I WOULD HELP ORGANIZE THIS INTERVENTION
STUDENT MEDIA WRITING CAMPAIGNS (WRITE ADVERTISERS WHO PROMOTE THE "IDEAL" BODY)				
POSTER AND/OR T-SHIRT CAMPAIGNS WHICH ENCOURAGE POSITIVE BODY IMAGES.				
A POSITIVE BODY IMAGE PEP RALLY - A CELEBRATION OF OUR NATURAL SIZES (SPEAKERS, FILMS, SINGERS)				
A HEALTHY EATING DAY (ENCOURAGE EVERYONE TO EAT AT LEAST ONE MEAL THAT FULFILS THE CRITERIA FROM THE CANADA FOOD GUIDE).				
OTHER(S) (PLEASE SPECIFY)				

5. PLEASE MAKE ANY ADDITIONAL COMMENTS OR SUGGESTIONS:

_____

_____

_____