EATING DISORDERS, BODY IMAGE AND WEIGHT CONTROL: LIFE ORIENTATION TEACHERS' KNOWLEDGE, ATTITUDES AND BEHAVIOURS

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ABSTRACT

The apparent increase in the incidence of both anorexia nervosa and bulimia nervosa worldwide has resulted in a surge of interest in effective treatment, prevention programmes and health promotion. Health promotion and the primary prevention of eating and body image problems among young people, and in particular adolescents, is emerging as one of the most desirable achievements in contemporary health and nutrition education. Eating disorders usually have their origin during the teenage years, and as such, high schools provide useful sites for the implementation of prevention programmes. Educators can play an important role in the prevention of eating disorders and act as socialization agents who either reinforce or buffer the dominant societal discourses that shape young women's views of themselves. There are calls, however, for caution in the design and implementation of school-based eating disorder curricula as school educators may inadvertently do more harm than good. It has also been suggested that female educators, as other women, are likely to possess a degree of normative discontent with their body shape and size, and that this dissatisfaction and negative beliefs about food may be unknowingly transferred to the learners within their care.

The current study used an exploratory, descriptive research design to investigate the knowledge, attitudes and behaviours related to eating disorders, body image and weight control of a group of Life Orientation educators. A biographical questionnaire, a questionnaire designed for the purposes of the current research and two standardised paper-and-pencil questionnaires, namely the Body Shape Questionnaire (BSQ) and the Eating Attitudes Test (EAT), were administered to 50 female Life Orientation educators in the Nelson Mandela Metropole. A non-probability purposive sampling technique was used in the selection of participants and descriptive statistics were used to explore and describe the data.

The results of the current research study indicated a lack of knowledge in those Life Orientation educators assessed regarding eating disorders and healthy diet. The results also indicated inaccurate knowledge amongst those educators assessed regarding effective and safe teaching practices of eating disorder pathology. The results of the two standardised questionnaires reflected an internalisation of the dominant societal ideals regarding weight and body shape, with 18% of the sample

demonstrating attitudes and behaviours that could be indicative of eating disorder pathology of either clinical or subclinical proportions.

Suggestions were made regarding future research and the need for further training of Life Orientation educators. Finally, the limitations as well as the value of the research were outlined.

Key words: eating disorders, prevention, life orientation educators, knowledge, attitudes, behaviour.

CHAPTER 1

INTRODUCTION

"I am dying of thirst
by the side of the fountain."
- Charles d'Orleans -

1.1. Introduction

Eating disorders have received much attention over recent years in both popular and academic literature (Ogden, 2003). Due to the increase in the incidence of both anorexia and bulimia nervosa, there has been in a surge of interest surrounding eating disorders which has resulted in comprehensive and systematic research regarding these disorders over the past 30 years (Halmi, 2003; O'Dea & Maloney, 2000; Simos, 2002).

When tracing the historical accounts of eating disorders, it becomes apparent that many of the practices of what has now come to be known as anorexia and bulimia nervosa were evident in historical accounts dating back to AD 130 – 200 (Halmi, 2003). Bulimic behaviours, for instance, were practiced in the ancient Roman Empire, where wealthy patricians indulged in orgies of binge eating and vomiting into special vomitoriums (James, 1743). Practices of self-starvation, today associated with the diagnosis of anorexia nervosa, have historically played a prominent role in the penitential practices of deeply religious and pious women since the middle ages (Vandereycken & Van Deth, 1993). Early religious literature describes many of the practices of these holy people who renounced the pleasures of the flesh (Garner & Garfinkel, 1997). Princess Margaret of Hungary, for instance, who lived from 1242 to 1271, practiced the austerities of fasting as well as other bodily penance and was hailed as a saint. She died at the age of 28 years with a mind that was clear and alert but with a reportedly wasted body (SMC, 1945). The 16th century saw the emergence of the phenomenon of the 'miraculous maidens' or 'fasting girls'. Until the late nineteenth century these girls achieved local and even national fame due to their miraculous abilities to eat little or nothing at all and nevertheless stay alive. Evidence through popular media such as pamphlets and newspapers of the time suggested that a fasting girl was understood to be a sign of God's presence on earth. In honour of the miracle or simply in gratitude for the enjoyed spectacle, people would offer the girls money or goods (Vandereycken & Van Deth, 1993).

By the late 19th century, however, a growing number of physicians began to warn against the unhealthy practices of these fasting girls. Increasingly, the former 'miracles' were represented as a form of hysteria, with prolonged abstinence from food being considered a pathological phenomenon (Vandereycken & Van Deth, 1993). London physician Sir William Gull and Paris neuropsychiatrist Charles Lasègue published papers at the time on the description and treatment of 'hysterical anorexia' (Gull, 1888; Lasègue, 1873). By the end of the 20th Century, the term 'anorexia nervosa' was commonly used to refer to cases of self-induced starvation. Similarly, while bulimic practices were first evidenced in the behaviours of the Ancient Romans and early saints, the term 'bulimia nervosa' describing a pattern of disordered eating and cognitions, was first coined in 1979 (Halmi, 2003).

While the accounts of the early saints, the fasting maidens and the Ancient Romans depict behaviours that echo the practices of those who display anorexia and bulimia nervosa today, one must wonder whether these behaviours have been influenced and shaped by the same discursive ideas across time. One can see immediate similarities between the fasting maidens and those with anorexia nervosa today, in that both these groups of women have demonstrated control and restricted eating in order to attain an ideal that is praiseworthy. For both the aforementioned groups, the behaviours of self denial have also been considered indicative of the desired characteristics of self-control and of not easily succumbing to impulsivity (Vandereycken & Van Deth, 1993). But these two distinct historical conditions also include substantial differences in content. Perhaps the most noteworthy in the context of the current study is the 'fear of fat' that distinguishes the modern day disorders of eating from the early historical accounts noted above (Garner & Garfinkel, 1997).

What further distinguishes modern day disorders of eating, is that the aforementioned 'fear of fat', reinforced by Westernised culture, forms part of a range of criteria for disordered eating that has been constituted, in line with the medical discourse, as a form of mental illness. Many critics have argued that mental illness can be conceptualised as a social category created by a process of expert definition (Sherr & Lowrence, 2000), and therefore as a discursive construction. While a medical discourse is one way of understanding eating disorders, such an understanding does not fully account for the meaning attributed to these practices. The medical discourse also does not sufficiently account for the range of socio-cultural ideals that sustain the practices of disordered eating. While the medical

discourse allows us to describe the behavioural practices of self-starvation that have remained somewhat consistent over time, it is the specific social context and the discursive meaning of these practices that require greater consideration. This contextual and discursive perspective allows for a more comprehensive understanding of what contributes to the development of eating disorders.

In the context of this discursive perspective, the practices of self-starvation and body modification can be understood within the dominant societal discourses that govern how women are expected to behave, speak and look. It could be argued that the dominant discourses that define the ideals of modern day femininity leave the vast majority of women experiencing themselves as deficient. As such, these women are required to *do* something in order to become acceptable. Thus, practices such as dieting and exercise have become common place amongst females today. Nichter (2000) argues that the pervasive discourse among women and girls around the ideal of slenderness is a critical component of girls' socialization. "Fat talk", associated with this discourse of slenderness, facilitates the creation and maintenance of social relationships amongst females and signals their membership in a group where dieting is often a shared activity. The socially shared practices of dieting and exercise for weight loss purposes have therefore become unquestioned means facilitating the attainment of the prescribed feminine ideal. But it is argued that it is these socially acceptable activities, and their associated ideals, that leave women vulnerable to the development of eating disorders (Gusmano, 2005; Wadden, 2004; Wilson, 1995).

While worldwide media exposure to Westernised cultural ideals has been noted as influential in sustaining the dominant discourses reinforcing the value of thinness (Nasser, 1994; Thompson & Heinberg, 1999), these cultural ideals are perhaps most powerfully mediated through groups or institutions such as families, schools and peers (Evans, Rich & Holroyd, 2004, Simpson, 2002, Torrence, 2003). It is thus through the interpersonal relationships that constitute institutions, that cultural ideals, such as those of femininity and body shape, are transmitted. Learners within a school, for instance, are subject to a range of institutional discourses that govern their behaviours and ways of seeing themselves within and outside the institution (Baxtor, 2003). These discourses are mediated through the relationships that learners have with, amongst others, educators. Due to their position of power and their status of being those who are knowledgeable, educators are in influential positions that allow them to transmit and sustain both institutional and societal ideals (Winslade & Monk, 1999). It

is therefore suggested that when addressing eating disorders within the school context, it is necessary to include those educators who are involved in shaping the views that these young people hold about themselves and society (Russel & Ryder, 2001(b)).

Anorexia nervosa and bulimia nervosa have come to be regarded as states that involve a diversity of etiological factors, including social prescriptions (Hepworth, 1994). This study has made use, therefore, of a *discourse perspective* to illuminate the social practices that may be working together to create vulnerability in girls and women within the school context. The study has explored the extent of the internalisation of the dominant societal ideals and knowledges regarding diet and weight issues that result from women's discursive positioning within Westernised culture. Thus a feminist post-structural discourse perspective has been employed as a theoretical foundation for the current study.

1.2. Motivation for the Research

As discussed, there has been an apparent increase in the incidence of eating disorders over the past 50 years (Hoek, 1993; O'Dea & Maloney, 2000; Simos, 2002). According to Hsu (1996), eating disorders are now one of the most common psychiatric disorders to affect young women in Western society. South Africa in particular has seen an increase in eating disorders within cultures that traditionally were not regarded as vulnerable. With the abolition of Apartheid in South Africa, the Westernised cultural ideals became available to those whose traditional ideals encouraged larger and more voluptuous figures. According to various authors (Edwards & Moldan, 2004; Senekal, Steyn, Mashego & Nel, 2001), there are definite signs of assimilation of the Western cultural norms concerning body shape and an associated link to increased eating disorders, amongst black males and females in South Africa.

With this increase in the incidence of eating disorders, there has been ensuing interest into the research of effective prevention programmes and mental health promotion (O'Dea & Maloney, 2000; Simos, 2002). The motivation for focussing the current study on the knowledge, attitudes and behaviours of Life Orientation educators with regards to eating disorders, body image and weight control, is that education is considered one of the principle vehicles for primary prevention of eating disorders and health promotion in general (Robert-McComb, 2001; Tudor, 1996). Because children and adolescents spend a great deal of time in school, educators can

play a significant role in the prevention of eating disorders via classroom instruction as well as in the detection and referral of those with eating disorders (Levine, 1987). While education is regarded as being an effective tool in the prevention of eating disorders, certain authors have cautioned educators regarding the dangers of educating young individuals about eating disorders and diet when not adequately trained to do so (O'Dea & Abraham, 2001).

Within the current South African schooling system, health promotion is regarded as an important outcome within the Life Orientation Learning Area (Department of Education, 2002). Thus Life Orientation (LO) educators are required to play an active role in the promotion of health, diet, body image and wellness (Department of Education, 2002). As such, these educators are required not only to facilitate the acquisition of knowledge regarding eating disorders and healthy diet, but are required to act as buffers to the dominant societal discourses that create vulnerability in their learners. After conducting a literature and research review for this study, however, it became evident that there was a paucity of research investigating the effectiveness of Life Orientation educators, or educators in general, in the prevention of eating disorders within the school context. As this study ventures into an area that has been poorly researched, the study aims to add to the limited body of research available in this field.

Apart from the participants of this study benefiting from feedback in terms of the accuracy of their knowledge with regards to eating disorders and a healthy diet, as well as weight control practices and their level of body dissatisfaction, insight will be gained into the needs of these Life Orientation educators, particularly regarding their training. With eating disorders being a growing problem in our society, specific competencies are required among educators to identify and care for these individuals (Hoek, 1993). This study therefore aims at exploring and describing the competencies of Life Orientation educators, specific to eating disorder prevention, in order to provide those who are involved in the training of these educators with ways of assisting them to improve their effectiveness.

1.3. Primary Aims of the Research

Having outlined the motivation for the current study, the main aims of the study will be to:

1. Explore and describe the knowledge of Life Orientation educators with regards to eating disorders and healthy diet.
2. Explore and describe the attitudes held by Life Orientation educators with regards to their own body image.
3. Explore and describe the behaviour of Life Orientation educators with regards to eating habits, dieting and exercise

1.4. Chapter Overview of the Study

The first four chapters of the study seek to lay a foundation for the research study that follows. The final three chapters outline the details of the research that was conducted as well as the results and the discussion thereof. Conclusions are drawn and limitations and recommendations discussed. An overview of the individual chapters is as follows:

Chapter 1 serves as an introduction to the present study and outlines the contextual background against which the study was conducted. The historical accounts of the practices of eating disorders are explored in relation to the current 'fear of fat' criteria of anorexia and bulimia nervosa. The chapter looks briefly at the feminist discourse approach to understanding eating disorders and the motivation for this study is outlined.

Chapter 2 aims to define eating disorders from a positivist scientific perspective. The criteria according to the DSM-IV-TR for anorexia nervosa and bulimia nervosa are outlined and the natures of these disorders are discussed. The Eating Disorder Continuum is introduced as a way of conceptualising attitudes and behaviours related to disordered eating, that occur along a continuum.

Chapter 3 aims to supplement the medical model of eating disorders with an understanding of these disorders from a post-structural perspective. In so doing, an attempt is made to understand these disorders as expressions of the way women have been positioned discursively within society. The discourses that govern schools are also examined, particularly those discourses that create vulnerability in learners for the development of eating disorders.

Chapter 4 aims to outline the position of schools and educators in the prevention of eating disorders. Concerns and recommendations regarding effective and safe teaching practices are outlined. Included in this chapter is a brief overview of the changes in the curriculum of South African education, as well as an examination of

the Life Orientation educator within this new curriculum and their role in health promotion.

Chapter 5 outlines the research design and methodology of the present study. The sample procedure, data analysis, and the procedures followed in conducting the research are outlined. A description of the measures that were used is supplied. Ethical considerations in terms of the present study are also reviewed.

Chapter 6 outlines the results of the research. These results are also discussed in relation to the literature.

Chapter 7 provides conclusions and recommendations based on the results of this research and limitations of the research are outlined.

CHAPTER 2
CLINICAL AND SUBCLINICAL EATING DISORDERS

"Our own physical body possesses a wisdom
which we who inhabit the body lack.
We give it orders which make no sense"
-Henry Miller-

2.1. Introduction

As mentioned, a post-structural discourse perspective will be used as the theoretical underpinning of the current research study, and as such discourses of various types will be explored. The medical discourse is one such discourse, and therefore has been included within this research study as it pertains to the understanding of eating disorders. The current chapter will explore eating disorders as they are defined from a medical perspective.

2.2. Eating Disorders Defined

The term eating disorders is used to refer to anorexia nervosa and bulimia nervosa and their variants (Fairburn & Hay, 1994). As discussed in Chapter 1, the practices of self starvation, binge eating and purging can be found in historical records dating back to around the middle-ages. The first recorded medical account of an eating disorder, however, may be traced back to 1686, when Dr. Richard Morton described a medical condition that he referred to as 'nervous consumption' which he believed was caused by 'sadness, and anxious cares'. Nearly two centuries later, in 1874, further cases of eating disorders were recorded by Dr Gull in England, who described a syndrome occurring in young women that included self-starvation, amenorrhoea and restlessness with the absence of an organic cause (Freeman, 2005). He further documented that, "the want of appetite is, I believe, due to a morbid mental stage" (Gull, 1874, p.22). It was Dr Gull who gave the name 'anorexia nervosa' to what is today a widely recognised and socially publicized illness. This term was used at the time to differentiate the symptoms of anorexia nervosa from those disorders of similar symptomotology, for instance, tuberculosis (Freeman, 2005).

The current understanding of eating disorders is that they are potentially devastating maladies brought on by a complex interplay of factors (Harvey, 2002). The core characteristics of these maladies are a disturbance in eating behaviour and

weight management practices, which significantly affect the life of the person with the disorder (American Psychiatric Association, 2003; Levine, 1987). The latest version of the Diagnostic and Statistical Manual of Mental Disorders - forth edition – text revision (DSM-IV-TR) outlines two specific eating disorders, namely anorexia nervosa and bulimia nervosa. A category, Eating Disorder Not Otherwise Specified, is also provided for disorders that do not meet criteria for a specific Eating Disorder. The International Classification of Diseases (ICD) includes, with anorexia nervosa and bulimia nervosa, simple obesity as a general medical condition, but this is not included in the DSM-IV-TR, as obesity has not been established by the American Psychiatric Association as consistently associated with a psychological or behavioural syndrome (American Psychiatric Association, 2003).

Attention will now be focused on defining the criteria and nature of anorexia and bulimia nervosa as understood from a scientific perspective.

2.3. Anorexia Nervosa Defined

Anorexia nervosa is a condition characterised by food denial, marked weight loss and amenorrhea (Simpson, 2002). The word ‘anorexia’ is a Greek word meaning *lack of appetite or avoidance and loathing of food* (Freeman, 2005). While the term anorexia may imply a loss of appetite, however, research now indicates that individuals with anorexia nervosa do not in fact experience a loss of appetite (Robert-McComb, 2001). The diagnostic criteria for Anorexia Nervosa as outlined in the DSM-IV-TR (American Psychiatric Association, 2003, p.589) include:

A. Refusal to maintain body weight at or above minimally normal weight for age and height (e.g., weight loss leading to maintenance of body weight less than 85% of that expected; or failure to make expected weight gain during period of growth, leading to body weight less that 85% of that expected).
B. Intense fear of gaining weight or becoming fat, even though underweight.
C. Disturbance in the way in which one’s body weight or shape is experienced, undue influence of body weight or shape on self evaluation, or denial of the seriousness of the current low body weight;

D. In postmenarcheal females, amenorrhea, i.e. the absence of at least three consecutive menstrual cycles. (A woman is considered to have amenorrhea if her periods occur only following hormones, e.g., estrogen, administration).

The onset of anorexia nervosa usually occurs between the ages of 10 and 30 years, with the most common ages of onset being between 14 and 18 years (Kaplan & Saddock, 2003). The DSM-IV-TR further outlines two types of Anorexia Nervosa. In the *restricting* type, the current episode of Anorexia Nervosa is characterised by a restriction of caloric intake (dieting/fasting or excessive exercise) with a disproportionate decrease in high-carbohydrate and fatty-foods, but is not regularly accompanied by binge eating or purging behaviours. In the binge-eating/purging type, the current episode of anorexia nervosa is characterised by regular episodes of binge-eating or purging behaviours such as self-induced vomiting or abuse of diuretics, laxatives, or enemas, while also displaying restrictive eating behaviours. Both subtypes are preoccupied with weight and body image, and both may exercise excessively everyday and exhibit bizarre eating behaviours (Kaplan & Saddock, 2003). Individuals diagnosed with anorexia nervosa may move back and forth between the two types as they have similar characteristics (Robert-McComb, 2001).

The individual with anorexia nervosa views his/her body as a tool that is used to experience a sense of control. Weight loss, to the anorexic, is seen as a sign of mastery, while weight gain is akin to failure (Robert-McComb, 2001). Even after significant weight loss has occurred, the intense fear of becoming fat is not alleviated. In fact, concern about weight gain often intensifies as weight loss occurs (American Psychiatric Association, 2003). The experience and significance of body weight are thus distorted in these individuals. While some individuals feel globally overweight, others realise that they are thin but are still concerned that certain parts of their bodies, particularly the abdomen, buttocks and thighs, are too fat. They may employ a wide range of techniques to measure their body size or weight, including excessive weighing, obsessive measuring of body parts, and persistent use of a mirror to check for perceived areas of fat (American Psychiatric Association, 2003). The diet of those with anorexia nervosa generally consists of “safe” foods, i.e. foods that can be consumed without weight gain such as lettuce, green beans and carrots (Robert-McComb, 2001).

According to Kaplan and Saddock (2003), those with anorexia nervosa tend to be socially isolated and have depressive symptoms. Some behaviours and attitudes associated with anorexia nervosa are (a) a fear of eating in public; (b) feelings of ineffectiveness; (c) need to control the environment; (d) inflexible thinking; (e) limited social spontaneity; and (f) overly restrained emotional expression (Robert-McComb, 2001). The exact cause of anorexia nervosa is not known. Certain predisposing factors have, however, been associated with this disorder. Some of these factors are (a) perfectionist behaviour; (b) low self-esteem; (c) a preoccupation with becoming thin; (d) dieting practices such as skipping meals; and (e) an over-concern with body weight and appearance (Robert-McComb, 2001). Adolescence is a particularly vulnerable time period for the development of this disorder because of the pubertal changes that accompany the passage of childhood into adulthood. Appearance ranks amongst the most desirable traits for adolescents. For teenagers, being attractive is essential for being well like, and for becoming noticed by the opposite sex. This creates vulnerability for the development of eating disorders, as will be discussed in future chapters. Furthermore, participation in certain types of sports, for instance gymnastics, athletics, ballet, etc., that promote, as part of their culture, an emphasis on maintaining a certain ideal body weight and shape for optimal performance, is consistent with a predisposition to eating disorders (Robert-McComb, 2001).

The vast majority of sufferers of anorexia nervosa are woman (O'Dea & Abraham, 1999; Ogden, 2003; Williamson, Barker & Norris, 1993), with the male/female ratio currently standing at 1:10. Male anorexia does appear, however, to be on the increase, particularly within vulnerable groups such as models, dancers and jockeys. It is mainly assumed that those with anorexia come from the higher socio-economic classes. However, research examining the relationship between high socio-economic status and a clinical diagnosis of anorexia nervosa is contradictory with the disorder being found progressively more in those of lower to middle socio-economic status (Ogden, 2003). Research has also addressed the extent to which the incidence of anorexia is related to ethnicity within the Western populations, with many clinical reports showing that the majority of patients with anorexia are white (Ogden, 2003). Almost no reports of non-Caucasian anorectics in clinical populations existed prior to the early 1980's. Since that time, an increase in eating disorder psychopathology in non-Westernised populations has been found in the United States, Britain, India,

Hong Kong, Taiwan, China, Malaysia, Singapore and South Africa (Caradas, Lambert & Charlton, 2001; Lee, 1996).

2.4. Bulimia Nervosa Defined

As discussed in Chapter 1, practices similar to those found in the behaviour of those with what is today referred to as bulimia nervosa were first practiced by the Ancient Romans and later by the early saints (Garner & Garfinkel, 1997). It is unclear, however, as to whether these early accounts are equivalent to the disorder we now know as bulimia nervosa. The important criteria of a morbid fear of fat found in modern day bulimia nervosa appeared to be omitted in these early practices (Garner & Garfinkel, 1997).

Bulimia nervosa was not officially recognised as a diagnosable disorder until 1979, through the work of Gerald Russell (Russell, 1979). The term 'bulimia' was derived from the Greek word *limos* ('hunger') with the prefix *bou* from *bous* ('bull' or 'ox'). 'Bulimia' has at least two meanings, i.e. 'hunger as great as an ox,' or 'sufficient to consume an entire ox' (Parry-Jones & Parry-Jones, 1991).

The essential diagnostic features of bulimia nervosa, as it is currently understood, are binge eating and inappropriate compensatory methods to prevent weight gain. The criteria for Bulimia Nervosa, as outlined in the DSM-IV-TR (American Psychiatric Association, 2003, p. 594) are:

A. Recurrent episodes of binge eating. An episode of binge eating is characterised by both of the following:
   (1) eating, in a discrete period of time (e.g. within a 2-hour period), an amount of food that is definitely larger than most people would eat during a similar period of time and under similar circumstances,
   (2) a sense of lack of control over eating during the episode (e.g., a feeling that one cannot stop eating or control what or how much one is eating)

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

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

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

E. The disturbance does not occur exclusively during episodes of anorexia nervosa.

As with anorexia nervosa, two types of bulimia nervosa have been identified, i.e. the Purging Type and the Nonpurging Type. Bulimia nervosa is more common than anorexia, occurring in one to three percent of young women (Harvey, 2002; Kaplan & Saddock, 2003), with its onset often being later in adolescence than that of anorexia nervosa. Those with bulimia nervosa are usually within the normal weight range for their age and height.

Individuals experiencing bulimia nervosa gain a sense of relief from negative mood states, at least in the short term, by binge eating and purging. Yet, the individual is likely to experience increased shame, guilt, anger and self-disgust subsequent to the binge eating and purging (Robert-McComb, 2001). During a binge, individuals eat food that is sweet, high in calories, and generally soft or smooth textured, such as cakes and pastry (Kaplan & Saddock, 2003). A feeling of loss of control generally occurs during such a binge (Robert-McComb, 2001). The food is eaten secretly and rapidly and is sometimes not even chewed (Kaplan & Saddock, 2003). An episode may or may not be planned in advance and often takes place after a period of food deprivation. Binge eating is typically triggered by dysphoric mood states, interpersonal stressors, intense hunger following dietary restraint, or feelings related to body weight, body shape and food. An episode of binge eating is often accompanied by a sense of lack of control (American Psychiatric Association, 2003).

Another essential feature of bulimia nervosa is the recurrent use of inappropriate compensatory behaviours to prevent weight gain. The most common compensatory technique is the induction of vomiting after an episode of binge eating. This method of purging is employed by 80%-90% of individuals with bulimia nervosa. The immediate effects of vomiting include relief from physical discomfort and reduced fear of gaining weight. Other purging behaviours include the misuse of laxatives and diuretics. Rarely, individuals with bulimia nervosa will misuse enemas following episodes of binge eating, but this is seldom the sole compensatory method employed (American Psychiatric Association, 2003). This vicious cycle of binging, purging,

experiencing guilt, and food restraint, followed by another binge, keeps perpetuating itself (Robert-McComb, 2001).

Characteristics that have been found in bulimic men and women are (a) a strong need for social approval; (b) conflict avoidance; (c) inability to identify and assert personal needs; (d) inadequate coping skills; and (e) high distress levels (Robert-McComb, 2001). Since bulimia nervosa is predominantly a female disorder, socio-cultural values specific to the idea of femininity, such as thinness, physical attractiveness, and beauty, are understood to predispose women to this disorder. As in anorexia nervosa, adolescence is a particular vulnerable period for the development of bulimia nervosa due to the need to achieve a new sense of physical self, the need to establish heterosexual relationships, and the need to develop independence (Robert-McComb, 2001). Dieting is also considered by many researchers as a strong contributing factor to the development of bulimia nervosa (Fairburn, Marcus & Wilson, 1993; Hsu, 1990; Robert-McComb, 2001).

2.5. Eating Disorder Continuum

Over the past two decades there has been rigorous debate concerning the necessary and sufficient conditions for the diagnosis of anorexia nervosa and bulimia nervosa. While the publication of the DSM-IV-TR (American Psychiatric Association, 2003) has further refined and clarified the diagnostic terms, substantial numbers of individuals with significant eating disturbances may still be excluded, as they fail to meet the diagnostic criteria of a formal eating disorder (Bunnel, Shenker, Nassbaum, Jacobson & Cooper, 1990). In contemporary society, dieting is a part of everyday life for many people. It is precisely for this reason that there is much confusion about when dieting can be regarded as abnormal (Polivy & Herman, 1987). The similarities between people who struggle with anorexia nervosa and bulimia nervosa, and those who experiment with dangerous dieting and exercise behaviours, allow one to question the traditional understanding of eating disorders (Brown & Jasper, 1993). Several research findings have shown that many young women experience some symptoms of eating disorders but not to the degree of this being a diagnosable disorder. This has led to the idea that eating disorders may not be discrete in nature (Button & Whitehouse, 1981).

Many authors have thus proposed the notion of an eating disorder continuum to aid in the understanding of similarities and differences among various types of eating

disturbances and disorders (Scarano & Kalodner-Martin, 1994). The first of such authors is said to be Nylinder (1971) who postulated that there are similarities between eating disorders and milder forms of eating problems that occur along a continuum. He argued that prolonged and intense dieting results in starvation symptoms that can lead to anorexia nervosa or a milder variant of the disorder. These milder versions of the eating disorders have been called subclinical eating disorders. Common central features of these disorders are preoccupation with the control of weight and eating, and an alternation of restrained eating with overeating binges, which may be followed by self-induced vomiting or abuse of laxatives. Such conditions arise against a backdrop of widespread concern about weight and shape. Many seek slimness by constant dieting; some develop unusual attitudes to weight and eating and a few go on to present clinically significant disorders (Clarke & Palmer, 1983).

The continuum hypothesis asserts that the fundamental differences among individuals with eating disorders who meet the DSM's criteria, and individuals with milder forms of eating disorders, are a matter of degree and not of kind. Although individuals with different types of eating disorders differ in eating-related behaviours, the continuum hypothesis suggests that the groups on the continuum share similar underlying psychological characteristics (Scarano & Kalodner-Martin, 1994). The continuum model has been shown to be particularly relevant for disorders in which binge-eating is involved, i.e. bulimia nervosa and anorexia nervosa – binge eating/purging subtype (Gleaves, Brown & Warren, 2004).

Various continuums have been suggested by different authors. Russell and Ryder (2001(a)) proposed a model that depicts the relationship between body image and disordered eating. This model provides a framework to assist in identifying the behaviours that may lead to an eating disorder and provides a context for understanding how an eating disorder might develop. Both bulimia nervosa and anorexia nervosa appear on the same continuum. Other authors postulate separate continuum models for anorexia nervosa and bulimia nervosa, depicting different developmental pathways for the two disorders (Boskind-Lodahl & Sirlin, 1977; Bruch, 1978; Fairburn & Garner, 1986; Polivy & Herman, 1987). Scarano and Kalodner-Martin (1994) formulated a continuum model depicting the progression from normal eating to bulimia nervosa. Anorexia nervosa is not included on this continuum. The groups of this continuum were defined according to the criteria for

bulimia nervosa as outlined by the DSM-III-R. The categories of the continuum, as will be discussed in detail, provide an indication of those behaviours that, while not severe enough to be diagnosable, place the person at risk for the possible future development of a diagnosable eating disorder. While other continuum models provide this, the individual categories of this model were regarded by the researcher as most useful and applicable to the current study in order to increase the depth of understanding of participant's eating behaviours and attitudes, particularly with regards to the measures employed to assess these constructs. This model will therefore be the continuum model discussed in this research and will be elaborated on in greater detail.

Several authors have examined the issue of the link between dieting and anorexia nervosa. Garner and Garfinkel (1980) asked the question whether anorexia nervosa is a distinct entity or simply an extreme form of a relatively common dieting disorder. While this was explored, a definitive answer was not reached. After reviewing the literature on eating disorders, Swartz (1983) was led to suggest that anorexia nervosa is a culmination of disordered eating that began with dieting. More recent authors, however, such as Gleaves, Brown and Warren (2004), regard the data pertaining to anorexia nervosa, restrictive type, and whether it differs qualitatively from normal dieting, as inconclusive. Scarano and Kalodner-Martin (1994) suggest that, while a different continuum model for anorexia nervosa may overlap with the 'normal eating to bulimia' continuum, it has not been empirically shown to do so. Based on the inconclusiveness of these findings, a separate anorexia continuum will not be discussed in this research. This study does not, however, attempt to distinguish between those with bulimia nervosa and those with anorexia nervosa, but looks rather at those with disordered behaviour and attitudes towards diet and body weight. The decision to discuss a continuum leading to disordered eating and attitudes as it pertains to bulimia nervosa and not anorexia nervosa should not, therefore, compromise the study in any way.

2.5.1. A Continuum Model of Bulimia Nervosa

Scarano and Kalodner-Martin's (1994) 'Continuum Model of Bulimia Nervosa' outlines six groups of persons, occurring along a continuum from normal eaters to so-called bulimics. In addition to providing practitioners and researchers with a diagnostic and descriptive conceptual framework for understanding eating disorders,

the continuum also provides a conceptualization of the developmental progression of eating problems. Differences between the groups of the continuum are illustrated according to patterns in eating-related behaviours, body-image-related cognitions and attitudes, and self-esteem. The researcher has provided a diagnostic illustration of Scarano and Kalodner-Martin's continuum model in order to allow for clarity in understanding (Appendix A, p.151).

By definition, chronic dieters, purgers, and individuals with a subthreshold or a diagnosis of bulimia, display eating-disordered behaviours, such as repeated dieting, binge eating, and purging. Because the groups are defined in terms of their food-related behaviours, an incremental increase in eating and exercise disturbances between the groups occurs along the continuum. Normal eaters, weight-preoccupied persons, chronic dieters, and purgers are significantly less impaired than are those within the subthreshold bulimic and the bulimic categories (Scarano & Kalodner-Martin, 1994).

The thoughts and feelings that go along with dieting and purging behaviours are important in distinguishing those across the groups on the continuum. Body dissatisfaction increases from the normal eaters through to the bulimic group in an incremental way. Similar patterns exist for variables such as thinking about appearance, food, feeling fat, and becoming fat. Fear of losing control while eating is another important factor differing incrementally across the continuum, with those within the bulimic group experiencing this fear the most profoundly (Scarano & Kalodner-Martin, 1994).

Self-concept and self-esteem are relevant psychological factors differentiating women at various points along the eating disorder continuum. As feelings of esteem diminish, the severity of the eating disturbance increases. Bulimics have been shown to differ significantly from subthreshold bulimics, purgers, chronic dieters and normal eaters in terms of esteem. Physical self-esteem is a critical variable in discriminating between individuals with bulimia, repeat dieters, and normal eaters in an incremental fashion (Scarano & Kalodner-Martin, 1994). The continuum, as outlined by Scarano and Kalodner-Martin (1994), is reflected as follows:

2.5.1.1. Normal Eaters

Logically, on the one end of the continuum are those who have 'normal' eating attitudes and behaviour. It is hypothesised that those who fall within this group are

those with the healthiest eating attitudes and behaviours, those who do not engage in attempts to change their body weight. They are neither markedly over- nor underweight. They eat in response to hunger cues and follow a balanced diet (Polivy & Herman, 1987). This group of people acknowledge that eating is about making healthy food choices by eating a variety of foods for nourishment and pleasure, recognising that food is our source of energy. There are no good or bad foods for those within this group and they recognize that they themselves are neither good nor bad according to their food choices (Russell & Ryder, 2001(b)). So-called 'normal' eaters are understood to have higher self-esteem and less body dissatisfaction than those who are weight-preoccupied, those who diet chronically, those who purge, or those who binge (Scarano & Kalodner-Martin, 1994).

2.5.1.2. Weight-Preoccupied Individuals

Individuals who fit into this group do not engage in dieting behaviour but feel especially concerned about their body weight and shape. Unhealthy attitudes toward weight and body image may exist and the social pressures to be thin may affect these persons (Scarano & Kalodner-Martin, 1994).

It has been argued that the process of normal gender-role socialisation leads women to be particularly concerned about their physical appearance as a means of gaining approval from others. Therefore, in Western societies where thinness is indisputably a strived-for beauty ideal, young women in the process of establishing their identity are especially vulnerable to dissatisfaction with their shape and the pursuit of thinness (Cogan, Bhalla, Sefa-Dedeh & Rothblum, 1996). According to Berzins (1999), surveys of the views of young girls have indicated that they are more afraid of becoming fat than they are of cancer, nuclear war, or losing their parents. Body image disturbance is understood to be so pervasive among women that it is normative, rather than unusual, for women to be unhappy with their bodies.

Body dissatisfaction is understood in terms of negative feelings towards and cognitions of the body's weight and shape (Ogden, 2004). Gruber, Pope, Lalonde and Hudson (2001) suggest three components of body dissatisfaction. The first is actual body fat; fatter women will likely be more dissatisfied with their bodies. The second is body ideal; two women may have equal levels of body fat, but one may have a thinner body ideal than the other and thus experience greater body dissatisfaction. The third is body perception; two women may have similar levels of actual body fat and

aspire to similar body ideals, but one may have higher perceived body fat and hence greater body dissatisfaction. While body dissatisfaction that leads to weight preoccupation was traditionally limited to those of the Western culture, various authors (Akan & Grilo, 1995; Cogan, Bhalla, Sefa-Dedeh & Rothblum, 1996; Lee, Leung, Lee, Yu & Leunge, 1996; O'Dea, 1995) have demonstrated that, through the process of acculturation, non-Western ethnic minorities living within Westernised communities internalise the Western norms of thinness as the ideal, and as a result show a greater degree of body dissatisfaction and related eating disturbances. This occurs especially with increased exposure to Western advertising, marketing, electronic media, entertainment and fashions (O'Dea, 1995).

Individuals with eating disorders show greater body dissatisfaction than those without; dieters show greater body dissatisfaction than non-dieters and women in general show greater body dissatisfaction than men (Ogden, 2004; Robert-McComb, 2001). Body dissatisfaction has been reported by some to be the single strongest predictor of eating disorder symptomology (Caradas, Lambert & Charlton, 2001; Cooper & Fairburn, 1993; Ricciardelli & McCabe, 2003; Vervaet & Van Heeringen, 2000).

2.5.1.3. Chronic Dieters

Those who fall within this group engage in dieting behaviour, and do so in response to dissatisfaction with their body shape and weight. Dieting involves the restriction of food or calorie intake, or both, with the intention of controlling body size (Russell & Ryder, 2001(a)), and is the most widely used method to improve body shape (Brownell, 1991).

The number of United States dollars spent on diet foods, programmes, books, etc. nearly doubled in the 1980's to close to $30 billion. According to Berzins (1999), thirty to forty percent of 9-year-old girls and eighty percent of 10- and 11-year-old girls have dieted. At any given moment, according to Lewis and Blair (1993), 50-70% of adolescent girls are dieting to lose weight. Russell and Ryder (2001(a)) suggest that dieting and weight control have become national obsessions in Canada.

Women diet not necessarily because they are fat, but because they believe they are fat (Brownell, 1991). According to Hesse-Bibher (1996), those living within the Western culture are bombarded with daily images of beauty and standards of thinness that are neither healthy nor realistic. Dieting is understood as an attempt to gain these,

often unattainable, standards of beauty and thinness. According to Brownell (1991), there are certain underlying assumptions inherent in the idea of dieting. The first is that the body is infinitely malleable, and that with only the right combination of programs, exercise, and eating plans can one look like the aesthetic ideal. The second assumption is that vast rewards await the person who reaches this goal. When one becomes slimmer, fitter, and more attractive, life will improve dramatically, or so we are led to believe.

But not only has dieting proved ineffective for 90 to 95 percent of people, resulting in weight gain within two to five years of losing the weight (Lutter & Jaffee, 1996; Garner & Wooley, 1991; Siegler & Ciliska, 1991), researchers have frequently linked dieting with many health and psychological problems (Russell & Ryder, 2001(a)). Lowe, Gleaves and McKinney (1996) demonstrated that significant negative affect may be generated as a result of weight preoccupation and episodic dieting, even in non-clinical populations. Gruber et al (2001) found that dieters continued to have significantly higher levels of body dissatisfaction even after having lost weight. So pronounced was this effect that a dieting woman would be predicted to experience levels of dissatisfaction comparable with those of a non-dieting woman with almost twice as much fat as herself. Physiological metabolic changes that occur as a result of dieting and the impact of cognitive restraint may lead to disordered eating (Polivy & Herman, 1985; Pesa, 1999).

Clarke and Palmer (1983) referred to the phenomenon of dieting leading to disordered eating as 'counterregulation', in which dieters (restrained eaters) were shown to overeat once they had started eating. These dieters tended to eat more than unrestrained eaters (non-dieters). "Clinical and research evidence tends to support the view that dietary restraint precedes binging rather than the reverse" (Clarke & Palmer, 1983, p.304). Emmons (1994) asserts that dieting results in a metabolic slowing that requires the individual to adopt more extreme methods to lose weight and maintain weight loss. As the body attempts to escape starvation, binge eating may develop. Wilson (1995) suggests that dieters are eighty times more likely to than nondieters to develop an eating disorder. A positive relationship therefore appears to exist between low-calorie dietary restraint in normal weight individuals and binge eating and eating disorders, a view supported by more current authors such as Wadden (2004) and Gusmano (2005).

2.5.1.4.. Purgers

Those who fall within this group engage in methods of purging, such as self-induced vomiting, laxative abuse, diuretic abuse and excessive exercise. This usually begins as a method of preventing weight gain by 'undoing' the caloric effects of normal eating or binge-eating. It becomes self-perpetuating, however, as it allows the person to satisfy the urge to eat but eliminates the feedback loop that would stem underlying hunger and food cravings (Garner & Blanch, 2002). The desire to purge usually follows a binge episode or a belief that the person has eaten 'bad' foods, i.e. high calorie foods. The person, experiencing feelings of guilt, depression, or self-disgust, seeks temporary relief through purging (Kaplan & Saddock, 2003).

Vomiting is common and is usually induced by sticking a finger down the throat, although some persons are able to vomit at will. Vomiting decreases the abdominal pain and the feeling of being bloated associated with overeating and allows the person to continue eating without fear of gaining weight (Kaplan & Saddock, 2003). Laxative and diuretic abuse is less common but as dangerous because it contributes to electrolyte imbalance and physical complications. Laxative and diuretic abuses also tend to be ineffective methods of trying to prevent the absorption of calories (Garner & Blanch, 2002). Compulsive exercise occurs when the primary motivation for exercise is to control or manipulate body size. Indications that exercise has moved from healthy activity to more compulsive behaviours may include the following: needing to burn off a certain number of calories, feelings of guilt related to missing an exercise session, and when workouts interfere with daily function through time, preoccupation, or both (Veale, 1993). When taken to the extreme, exercise has the potential to be detrimental instead of advantageous to health (Garner & Rosen, 1991).

2.5.1.5. Subthreshold Bulimia

Those who fall into the subthreshold category engage in the same behaviours demonstrated by individuals with bulimia, but to a lesser degree than those at the clinical level of bulimia (American Psychiatric Association, 1987). These individuals are often of normal-weight yet are diet conscious and involve themselves in a pattern of binging and purging, whether by fasting, vomiting or through self-induced diarrhoea. The distinguishing feature of such women as opposed to those of the previous categories is that they binge regularly.

The binge-cycle, involving binging, purging and restraint, tends to perpetuate itself. A feeling of loss of control usually occurs during a binge. The binge is most often preceded by a feeling of anxiety or some form of negative mood state. However, the giving over of oneself to the binge experience commonly leads to shame and guilt. The shame confirms the image of the person as unattractive and inadequate, as does his/her bloated abdomen. The individual is therefore likely to engage in purging behaviour in order to compensate for having overeaten and to get rid of the negative feelings about themselves. In an attempt to feel good, in control and disciplined, the purging behaviour tends to be followed by fasting and starvation (Boskind-Lodahl, 1976; Robert-McComb, 2001).

2.5.1.6. Bulimia Nervosa

Those who fall into this category are those who fulfil the DSM-IV-TR's criteria for bulimia nervosa. Those individuals within this category, as defined in section 2.2., are within the final stages of Scarano and Kalodner-Martin's (1994) 'Continuum Model of Bulimia Nervosa'.

2.6. Conclusion

Although specific eating disorders such as anorexia nervosa and bulimia nervosa are referred to most often in the media, they represent only one extreme of a broad spectrum of disordered eating, including those who diet frequently and exercise compulsively. Individuals experimenting with these behaviours do not meet the diagnostic criteria for eating disorders, but are still potentially at significant physiological and psychological risk. These behaviours may compromise the growth and development of young women and men, and if left unattended, may progress to a diagnosable eating disorder (Russell & Ryder, 2001(a)). While society tends to stigmatize individuals at the extreme end of an eating disorder continuum, i.e. people with anorexia nervosa and bulimia nervosa, they tend to praise and even reward those at the other end of the continuum, i.e. those who engage in behaviours such as dieting and exercise for weight control. It seems absurd that we would endorse and in fact encourage the very behaviours that potentially lead to disordered eating, and then pathologize those who have developed an eating disorder. The medical scientific model has played a significant role in understanding eating disorders and their origins. Etiological factors that have been identified include family dynamics, genetic

vulnerability, biological factors, and personality characteristics (Kaplan & Sadock, 2003). It is important to note, however, that the above mentioned absurdity of first endorsing and then pathologizing disordered eating is embedded within a culture and history that has placed extreme expectations on both men and women with regards to how they should look, speak, behave, think etc. In order to be found acceptable, women have been expected to mould themselves both physically and personally to fit a certain ideal, both personally and physically. While this ideal has changed over time, it has consistently placed women at personal risk. One might propose that a risk of the current feminine ideal is the development of an eating disorder. The following chapter will explore the social discourses that have shaped and influenced women in their pursuit of the ideals that create vulnerability for the development of eating disorders.

CHAPTER 3
A FEMINIST POST-STRUCTURALIST DISCOURSE PERSPECTIVE

"However, one cannot put
a quart in a pint cup"
-Charlotte Perkins Gilman-

3.1. Introduction

Research on eating disorders has been dominated by a positivist scientific model for over a century since the works of Lasègue (1873) and Gull (1874). According to Hepworth (1994), however, medical research has almost without exception worked in isolation from other approaches in working with and researching eating disorders. Anorexia nervosa and bulimia nervosa have come to be regarded as states that involve a diversity of etiological factors (Hepworth, 1994; Johnson, Conners & Tobin, 1987). The relationship between social factors in particular and the development of eating disorders has been evidenced by the diverse employment of psychological, social, and feminist theories in various perspectives since the late 1970's. These theoretical perspectives emphasise the significance of the social pressures and expectations of women within Western society that coexist with the gender-specific nature of eating disorders (Orbach, 1986; Lawrence, 1987).

The overwhelming reported prevalence of eating disorders in women has been well-documented with an estimated 90-95% of anorexia nervosa being diagnosed in females rather than males (American Psychiatric Association, 2004). This feature requires that we consider the representation of women within literature on eating disorders (Hepworth, 1994). Feminist literature provides a valuable perspective in understanding the specific experiences of women within society, and how these have shaped their experiences of their bodies and their behaviour in relation to their bodies. Feminism has allowed us to explore the diversity and multiplicity of women's identities, to explore the process by which identities are negotiated and constructed through social interactions, and to understand the concepts of power and powerlessness with regard to gender (Mills, 2002).

Language is regarded by many as playing an important part in structuring our experience of the world. At the heart of the post-structuralist perspective lies the principle that language produces social reality, which varies across cultures and time (Pilcher & Whelehan, 2004). According to Baxtor (2003), language is seen as the

common factor in any analysis of power, social meanings and the construction of identities. Post-structuralism seeks to understand the complex relationships between language and power in placing particular emphasis on the notion of discourses. Individuals are seen to negotiate meaning according to the way they position themselves, and are positioned by a specific discursive context (Baxtor, 2003). Post-structuralists therefore reject the idea that there is a fixed underlying structure of people, families, societies and cultures that shape life. They also reject the idea that people can be seen as discrete and separate units, unrelated to others (Thomas, 2002).

The self is seen by post-structuralists to be nomadic, constructed briefly at the intersection of various discourses, and changing through the repositioning of itself within these discourses (Grodin & Lindlof, 1996). Thus, our identities are constantly created in relationship with others, with institutions and with broader relations of power (Thomas, 2002). The identities of learners within a school culture, for example, could therefore be seen to be created and recreated through the relationships they have with their educators, families, peers, etc; through the rules and expectations that govern their schools and families; and through the power relations that are constantly shifting with regards to their gender, social class, race, and religion. In a similar way, eating disorders, rather than being seen to be researched as a discrete and isolated object, need to be understood within the context through which they have been created.

In combining the feminist and post-structuralist approaches, feminist post-structuralist discourse analysis (FPDA) (Baxtor, 2003) can be useful in incorporating the richness of both approaches. FPDA can be defined as "a feminist approach to analysing the ways in which speakers negotiate their identities, relationships and positions in their world according to the ways in which they are located by competing yet interwoven discourses" (Baxtor, 2003, p.1). The feminist post-structural discourse analysis perspective will be used as a necessary theoretical underpinning for the present study. This perspective is regarded by the researcher as most useful in conceptualising the societal discourses that influence educators as women, in exploring how these discourses influence women's perceptions of themselves with regards to their bodies and in looking at the possible ways that these perceptions influence their behaviours with regards to eating and exercise and in the type of information they pass on to the learners within their care.

Attention will first be focused in this chapter on further defining feminism, post structulism and the concept of discourse. Thereafter, various discourses will be expounded upon and applied to the understanding of eating disorders.

3.2. Defining Feminism

Like post-structuralism, feminism draws upon a short but thoroughly diverse theoretical tradition (Baxtor, 2003). The word 'feminism' itself originated from the French word *féminisme* in the late nineteenth century, either as a medical term to describe the feminisation of the male body, or to describe women with masculine traits. By the time it was used in the United States in the early part of the twentieth century it was used to refer to a certain group of women, "namely that group which asserted the uniqueness of women, the mystical experience of motherhood and women's special purity" (Jaggar, 1983, p.5). It soon became understood to denote a political stance of someone committed to changing the social position of women.

Since then the term has taken on the sense of one who believes that women are subjugated because of their sex and that women deserve at least formal equality in the eyes of the law (Pilcher & Whelehan, 2004). Since the 1980's it has become common practice to use the plural form when talking about feminism in order to signify that although all feminists may share a basic commitment to ending female oppression, they do not always approach this problem from the same philosophical or political base. This diversity and heterogeneity of positions is seen to add to the richness of feminism's legacy (Pilcher & Whelehan, 2004).

In her account of 'third wave' feminism, Mills (2002) suggests that it is possible to identify three distinct waves in the history of feminism. Pre-modernist or 'first wave' feminism is generally associated with the original quest for female suffrage in the United States and Western Europe in the late 19th and 20th centuries (Baxtor, 2003). Modernist or 'second wave' feminism is a term used to describe a new period of feminist collective political activism and militancy which emerged in the late 1960's. Whereas the first wave lobbied for women's enfranchisement via the vote and access to professions as well as the right to own property, the second wave feminists talked in terms of 'liberation' from the oppressiveness of a society defined by patriarchal values. Arguably, for second wave feminists the key site of struggle was the female body itself – its representation and the meanings attached to the biological differences of males and females (Pilcher & Whelehan, 2004).

Third wave feminism, according to Mills (2002) refers to a range of theory that incorporates constructivist rather than essentialist principles such as social constructionism and post-stucturalist feminism. Third wave feminism can be identified by the following six aspects:

1. the diversity and multiplicity of women's identities
2. an understanding that gender is something people enact or do, not something they are, own or characterise
3. a focus upon context-specific gender issues rather than more generalised questions. Terms like 'patriarchy' and 'sexism' are therefore considered out of date
4. the importance of co-construction, that is, the process by which identities are negotiated and constructed through social interactions
5. an understanding that powerlessness is no longer considered a feature of all women. Powerlessness may pertain to many women some of the time or to a minority of women most of the time
6. an emphasis upon notions of female resistance to, and a reinterpretation of, stereotyped subject positions rather than notions of struggle against the subordination of women (Mills, 2002).

From a feminist perspective, eating disorders have been conceptualised as a reaction of some women to a relative social powerlessness and an inability to control their environment. These women, according to Lawrence (1979, p.93), attempt to gain "perfect and absolute control" at two levels: physically expressed, in the fear of becoming fat, and morally, in seeing themselves as "gluttonous and debased" (p.93). Thinness becomes their supreme achievement. The anorexic uses starvation and the dominance of bodily desires in her search for control, identity and competence, and uses the resulting thinness as a sign that her control is effective (Bruch, 1973). The meaning that food comes to have for those with eating disorders, and how girls make sense of their experience of eating, is seen to be socially constructed (MacSween, 1993).

For MacSween (1993), food and eating are major female concerns, and eating disorders can therefore be viewed as an extension of the difficulties of all women. The control and manipulation of the body is seen as a major facet of female existence. Lawrence (1984) argues that appearance is central to women's acceptability, and today, sexual acceptability demands slimness. Weight control, therefore, is

commonplace in women's lives, both in the attempt to conform to a cultural stereotype, and as an expression of the idea that if women experience problems, they should change themselves rather than their society in order to deal with them (Lawrence, 1984). Control of food and the body are understood to be two of very few areas accessible to female control, due to their positions within society. From a feminist perspective, a central difficulty in eating disorders is the conflict over independence and autonomy (Lawrence, 1979).

3.3. Defining Post-Structuralism

Post-structuralism, like feminism, remains ultimately difficult to define because of its pluralities and its denial of a singular definition. Post-structuralist thought is seen to emerge primarily from the work of Jacques Derrida, Jacques Lacan and Michel Foucault. It offers an antidote to liberal humanist ways of seeing the world, particularly in their theories of the self (Pilcher & Whelehan, 2004). Humanist discourses presuppose an essence at the core of an individual, which is unique, fixed and coherent, and which makes a person recognisably possess a character or personality. Conversely, post structuralist theory argues that individuals are never outside cultural forces or discursive practices but always 'subject' to them. Their identities are determined by a range of ways of being, approved by their culture, and made available to them by means of the particular discourses operating within a given discursive context (Baxtor, 2003). Post structuralists argue that we only come to know ourselves through the medium of language, and individual words themselves only gain meaning as part of a system. Meanings, it is argued, cannot be fixed or remain stable, but are endlessly remade through the process of reading/speaking and changes in social life (Pilcher & Whelehan, 2004). The concept of discourse, very much the product of Michel Foucault's theoretical work, is also central to the post-structuralist perspectives (Pilcher & Whelehan, 2004).

3.4. Defining Discourse

The use of the term 'discourse' is as a form of social/ideological practice (Fairclough, 1992) central to the post-structuralist perspective. Foucault (1972) defines discourses in the plural sense to denote "practices that systematically form the object of which they speak" (p.49). Thus discourses are forms of knowledge or powerful sets of assumptions, expectations and explanations governing mainstream

social and cultural practices. A discourse is historically located, in that an analysis will always look at how the systems of statements making up the discourse emerged, how the forms of knowledge were legitimised and how the structures came to be seen to be natural (Parker, 1992). They are systematic ways of making sense of the world by inscribing and shaping power relations within all texts, including spoken interactions (Baxtor, 2003). Discourses are therefore inextricably linked to institutions, for example education, and to the disciplines that regularize and normalize the conduct of those who are brought within the ambit of those institutions (Torrance, 2003).

Discourses are as such closely associated with 'discursive practices'. These are the social practices that are produced by or through discourses (Baxtor, 2003). Post-structuralists argue that subjects are constituted within discourses that establish what it is possible (and impossible) to be within social practices, for example, a women, mother, educator, child, etc, as well as what will count as truth, knowledge, moral values, normal behaviour and intelligible speech when being a women, mother, educator, child, etc (Torrance, 2003). Discourses therefore not only circumscribe what it is possible to say, know and do, but also establish what kind of person one is entitled or obligated to be. It is impossible then to speak without speaking as the kind of person who is invoked by one discourse or another (Torrance, 2003). Parker (1992) agrees and further suggests that we, in fact, cannot avoid the perceptions of ourselves and others that discourses invite.

Individuals, therefore, negotiate meanings according to the way they position themselves and are positioned by a specific discursive context. While certain individuals may be relatively powerfully positioned, others will be less so. The terms 'power' and 'powerfulness' within post-structuralism refer to the way in which individuals are often better placed than others to benefit from the experiences, interests and goals of a particular context by virtue of their more privileged positioning within a combination of dominant discourses (Baxtor, 2003). Post-structuralists have argued that individuals are not uniquely positioned as either powerful or powerless, but that they are positioned within power relations that are constantly shifting, rendering them at times powerful and at other times powerless. Thus, it may be that the same individuals are powerful within one discursive context and powerless within another. Far more subtly, people can shift continuously within the same discursive context so that they experience positions of relative powerfulness

and powerlessness either concurrently or in rapid succession (Baxtor, 2003). As Walkerdine (1990) illustrates, a young female educator who is being taunted by two boys within her class is shown to be both powerful in acting out her superior status as an educator and yet powerless as a women in her inability to resist their sexist constructions of her. Discourses can thus be contradictory, offering competing versions of reality, and serving different and conflicting power interests (Baxtor, 2003).

Educators and learners are, as with other individuals, in the process of constructing meaning and establishing identity through being positioned and positioning themselves within the discourses of our society, the discourses within the educational institution within which they work, the discourses within their families, and the discourses within their religious groupings, etc. In the context of the present study, however, it is of interest to explore those competing yet interwoven discourses through which educators and learners, as women, negotiate their identities and relationships that result, perhaps, in them being more vulnerable to the development of eating disorders.

In speaking of these discourses it is important to note that the researcher is aware that in defining the presence of such discourses and through referring to them by name, we are in fact giving the object to which the discourse refers a reality. Discourses are, however, understood as being a "representational practice" (Woolgar, 1988, p. 93). They therefore construct a representation of the world rather than being reality within themselves. As Bates (1983) explains, we know of the objects only through their effects, similar to the way that we know of the reality of atoms, electrons and gravity today. While not being able to see them, we can speak of them as if they were objects due to the effects that they have on those things we can see. The researcher is also aware that, while preferencing certain discourses that potentially create meaning and identity for educators and learners as women, one is omitting other discourses with which the discourses referred to may be imbricated and which may similarly create meaning and identity for educators and learners as women. It may be argued that such discourses do not come into being as discrete entities in the lives of those experiencing their effects. In order for us to analyse them, however, it is seen as necessary to isolate them for a moment. This is done with the understanding that these, as with all discourses, are interwoven, that they draw

support from each other and that they, at times, work in opposition to each other and to other discourses that are not referred to in this research project.

The remainder of the chapter will be devoted to the discussion of four discourses that potentially create vulnerability in women for the development of eating disorders.

3.4.1. Discourse of Gender

Lips (2003, p.138) asks, "If someone is biologically female, does that automatically make them female?" It is of interest to consider what it is that makes a woman a woman. The simplicity of the question belies the complexity of the answers that have been suggested by theorists concerned with the categories of gender and sexual difference (Reischer & Koo, 2004). The concept of gender, as we now use it, came into common use during the early 1970's. It was used as an analytical category to draw a line of demarcation between biological sex differences and the way these are used to inform behaviours and competencies, which are then assigned as either 'masculine' or 'feminine' (Pilcher & Whelehan, 2004). Historically, therefore, the ideologies that have defined the male and female nature and competencies have relied upon the physical materiality of the male and female body. This body and its natural physical characteristics have come to count as definitive emblems of male and female identity (Balsamo, 1996). According to Lips (2003) the main differences that develop between females and males are reproductive and sexual. The female develops with ovaries, a womb, and a vagina and these characteristics become defining aspects of her femaleness. She menstruates and she can become pregnant. She cannot make anyone else pregnant, but someone else can make her pregnant against her will.

The female capacity to become pregnant has played a crucial role in the way girls are socialised toward vulnerability or power in many cultures (Lips, 2003). For example, as Jordanova (1980, p.49) observed, "Women's occupations were taken to be rooted in and a necessary consequence of their reproductive functions…Women's destiny to bear and suckle children was taken to define their whole body and mind, and therefore their psychological capacities and social tasks". A significant correspondence exists then between women's bodies and their position in society, a connection largely mediated by social ideologies of gender, gender being a bodily fact that carries social importance and consequences (Reisher & Koo, 2004).

It has been assumed that women gravitated to subordinate roles because they were passive and dependent (Beall & Sternberg, 1993). Historically, for instance, women

have been more likely than men to work as secretaries and nurses (Lips, 2003). Such subordinate roles both require and encourage dependence, accommodation and deference to the superiors' decisions and time schedules, sensitivity to the superior's needs and preferences, and nurturance of them. Thus, while the behavioural requirements of subordinate roles were seen to be better fulfilled by women, they in fact came to be seen as characteristically feminine (Beall & Sternberg, 1993). Women came to be seen therefore as submissive, deferent (toward men), emotional, subjective, gullible, dependent, sensitive to others, caring, nurturing, able to devote themselves to others, and good at domestic tasks and childrearing. Conversely, high status roles have traditionally required dominance, initiative and objectivity. Men have historically held such roles in society and have in turn been seen as dominant, rational, objective, independent, decisive, competitive, aggressive, capable of leadership, good at science and mathematics, and interested in business, sports, and politics. Again, these characteristics came to be definitive of masculinity and what was needed to fulfil a position of authority (Bem, 1974; Bergen & Williams, 1991; Spence & Helmreich, 1978; Williams & Best, 1982).

Campbell (1967) asserts that it is a fundamental attribution error that has caused the high-status characteristics to appear as internal personality traits of men and the subordinate characteristics to be dispositions of women. In addition, the error has been compounded through assuming that the traits are innate and sex linked (Campbell, 1967). The stereotypical gender attributes have been assumed to be true not only because they have been perceived as internal dispositions, but also because they have been consensual in society (Beall & Sternberg, 1993). Gender stereotypes are consensual through society because, even while we may reject them consciously, we still enact them and see others enact them in the unequal roles and status of our daily life (Bem, 1974; Spence & Helmreich, 1978). Through observation, it has been argued that children learn a variety of behaviours associated with being a man or a woman (Deaux & Stewart, cited in Unger, 2001). In the process of becoming 'woman', for instance, it is argued that women follow scripts of femininity taught to them through the family, through school, and through the myriad representations of 'normal' gender roles in culture (Ussher, 2000). Reinforcement contingencies are thought to shape the display of behaviours, resulting in a greater likelihood of children acting in ways that are consistent with societal norms of their gender (Deaux & Stewart, cited in Unger, 2001). As a result of the stereotypical gendered traits being

perpetuated, all men and women are assumed to posses those traits referred to above. Even when objective evidence disconfirms the consensus, we still see the consensus as true. Because consensus defines the truth, it also transforms gender stereotypes from assumed facts into values. Because there is no objective criterion of what a true feminine personality is, if everyone agrees that women are emotional, dependent and nurturant, then emotionality, dependence and nurturance become hallmarks of true femininity. As a result, these traits become normative and valued for women in that, through displaying these traits, their true femininity is both defined and validated (Beall & Sternberg, 1993). According to O'Dea (2000), women conform to contemporary ideas of femininity in order to increase their marriageability and to gain economic and social stability.

A view held regarding females and mental illness in general is that, women who take up the archetypal feminine position are more at risk for mental health problems than those who challenge this position. This is because this so-called feminine role requires self-sacrifice, self-denigration, and a stifling of independence and desire (Ussher, 2000). Wolf (1991) observed, however, that the rise of eating disorders in the 1980's coincided with the rise of women to positions of power and authority within the workplace. The shifting nature of women's work as they entered positions and professions previously seen as exclusive to men, introduced new challenges. The traditionally feminine characteristics of being submissive and deferent were no longer applicable in the high powered positions they were now able to take up. As Rodin (1993) notes, it became necessary for women who were successful in previously male-dominated professions to both minimise their female status and to retain it. Women found it increasingly important to look beautiful (generally synonymous with being feminine), as this tempered their unfeminine ambition. Feminine beauty is associated with the pursuit of the thin body ideal.

Like Rodin (1993), Reischer (2000) argues that women in male-dominated professions experience their bodies as central to workplace dynamics; they encounter a host of occupational pressures and challenges in their work environment, particularly around issues of appearance, reproduction, and sexuality, challenges that are largely related to these women's experience of a paradoxical imperative to minimise their femininity even as they must also affirm it. The conflict then is a double bind of pursuing individualistic success which is seen to involve a rejection of

affiliation and feminine characteristics, and/or becoming fully feminine and therefore subordinate, defining the self in relation to the needs of others (MacSween, 1993).

According to Lawrence (1984, p.67), anorexia nervosa is one way to "step outside" this conflict, and could be seen as a retreat from the confusion and conflicts between success and dependent femininity. The anorexic girl, having seen herself through a dominant gendered discourse, has always accepted the valued female qualities of compliance, passivity and unselfishness. Thus, when she reaches a point in her life at which independence and autonomy are required, she is likely to feel unable to cope (Lawrence, 1984). The individual with anorexia is understood to use starvation and the dominance of bodily desires in the search for control, identity and competence, and use the resulting thinness as a sign that the control is effective (Bruch, 1973). Control of food and the body are understood to be two of a few areas accessible to female control due to their positions within society (Lawrence, 1979). Eating disorders are thus understood to work to prevent movement into the public sphere (Chernin, 1986). The initial conscious denial of food is transformed, however, and food refusal becomes involuntary. Eating becomes a dangerous and 'illegitimate' activity and food becomes a forbidden substance to which the anorexic woman has no right (Orbach, 1986).

3.4.2. Discourse of Body Ideal

In the context of the present study, it is of interest to explore how the ideal image of the woman's body, as a mark of social values, has been discursively constituted and socially constructed. Starting from the notion that the bodies women cultivate are ultimately indexes and expressions of the social world we inhabit, an exploration of the impact of the social world on the female body ideal will be undertaken.

Women in many times and places have been pulled, squeezed, bleached, painted and starved (or force-fed) into the 'right' appearance (Lips, 2003). Historically bodies have been modified for many reasons, for example to signify participation in a social group or signal a significant change in social status. The overarching theme and primary end of most body work, though, is the pursuit and attainment of beauty (Reischer & Koo, 2004). The female body can be a source of joy, pride and pleasure, but research tells us that for many women it is the opposite. Women are frequently ashamed of or embarrassed by their shape, their skin, their hair, their menstrual changes, and their physical reactions to pregnancy (Lips, 2003). Research suggests

that females, on average, have higher psychological distress, a greater desire for thinness and lower life satisfaction than males (Chase, 2001). Why do women display such normative discontent with their bodies? Why are women more likely than men to display behaviours that involve, for example, restrictive eating, exercising to reduce weight, and purging?

In the West, the condition of thinness has become such a widely accepted prerequisite of the body beautiful that it almost seems natural to assume that a thin body is aesthetically preferable to a corpulent one. In their pursuit of this ideal, women have subjected themselves to extreme regimens of diet, exercise and other forms of physical self-improvement, efforts that all to often become all consuming to the detriment of more socially relevant projects (Reisher & Koo, 2004).

The thin body ideal has not, however, always been the standard (Hesse-Biber, 1991). A review of Western civilization's aesthetic and health ideals indicates the novelty of current beliefs. By looking at the visual evidence provided by paintings of Gothic and Mannerist nudes and dressed people, we can see that the heavier and more voluptuous female figure was considered the aesthetic standard. The women within these paintings had no bones or muscles showing (Fallon, Katzman & Wooley, 1994; Hesse-Biber, 1991). The Romantic vogue in the 1830s-1850s encouraged young ladies to strive for the tiny waist favoured by fashion and men (Fallon, Katzman & Wooley, 1994). The corset created an upright, regal appearance and emphasised the feminine smaller waist. Women wearing corsets were incapable of bending and so needed to be waited on, and, constantly breathless, they required a male arm to steady them (Ogden, 1992). Indeed, the corset applied between 20 and 80 pounds of pressure on the abdomen, causing difficulty breathing and often leading to fainting (Fallon, Katzman & Wooley, 1994). While women of the Romantic period may have wanted tiny waists, however, they also wanted their shoulders, arms, calves, and bosoms ample, indicating an 'amorous plenitude' (Fallon, Katzman & Wooley, 1994). As fashions changed, the corset provided a basis to enlarge or flatten the stomach and to round or flatten the bottom (Ogden, 1992). Overall thinness, however, was considered ugly, a woman's misfortune.

Body ideals and ideas were thus the reverse to those that are now endorsed. The female ideal was tall, full-busted, full-figured and mature. Dimpled flesh, what we today call cellulite, was considered desirable. The undergarment industry even came to the aid of the slighted thin women with inflatable rubber garments, replete with

dimples, for her back, calves, shoulders and hips. Fat was seen as a 'silken layer' that graced the frames of elegant ladies. Plumpness was deemed a sign of emotional wellbeing. It was identified with a good temperament, with a clean conscience, with temperate and disciplined habits, and above all with good health.

Today, of course, society has totally inverted these associations (Fallon, Katzman & Wooley, 1994). While the body ideal before the 20th century was the opposite of the current ideal marked by 'fat phobia', women were still demonstrating a willingness to mould their bodies to create an ideal form. According to Ogden (1992, p.3), the main message of the corset for instance was, "I am prepared to change my body and suffer pain in order to be of marriageable material". Without conformity to these norms, women were considered ugly or immoral by men and blocked from marriage or otherwise functioning in society (Fallon, Katzman & Wooley, 1994).

According to Fallon, Katzman and Wooley (1994), the culture of slimming as we know it is really a post-World War II phenomenon. Key ideas that would take full force in subsequent decades began to emerge. Chief among these was "fat phobia", the conviction that animal fat of any kind was dangerous. The perception developed that Americans were too fat and getting fatter; that they ate too much, ate the wrong foods, and were sedentary and therefore flabby. These announcements did not abate, even though average life expectancy continued to improve (Fallon, Katzman & Wooley, 1994). While restrictive diets and exercise aimed at weight loss were being promoted as necessary ways of achieving the body ideal, icons such as Marilyn Munroe and *Playboy* centrefolds continued to demonstrate a body ideal that was voluptuous and curvaceous (Tavris, 1992).

In subsequence decades, however, the emerging slimming ideas intensified. The mid-sixties saw the British model Twiggy being elevated to becoming the epitome of female beauty. Susan Cheever (cited in Tebbel, 2000) asserts that Twiggy was, "the negative image of everything a woman was supposed to look like. She was so skinny it was hard to tell she was a woman at all. The power of her appeal redefined femininity" (p.91). Hollywood has continued to reinforce this thin body ideal as seen by those cast as female leads, and by the journalist fascination with weight and diet. Even the female characters in popular animated films, e.g. the heroines of Beauty and Beast, The Little Mermaid, Pocahontas and Aladdin, are drawn as thin and big breasted (Tebbel, 2000). Women's magazines along with the fashion and cosmetic advertisements continue to reinforce this ideal of body and what it means to be

ultimately feminine. According to Tebbel (2000), magazine advertisers are happy to be seen to be in support of the editorial formula of diets, plastic surgery, fashion and beauty. “The objective of these features is to help readers understand that the only way they can hope to succeed or survive in this competitive world is to buy our magazine, and all the products in it, so *you* can become the person *we* think you should be” (p.115). That person, of cause, is the one portrayed most in these magazines – young, white and generally emaciated. These faces and bodies are uniformly attractive and airbrushed to perfection, for, according to Tebbel (2000), “perfection of face and body is what women are taught to associate with success” (p.116).

Beauty, though subjective, is however more than simply a matter of aesthetics or taste. The notion that women cultivate their appearance chiefly in regard to men’s preferences may be an oversimplification because this explanation overlooks other social and symbolic aspects of physical form (Fallon & Rozin, 1985). Cultural ideals of beauty are also an index and expression of social values and beliefs, so that, according to Jury and Jury (1986), the history of society is to a large degree the history of women’s beauty. According to Reischer and Koo (2004), the body may be viewed metaphorically as a text that can be ‘read’ as a symbol or signifier of the social world that it inhabits. The ‘texts’ upon which social meanings are inscribed are, however, generally only understood by those within the same culture (Reischer & Koo, 2004). In the Western culture, for instance, witches are understood to be ugly, while gentle maidens are ever beautiful (Arthurs & Grimshaw, 1999). Bordo (1993) argues that, “the firm, developed body has become a symbol of correct attitude,” suggesting “willpower, energy, control over infantile impulses, the ability to shape your life” (p.195). The size and shape of one’s body has therefore come to signify the moral state of the individual. A flabby, fat body, however, has come to symbolise a lack of self-control and laziness (Lips, 2003; Wiese, Wilson, Jones & Neises, 1992). Developing and displaying an ideal body type thus signals one’s cooperative participation in a culturally meaningful system of values (Reischer & Koo, 2004).

The Westernised slender body ideal symbolises not only an aesthetic ideal, but also the internal discipline that may be necessary to achieve it. As many critics have observed, the desire to demonstrate such discipline has manifested itself in the remarkable rise of eating disorders in recent decades (Bordo, 1993; Callaghan, 1994; Chernin, 1981; Nichter & Nichter, 1991; Wolf, 1991). The thin body has also come to

symbolise power and position. It has been shown that women who are fuller-figured are more likely to be excluded from social events at work, passed over for promotion, and are less likely to be selected as a representative for their organization or company. An 8-year study by Gortmaker (1993), of more than 10 000 people, showed that fat women were more likely than other women to lose socio-economic status. This finding was independent of the status and income of the women's family of origin and independent of the scores they acquired on achievement tests taken when they were adolescents. The overweight women were less likely to marry, had household incomes that were lower and were 10 percent and more likely to be living in poverty. Wolf (1991) asserts that beauty is not merely a desirable asset but a "legitimate and necessary qualification for a women's rise in power" (p. 28). Through a rigorous reshaping of the body and a constant vigilance against the noticeable and ultimately unavoidable effects of aging, women might attain the beauty upon which their professional success depends.

But the body as a symbol is not understood in the same way by all cultures. Traditionally, for instance, the African culture has upheld the fuller-figure women as being desirable and one symbolising wealth (Seed, Olivier & Smit, 2002). Developing societies often link being fat with beauty. The Hima people of Uganda have traditionally linked fatness with beauty and prepared young women for marriage by fattening them up (Tiffany, 1982). As many of these cultures become more westernised, however, research indicates that they begin to adopt the body symbols held by those within the western culture (American Psychiatric Association, 2003). A recent study of South African Zulu women reported an increase in eating disorders and body dissatisfaction, something not noted within the Zulu culture until 1995. It was pointed out that there was a discrepancy between the traditional female shape and how the girls feel they need to look now. They reportedly felt a need to look thinner in order to be fashionable and to be attractive to men (Seed, Olivier & Smit, 2002).

Body dissatisfaction is regarded by many as the single strongest predictor of eating disorder symptomology (Caradas, Lambert & Charlton, 2001; Cooper & Fairburn, 1993; Ricciardelli & McCabe, 2003; Vervaet & Van Heeringen, 2000). The majority of women do not 'fit' the current Westernised body ideal that is represented by the young, white, thin woman who is supposedly self-controlled, successful and married. As the body is one area available to female control (Lawrence, 1979), the pursuit of this body ideal, though at times unrealistic, sees practices like dieting and self-

starvation becoming common place in the lives of women. Dieting is regarded as a precipitating factor in the development of eating disorders (Wadden, 2004).

3.4.3. Discourse of Healthism

The thinner body ideal of the 1960s has been linked to the 1959 publication of the Metropolitan Life Insurance Company tables of ideal healthy weights, and to the publication in the 1950's, of the first empirical studies to report a benefit of decreased mortality with weight loss (Williamson & Pamuck, 1993). The subsequent campaign by the health professionals is considered to have played a key role in creating Western culture's contemporary distain for body fat (Rothblum, 1994). The argument that fat is unhealthy began, therefore, well before the pages of the fashion magazines became choked with pictures of emaciated models and words of 'experts' on how to lose weight (Fallon, Katzman & Wooley, 1994). While the 'war on obesity' declared and waged by the medical establishment cannot be fully blamed for the thin images of women that graced the pages of such magazines, it did however prepare the ground for what followed by initiating a discourse on dieting (Fallon, Katzman & Wooley, 1994).

Through the development of the Metropolitan Life Insurance Company tables, and the subsequent Body Mass Index (BMI) calculations, the health industry embraced the questionable concept of 'ideal weight', that is, the idea that the weight associated with optimum health and longevity could be determined by height. It was therefore deemed that every one of the same height and bone structure should meet this ideal. The obvious corollary was that everyone should reduce to their ideal weight and that everyone could do so easily if they exerted enough willpower (Fallon, Katzman & Wooley, 1994). In short, these decrees blamed the person; if you were fat, it was your fault. This fuelled prejudices against fat and has allowed the thinness mania to spiral into mammoth proportions (Fallon, Katzman & Wooley, 1994).

Along with diets, the fitness industry has exploded during the last fifteen years or so. Health clubs, gyms, exercise classes and the availability of personalised exercise training are now routine features of popular culture. Publications of magazines devoted exclusively to exercise and fitness have proliferated, with photographs of 'ideal' male and female bodies on the covers (Arthurs & Grimshaw, 1999). Discourses of health, fitness and beauty have become scarcely separable from each other. The body which is most commonly coded for sexual attractiveness is the 'fit'

body – "toned, lightly muscled and gleaming" (Arthurs & Grimshaw, 1999, p.5). Classes and gyms offer to male and female participants a vision of attaining this fit body, one that is slim, taut and well-toned. These exercise practices are legitimised by the reference to notions of 'health'. The kinds of health benefits invoked by these practices include benefits to the cardio-vascular system and increased stamina and suppleness. Exercise, it is also claimed, increases energy and vitality, improves the quality of life, and enhances self-esteem (Arthurs & Grimshaw, 1999).

Moya Lloyd (1996) has suggested, however, that while aerobics is commonly coded as 'healthy' and concerned with 'fitness', it inhabits contradictory and competing discursive spaces. While the 'healthy' aerobically exercised body might be opposed to the unhealthy and pathologically starved body of the anorexic or bulimic, Lloyd (1996) suggests that aerobics shares with anorexia nervosa and bulimia nervosa an aversion to flesh and to fat. The connections between aerobics and body shape involve a notion of an 'ideal body', and particularly a body that is not fat. Much of the publicity surrounding exercise and working-out is oriented around notions of fat, fat-burning or fat-busting. Fat is always inscribed negatively, especially if it is on the stomach, hips and thighs. Lloyd (1996) argues that underlying all the competing discourses within which aerobics are framed, is the overarching imperative that women be slim.

Grimshaw (cited in Arthurs & Grimshaw, 1999), in summarising the main elements of recent feminist critiques on the discourses of exercise and fitness for women, suggests the following messages:

1. It hails the youthful body, and reinforces in women a panicky desire to hang on to the youthful body as long as possible.
2. It idealises the thin or hard body, seeing any female softness or fleshiness as disgusting 'flab' which has to be worked off. Lean and muscled hips, thighs and arms should ideally be complemented by rounded breasts, not visibly damaged by the ravages of time or childrearing.
3. It destroys the 'unity' of the body. The body is broken into 'parts' which have to be worked on, e.g. thighs, buttocks, etc.
4. It is premised on the illusionary attempt to imagine that in the end, the body can be controlled and the processes of aging defeated.
5. It suggests that controlling the body somehow means that one's life is in control.

6. It epitomises the need, in a capitalist and consumerist society, for the presentation of self to be constantly worked on. What matters above all is how one looks. And although there is evidence that men are becoming increasingly aware of appearance, issues concerning how one looks are still heavily gendered.

Not all theorists, however, support the view that that being thinner is healthier than being fat. Various authors have suggested alternative views. According to Fallon, Katzman and Wooley (1994), in recent years, more and more evidence is emerging that discredits the theory that the thinner are healthier and fitter. Andres, Muller and Sorkin, (1993) suggests that the thin body is at risk for increased morbidity and mortality. An analysis of epidemiological studies finds that long-term weight loss (non-disease related), as well as excessive weight gains, are associated with the highest mortality rates (Andres, Muller & Sorkin, 1993). Singh and Lindsted (1998), for example, found that weight loss increased the risk of fatal respiratory disease in non-smoking women. Thinness does not appear to provide the mortality benefit for diabetic females that average-weight status does (Ross, Langer & Barett-Connor, 1997); and, in adolescents, being underweight is associated with lung disorders, scoliosis and intestinal conditions (Lusky, Burell, Lubin, Kaplin, Layani, Shohat, Lev & Weigner, 1996). As Frisch (1985) indicates, the regulation of menstruation and ovulation is dependent on a critical ratio of body fat to lean muscle; an excessive loss of body fat (10% to 15% of body weight) severely compromises fertility, successful pregnancy, and lactation. In addition to reproductive complications, low body fat and low weight predict more sickness and lower work capacity (James, 1994).

There are also adverse psychological effects associated with both weight loss and weight-loss attempts in normal-weight females. The body weight concerns of adolescent girls are commonly associated with depression (Rierdan & Koff, 1997). Adolescent and college-age females represent specific risk groups as their concerns about body fat and weight compete with the biological reality that increased deposits of fatty tissue at key developmental junctures signals biological health (Owen & Laurel-Seller, 2000). Our fundamental belief that people can exercise absolute control over their body weight is also flawed. Numerous studies demonstrate that the majority of the ‘fat’ cannot be slimmed down permanently. The problem is not the overweight individual’s lack of willpower, but the unreasonable expectation placed on them to weigh a certain amount (Fallon, Katzman & Wooley, 1994).

3.4.4. Discourse of Schooling

Both Winslade and Monk (1999) and Caradas, Lambert and Charlton (2001) refer of a discourse of schooling that has its own distinctive language. This distinctive language uses words to describe people that are seldom uttered anywhere else. Words such as bright, average, slow, gifted, hardworking, lazy, delinquent, teacher's pet, disruptive, bully and class clown, to name but a few, are all descriptions involved with some kind of evaluation or assessment of the person within the school context. Behind each evaluation lies an implicit standard of normality against which the measurement is made (Winslade & Monk, 1999). Learners within a school are subject to a range of institutional discourses offering knowledge about approved ways to be, in terms of their behaviour, their learning and educator-learner relationships (Baxtor, 2003). These standards often remain hidden; the cultural and social biases built into accepted standards of normality are seldom, if ever, open to question (Winslade & Monk, 1999).

Evans, Rich and Holroyd (2004) refer to two specific standards that pervade the culture of schools, that is "body perfection codes" (p.129) and "performance codes" (p.131). The term code is used by Evans, Rich and Holroyd (2004, p.127) to "trace connections between language, culture and consciousness, to connect social processes outside and inside schools; to explore how the distribution of power and principles of control in society translate into pedagogic codes and modalities in schools; and thereafter, how these codes and their modalities are acquired, shape pedagogic consciousness and … are embodied". Performance codes are understood to be reflected through the intensification of schoolwork, the increasing pressure wrought by examinations, assessment, expectations for achieving high grades, and achievement in sport. Those who perform in a school context are rewarded and praised; those who do not are corrected and helped in order to achieve. Thus performance becomes an expectation for all those within the context of school. Words of evaluation, such as lazy, hardworking, bright, average, etc, are used to describe those who either achieve or do not.

While not all words of definition are internalised, it is important to take note of the power imbalance that exists between the educator and the learner. What the educator says carries more weight than what the learners says. The authority of the educator capitalizes on the knowledge that the learner knows that the educator has the power to direct many day-to-day aspects of a learner's life in school. The accumulated

knowledge on which the educator's professional role is based lends further authority to the descriptions they deploy. Therefore, educators' descriptions of young people are difficult to resist (Winslade & Monk, 1999). Michel Foucault (1973, p.108) referred to "the gaze" as the requirement to subject ourselves to a comparative and evaluative scrutiny through which we learn to see ourselves, not through our own experience, but through the eyes of this scrutiny. As learners go through school, they are faced with being evaluated according to their performance on a number of levels. Even when the evaluation of the educator is no longer around, the learners learn to see themselves through the eyes of this scrutiny. In this way, learner's identities, even outside the context of school, come to be shaped through their level of performance, the truth of these statements being difficult to question. Garfinkel and Gardner (1982) make reference to performance expectations as being important cultural components influencing disordered eating in young women. Certainly not all learners who are positioned within the discourse of schooling and the discourse of achievement develop eating disorders. For the vulnerable few, however, the need to achieve may coincide with other problematic features of their lives and may reinforce certain ways of being and deficiencies that are already experienced (Evans, Rich & Holroyd, 2004).

Perfection codes are understood to be expressed through a culture of 'heathism' in schools. These perfection codes are not always transmitted obviously, but are mediated by educators, learners and peers in subtle and incidental ways. Perfection codes are transmitted indirectly, albeit in good faith, through what Evans, Rich and Holroyd (2004) refers to as an "obesity discourse" (p.133) that is featured in the Physical Education and Health curricula of schools. The pedagogies of these learning areas are seen to allude to a narrow perception of health as a human condition, as an achieved outcome of eating the 'right foods, 'exercising' and achieving the 'right size', thus reinforcing and even endorsing societal pressures and discourses. The pressure to achieve the right body size or shape is not simply understood as being healthy but also carries moral characterisations of the obese or overweight as lazy, self-indulgent and greedy (Gordon, 2000). The slim body, on the other hand, is understood as a way of demonstrating self-control, autonomy, individuality and achieving recognition by others as the end product of disciplinary restraint. In effect, the body becomes an outward marker of 'value' in a consumer culture reflected in schools (Bordo, 1993). While not wanting to blame schools and educators for the

development of eating disorders in the young women within their care, Evans, Rich and Holroyd (2004, p.138) believe that the conditions of schooling cannot be ignored as they are "coincident contributory factors" in the development of eating disorders rather than playing an active role in prevention.

But not all discourses are institutionally regulated. Competing or resistant discourses will also be constituted by peer value systems and will partly govern peer identities and relationships both in and out of the classroom. These discourses will be interwoven with broader societal discourses of age, gender, ethnicity, class and the like. The female learner, for instance, may be subject to various competing discourses within the school context offering sets of positions relating to her age, gender and ethnicity and so on, as well as her participation as a learner and membership of a peer group (Baxtor, 2003).

Gender differentiation is seen to be deeply embedded within the structures of classroom discursive practice. This is manifest, for example, in the rules of social engagement between boys and girls, in their styles of speaking and listening, in small group and whole class dynamics and in educator-learner relationships (Pilcher & Whelehan, 2004). We cannot assume, however, that there is simply one discourse determining gender within the classroom. There may be dominant discourses constructing stereotypical assumptions about masculinity and femininity, but there may also be resistant or oppositional discourses advocating, for example, gender diversity, inclusion or separatism. Discourses of gender will therefore be competing with other institutionalised or less formalised discourses within the classroom, such as discourses constituting peer or educator approval; discourses of performance and perfectionism; discipline and punishment; or models of teaching and learning. Such discourses do not operate in discrete isolation from each other but are likely to be interwoven with and infused by traces of the others (Baxtor, 2003). All these discourses are founded at a deeper level by a gender differentiation within our culture.

For adolescents, the role of identity formation is crucial. The related construction of peer-approved gendered identity is likely to be a critical factor in gaining social acceptance. Thus, Pilcher and Whelhan (2004) believe that it is a brave or eccentric young person who is able to resist our culture's prevailing norms of masculinity or femininity that are possibly being reinforced within the context of their schools. The norms of femininity, of being submissive and dependent for example, are understood by feminists as being central to the eating disordered woman's struggle for autonomy

and independence (Lawrence, 1979). Thus, through the advocacy of dominant gendered stereotypes, schools may very well be advocating that which lays foundation to the development of eating disorders.

Educators are important socialising agents for the learners within their care (Smolak, Harris & Levine, 2001). As there are various discourses operating within the classroom at the same time, and due to the power imbalance between the educator and learner, the educator can play an influential role in preferencing certain discourses over others. In this way the educator can act either as a buffer to dominant societal discourses of performance, perfectionism, healthism and gender differentiation, discourses that are seen to produce vulnerability to eating disorders, or can act to reinforce such discourses (Piran, 1997).

3.5. Conclusion

While these dominant discourses have the potential to powerfully shape the way women view themselves, their bodies and their relationships, it is important to note that women can both recognise these discourses at work, and at times resist the normative pressures of such discourses. Women are not powerless in resisting being subjected to the practices and expectations of such things as gender, fashion, fitness and beauty. The social and historical constitution of the subject is not a limit on women's agency, but is a precondition for understanding the possibilities for action and change (Baxtor, 2003). If not aware of the effects of such practices on their lives and on their relationships with others it would be difficult to take a position outside of these dominant discourses of our society.

In the context of this research, it would be of vital importance for female educators to be aware not only of the discourses affecting the lives of their learners, but also of those potentially affecting their views and experiences of themselves, particularly in light of the power imbalance existing between them and the learners within their care. The chapter to follow will explore the role of educators and schools in the prevention of eating disorders in young individuals. It will be suggested that these educators do not only play a role in the dissemination of knowledge within the school context, but act as socialising agents as well. It is for this reason that awareness is required of the dominant societal discourses that may be prominent in their personal lives and within the life of their school.

CHAPTER 4
THE PREVENTION OF EATING DISORDERS WITHIN THE SCHOOL CONTEXT

"Education is like a double-edged sword.
It may be turned to dangerous uses
if not properly handled"
-Wu Ting-Fang-

4.1. Schools as Useful Sites for Early Identification and Prevention

According to O'Dea (2000), the primary prevention of eating and body image problems among young people, and in particular, adolescents, is emerging as one of the most desirable achievements in contemporary health and nutrition education. If eating disorders are to be prevented, however, intervention needs to occur before the relevant behaviours and attitudes start becoming unhealthy (Russel & Ryder, 2001(b)). Eating disorders have a reputation for being difficult to treat. The chances of a complete recovery increase, however, if disordered eating habits can be identified and treated in their early stages (Anderson, 1995).

As discussed in Chapters 2 and 3, eating disorders occur predominantly among females and usually have their beginnings in the teenage years. Puberty and adolescence are critical and challenging times for young people (O'Dea & Abraham, 1999) during which they begin to establish an individual identity outside the family unit (Berk, 1999). Physical appearance becomes a major factor in the establishment of their personal identity and there is widespread desire to be liked and accepted by the same and opposite sex peers. While puberty for males is generally considered to be positive as their normative growth spurt is consistent with the cultural ideal for masculinity, the physical changes experienced by girls during puberty may factor into the increased prevalence of body dissatisfaction and weight management behaviours in females (Ricciardelli & McCabe, 2001). The normative 'fat spurt' and accumulation of fat that is associated with puberty in girls may exacerbate the drive to lose weight as it is in direct contradiction to the dominant discourse of body ideal for females as outlined in section 3.4.2. Girls at this stage are therefore particularly at risk of developing low self-esteem and dissatisfaction with body shape and weight (O'Dea & Abraham, 1999). According to Friedmann (1998), 80% of 10- and 11-year-old girls are convinced that they should be thinner. This body dissatisfaction may lead the

young adolescent to engage in dangerous weight management techniques (Brookes-Gunn & Warner, 1988). Phelps, Andrea and Rizzo (1994) report that over one third of adolescent females engage in aggressive weight control practices such as chronic dieting, excessive exercise, self-induced vomiting, and abuse of laxatives, diet aids and water pills .

With the changes in physical development, the onset of puberty, peer focus, and the task of identity formation, the development of a healthy body image is an important factor for adolescents (Mussel, Binford & Fulkerson, 2000). Because body dissatisfaction is the single strongest predictor of eating disorder symptomology (Caradas, Lambert & Charlton, 2001; Cooper & Fairburn, 1993; Ricciardelli & McCabe, 2003; Vervaet & Van Heeringen, 2000), body dissatisfaction during puberty may predispose the adolescent to develop eating problems in middle to late adolescence (Attie & Brooks-Gunn, 1989). Understanding the physical changes of puberty and the associated behaviours that adolescents exhibit are therefore essential for those involved in adolescents every day lives (Akos & Levitt, 2002).

Schools are seen to be particularly useful sites for the implementation of prevention programmes because they offer a relatively easy way to reach large groups of children and adolescents as they spend an average of 40 hours per week in school (Smolak, Harris, & Levine, 2001). Educators can have a significant impact on eating disorder prevention and are seen as indispensable in the early identification of eating disorders as they are in a unique position to detect changing attitudes around food, weight and body shape (Falkenhagen, 2004; Russel & Ryder, 2001(b)). In addition, schools comprise the first experience for children of attending large scale organised institutions, institutions that inevitably transmit ideals and ways of being, sanctioned by dominant societal discourses (Piran, 2004). Educators and school administrators are crucial socialization agents as they are at the forefront conveying, from a position of power and through direct and indirect ways, these dominant societal discourses including critical information, values, norms, and other culturally laden material (Piran, 2004; Smolak, Harris & Levine, 2001). As role models, they can either serve to reinforce or buffer the negative societal messages endorsed by dominant discourses that bombard young people (Piran, 1997).

4.2. School Based Intervention Programmes

Since 1986 there have been over 40 American studies of eating disorder prevention programmes. Most of these prevention programmes were school-based and the majority involved at least some classroom type lessons or discussions.

In light of the fact that most prevention programmes involve the dissemination of knowledge in the form of classroom instruction, one might start by taking a brief look at how knowledge is disseminated. One view of teaching, endorsed explicitly by most traditional institutions, is that it is simply the transmission of some existing body of knowledge. This knowledge is viewed, however, as consisting of a reservoir of interrelated concepts that concern various aspects of our environment, which for some reason are in the forefront of the culture (Hasan, 1995). Official education can be essentially seen as a moral activity that articulates the dominant ideology/ies of dominant groups. Knowledge, we could therefore suggest, is not just a grouping of pure facts, but is always embedded, reflecting and perhaps reinforcing a cultural discourse. In the dissemination of this knowledge, Hasan (1995) asserts that an educator's way of saying and meaning is never independent of their social positioning (Hasan, 1995). Thus, knowledge and culture can never be seen as completely separate, and the dissemination of it never completely separate from the value position of the educator.

The famous Russian scholar, Luria (1976), spoke of two ways in which people acquire knowledge, with experience on the one hand, by which he meant learning through everyday life, and systematic instruction or more complex forms of communication on the other hand. While this distinction is recognised for the purpose of analysis, it does not seem justifiable to believe that, for learners who are positioned within social and cultural systems, the two ways of learning could remain compartmentalised, each having a separate existence from the other. According to Luria (1976), experience of everyday living will colour the meanings in systematic instruction. In this way, not all learners will learn the same thing from a discourse. The fact that the educator's discourse is materially available to all learners alike does not mean that they all necessarily engage with the discourse in the same way. What the message will be to whom, and what will or will not appear relevant, will be determined according to the social identity of the hearer. Receiving information is thus not a passive process. Meaning is refracted through the experience of one's social

location. Thus a given instance of systematic instruction may in fact not be the same for children coming from different social locations (Hasan, 1995).

In designing programmes aimed at the prevention of eating disorders it would be important, in light of the above, to consider that the knowledge being disseminated not only reflects and even endorses certain sanctioned societal values held by the educator, but is received by individuals with a variety of experiences through which the knowledge will be coloured and meaning will be acquired. The meaning acquired is therefore not always the meaning intended.

While school-based health education programmes that are properly planned and evaluated can, according to O'Dea and Maloney (2000) have a positive and lasting impact on body image, eating behaviours, attitudes, and self-image of adolescents, there have been calls for caution in the design and implementation of such school-based eating disorder curricula. Research suggests that school educators and other educators may inadvertently do more harm than good when attempting to educate susceptible adolescents about the perils of dieting and the pursuit of the ideal body (O'Dea & Abraham, 2001). For instance, school-based programmes may treat food and nutrition issues negatively by referring to good foods, bad foods, and junk foods. The negative focus may contribute to an underlying fear of food, dietary fat, and weight gain, which may precipitate eating problems (O'Dea & Maloney, 2000). The widespread obsession with food, dieting and weight loss that typifies the experience of many have led health educators to ask the question, "have messages about healthy eating been 'read' by girls and women (and some boys) as meaning that they should lose weight, thus adding to the pressure to be slimmer, which they face already?" (Dixey, 1998, p.32). As stated earlier, the message that is intended by the educator is not always the message received by the learner. The meaning that is actively acquired by the learner is likely to be consistent with dominant cultural discourses involving anti-fat messages.

Whilst the use of the school as a setting within which to tackle the health issues of young people is to be welcomed, there is little existing research evidence which indicates whether the messages received by children in schools about healthy body weight and healthy eating reinforce or reduce unhealthy dieting and preoccupation with the body. In a study conducted by Evans, Rich and Holroyd (2004), evidence was found to suggest that the messages that the young women within their study were hearing in health education was that "*they* are to *take control* of their health by

making ‘healthy choices’, particularly in relation to diet, where schools were teaching them what was ‘good’ (i.e. fruit and vegetables) and ‘bad’ (i.e. fat-laden foods)” (p.135). One learner within the study commented that she “honestly thought that she was just being healthy by cutting out fat entirely” and noted that this was how her eating disorder started (p.135). It is suggested therefore that care be taken in the selection of images used in nutrition education, so that the idea of healthy eating is primarily about eating a balance of foods and not about being too fat (Dixey, 1998).

Various studies (Carter, Stewart, Dunn & Fairburn, 1997; Mann, Nolen-Hoeksema, Huang, Burgard, Wright & Hanson, 1997; Russell & Ryder, 2001(b)) have indicated that school-based education programmes that provide information about eating disorders may increase participants’ knowledge and symptoms of eating disorders such as dietary restraint and purging. Prevention programmes that focus upon the use of case studies such as media reports, discussions led by recovered peers, or drama activities about sufferers of eating disorders, have been found to be counter productive. While these methods are often used in order to highlight the dangers of eating disorders, they in fact tend to reduce the stigma of these extreme disorders, inadvertently glamorising the problem. Popular media reports of eating disorders among the rich and famous, such as Princess Diana, are examples of this phenomenon. Frequent coverage of eating disorders in the media and in school lessons may also produce a sense of normalization of the problem, where children begin to believe that disordered eating practices such as starvation and vomiting are common and therefore appear to be normal and socially acceptable behaviours (O’Dea, 2000).

A review of the most effective eating disorder prevention programmes to date suggests that school-based interventions are most effective and safe if they avoid direct instruction about eating disorders and employ self-esteem development (O’Dea & Maloney, 2000; Vandereycken & Noordenbos, 1998). According to Robert-McComb (2001), educational strategies in the prevention of eating disorders need to be multifaceted and emphasize a wide range of components including: (a) the development of positive self-esteem, self-efficacy, and a healthy body image; (b) the development of important life skills, including personal skills, social skills and coping skills; (c) promotion of experiences that encourage self-confidence and independence; (d) education about the importance of balanced nutrition and physical activity to health and wellness; (e) opportunities to challenge sociocultural myths and attributes

regarding body shape and size and gender roles; and (f) activities that promote change in unhealthy beliefs and practices regarding body weight regulation within the social milieu. According to Vaschenko (2005), educators should create a healthy and positive environment in the classroom in which all learners are treated equally regardless of size. It is seen as important to establish a zero tolerance policy against teasing about body size, glamorizing eating disorders and discussing weight loss.

In preventing eating and body image problems amongst adolescents, it is suggested that educators and other school and community personnel may require training to understand eating problems, training in effective and safe prevention strategies, and access to counselling and referral services (O'Dea, 2000). Three American surveys conducted with educators (Neumark-Sztainer, Story & Coller, 1999; Rayman & Piran, 2002; Smolak, Harris & Levine, 2001) regarding their role in the prevention of eating disorders demonstrated an expressed interest from educators to be provided with additional resources and information. Specifically, they expressed interest in training that allowed for more constructive interactions between educators and learners in areas such as body image, role modelling, peer teasing, and school policies and also prevention material that is integrated into the curriculum. In addition, these educators expressed a need for assistance in knowing how to help a learner who appeared to have developed an eating disorder.

4.3. School Educators as Socializing Agents

As discussed in Chapter 3, it has been suggested that one of the strongest sociocultural factors influencing young girls and woman today is the western beauty ideal, in which fatness is stigmatised and thinness is praised (Rodin, Silberstein & Streigel-Moore, 1984). Worldwide media exposure to Westernised cultural ideals is a powerful force in shaping public perceptions regarding the value of thinness (Nasser, 1994; Thompson & Heinberg, 1999). Haworth-Hoeppner (2000) indicates, however, that while all women are exposed to cultural standards of beauty, not all women develop eating disorders. It is suggested that, although culture plays an important role in the development of eating disorders, the values of these dominant cultural discourses are mediated through groups such as the family, schools and peers (Evans, Rich & Holroyd, 2004; Simpson, 2002). According to Simpson (2002), the cultural messages conveyed by social groups may result in the internalisation of media imagery particularly when it contains information on the means of achieving the ideal

body shape, e.g. fasting and over-exercise (Simpson, 2002). Role models can, therefore, serve either to reinforce or buffer the negative societal messages that bombard youth (Piran, 1997).

It is seen as imperative, therefore, to include the role models involved in the lives of children when addressing eating disorders (Russel & Ryder, 2001(b)). While educators are in a unique position to act as positive role models and mediate the messages given by the media regarding body image, health and nutrition, we have little understanding of whether educators are in fact appropriate role models (O'Dea & Abraham, 2001). According to Loewy (1998, cited in Akos & Lewitt, 2002, p.3), "it is not only peers who endorse prejudicial attitudes with regards to fat children, but also parents, teachers, and school counsellors". Weightism is seen as a pervasive social prejudice regarding people of heavier weight and about body fat (Steiner-Adair & Purcell Vorenberg, 1999). An educator's ability to establish non-weightist norms within the classroom depends a great deal on their own prejudicial attitude (Piran, 2004). O'Dea (2000) suggests that educators, as with other women, are likely to possess a degree of normative discontent with their body shape and size; and this common concern and dissatisfaction with weight, shape, and body composition and negative beliefs about food may be unknowingly transferred to the young women and learners in their care. Similarly, those educators with un-informed views of what constitutes a normal body weight or normal percentage of body fat in male or female adolescents may transfer incorrect and unhelpful anti-fat messages to young people (O'Dea, 2000).

According to Akos and Levitt (2002), therefore, it is incumbent upon those who promote healthy body image in the school environment to consider their own attitudes and behaviours about body image. Influential adults in learners' lives should have an awareness of self that allows them to avoid inadvertently projecting body dissatisfaction onto learners in their homes, communities and schools. The attitudes endorsed and portrayed by key personnel are critical in building healthy body image in learners. While educators, as women, are certainly not immune to the influences of dominant societal views, O'Dea and Abraham (2001) argue that, as role models for learners, it may be appropriate to expect educators to be better able to cope with body image and weight concerns than other women in the community. Piran (2004) suggests that educators deserve to have the opportunity to be exposed to a critical examination of the social forces that disrupt children's and adolescent's connections

to their bodies so that they can be able to provide alternative perspectives and experiences to their learners. Without awareness of the dominant societal discourses however, such as those discussed in Chapter 3, and their effects on shaping the beliefs and experiences of women and girls, educators will not be in a position to challenge such views or provide alternatives.

While the above mentioned discussion has covered the literature and research on eating disorder prevention and the role of educators in this regard on an international level, the current research study takes place within a South African context. It is therefore important to take a look at the education system within a South African context, and the role that educators are expected to play in eating disorder prevention in South African schools.

4.4. Curriculum Revision within South African Education

The delivery of education in South Africa before 1994 was dominated by the discriminatory policies of the apartheid government. All facets of education were arranged according to the dictates of the system of apartheid, so this meant that people from the different racial groups were provided for in terms of their racial identities (Botha, 2002). As a result of such policies, the minority White population benefited from sound education, delivered by competent well-trained educators in schools where both equipment and books were freely available. So-called Black schools, on the other hand, were largely characterised by an inadequate number of under-qualified teaching staff. These schools struggled with large educator/learner ratios, overcrowded classrooms, lack of equipment, books or paper, and were often without electricity, telephones, toilets or even running water. This obvious advantage of those within so-called White schools, along with other discriminatory laws, allowed minority sections of the population to advance economically, socially and educationally at the expense of majority Black populations (Elkonin, 1999). At the time when the majority elected government of the African National Congress came into power in 1994, education in South Africa was seen to be in crisis, characterised by, amongst other things, unequal educational opportunities, irrelevant curricula, and inadequately qualified teaching staff (Botha, 2002). Educational reform became an obvious priority.

With the inauguration of a new government came the adoption of a new constitution of the Republic of South Africa (Act 108 of 1996). This constitution aimed to:

1. Heal the divisions of the past and establish a society based on democratic values, social justice and fundamental human rights;
2. Improve the quality of life for all citizens and free the potential of each person;
3. Lay the foundations for a democratic and open society in which government is based on the will of the people and every citizen is equally protected by law;
4. Build a united and democratic South Africa able to take its rightful place as a sovereign state in the family of nations.

Education as whole and, in particular the curriculum taught in schools, was seen to play an important role in achieving these aims. Education was understood to be capable of shaping ideas regarding equality and democracy. It was therefore seen as an important focus area in the development of the 'New South Africa'.

On 24 March 1997, the South African Minster of Education, Minister Bengu, announced the launch of Curriculum 2005 in Parliament (Cross, Mungadi & Rouhani, 2002). The introduction of Curriculum 2005 marked a dramatic departure from the apartheid curriculum, and aimed to redress issues such as poverty, inequality, race, gender, age, disability and challenges such as HIV/AIDS. It also represented a paradigm shift from content-based teaching and learning to an outcome based one (Cross, Mungadi & Rouhani, 2002). Outcomes Based Education, or OBE, as a model was chosen as the most likely to address the crisis in South African education. As a method of reform, OBE promised to improve the quality of education in South Africa and in so doing, enable all learners to achieve their maximum ability. It encouraged a learner-centered and activity based approach to education and varied from the traditional models of teaching by outlining the outcomes to be achieved by the learners at the beginning of the process. The curriculum aimed at creating an "awareness of the relationship between social justice, human rights, a healthy environment and inclusivity" (Department of Education, 2002, p.2). Learners were encouraged to develop knowledge and understanding of the rich diversity of South Africa, including the cultural, religious and ethnic components of this diversity (Department of Education, 2002).

The introduction and implementation of Curriculum 2005 within the South African context did not come, however, without negative reactions from South African

communities, educationists, teachers and the press. Many citizens, educators and politicians saw this legislation as one of the most controversial changes within education in the history of South Africa (Botha, 2002). Shortcomings have been noted on both the conceptual and process levels. Most noteworthy in the context of the current research, involves the lack of alignment between curriculum development, educator development, and selection and supply of learning materials (Potenza & Monyokolo, 1999). Curriculum 2005 was implemented within a context of inequality. According to Jansen and Christie (1999), the desired impact of OBE cannot be expected to be equal when being implemented in unequal conditions. "Due to the legacy of apartheid, many of the historically Black schools are under-resourced and their educators under-trained. These schools lack the capacity to implement the OBE model successfully" (Singh, 2000, p.108). The procedures for developing any such learning programme are deemed complex and hence there is a need for better educators. Many educators, however, are inadequately prepared for basic teaching, let alone comprehending the new curriculum (Cross, Mungadi & Rouhani, 2002). Left to their own devices, learners will often struggle to succeed if not assisted by a dedicated and competent educators (Botha, 2002). The implementation of Curriculum 2005 therefore favours well-resourced schools with well-qualified educators (Cross, Mungadi & Rouhani, 2002).

Curriculum 2005 is seen to focus too much on outcomes. In so doing, it has neglected issues of content, which has been left to individual educators to construct (Cross, Mungadi & Rouhani, 2002). While this provides educators with a large degree of freedom to select content and methods through which their learners will achieve those outcomes (Botha, 2002), given the poor training of educators and lack of resources, the majority of educators have found it difficult to know what content to teach. Knowledge in the classroom has therefore been reduced to the constructs that educators and learners individually bring into the classroom, i.e. personal knowledge embedded in personal experience, or just a product of classroom interaction through some form of progressive pedagogy, i.e. group work, integrated studies, etc (Cross Mungadi & Rouhani, 2002). Observations of the implementation of OBE in classrooms concluded that, many of the activities that children were involved with, involved them sitting in groups and talking about their everyday experiences, often with little or no conceptual content or direction. It was also noted that books were rarely used in the classes observed (Taylor, 2000).

The successful implementation of OBE in South Africa places enormous demands on educators, and in particular, on educator's personal knowledge and attitudes when steering learners towards pre-set goals or outcomes (Botha, 2002; Muller, 2000). The educator thus remains the key person who can maintain efficiency and effectiveness (Botha, 2002).

The justification for the implementation of OBE in South Africa is noteworthy. Its value remains unquestionable (Cross, Mungadi & Rouhani, 2002). The reality is, however, that there are some major problems with the implementation process of the new curriculum in South Africa. The inadequate training of educators to teach in an outcomes-based manner and the lack of financial resources to train these educators efficiently and effectively is probably the most important of these problems (Chrisholm, 2000). According to Botha (2002, p.13), "outcomes based education will flounder if there is not appropriate high quality staff development and the provision of sufficient support".

4.5. The Role of the Life Orientation Educators

The advent of Curriculum 2005 initiated the development of eight new Learning Areas. These were regarded as a way of breaking away from strict boundaries between traditional school subjects and a way to ensure integration within and across the different disciplines (Cross, Mungadi & Rouhani, 2002). Life Orientation (LO) is one of the above mentioned eight new Learning Areas. While OBE is currently only taught from grades R to 9, 2006 will see the progressive introduction of OBE up until grade 12 in the year 2008. Life Orientation will at this stage be compulsory for all learners in all grades.

According to the Revised National Curriculum Statement Grades R-9 Policy (Department of Education, 2002), Life Orientation is central to the holistic development of learners and is "concerned with the social, personal, intellectual, emotional and physical growth of learners, and with the way in which these facets are interrelated" (p.4). It is seen to develop skills, knowledge, values and attitudes that empower learners to make informed decisions and take appropriate actions. The Learning Area's vision of individual growth is seen as part of an effort to create a democratic society, a productive economy and an improved quality of life (Department of Education, 2002).

The Revised National Curriculum Statement Grades R-9 Policy (Department of Education, 2002, p.3) outlines the type of educator that is envisaged for those involved in the teaching of the new national curriculum, i.e.

> All teachers and other educators are key contributors to the transformation of education in South Africa. This Revised National Curriculum Statement Grades R-9 (Schools) envisions teachers who are qualified, competent, dedicated and caring. They will be able to fulfil the various roles outlined in the Norms and Standards for Educators. These include being mediators of learning, interpreters and designers of Learning Programmes and materials, leaders, administrators and managers, scholars, researchers and lifelong learners, community members, citizens and pastors, assessors and Learning Area or Phase specialists.

From the statement above it becomes evident that there is much expectation placed on the shoulders of these educators to, not only be competent in their Learning Area, but to be specialists, leaders, researchers and lifelong learners of the material they teach. One must question as to the provision being made for the development of these educators in these ways.

The curriculum of Life Orientation is shaped by five focus areas. These focus areas are referred to as Learning Outcomes. These Learning Outcomes outline that which the learners are expected to achieve by the end of the assessment period. While the Learning Outcomes (LOs) remain more or less the same for grades R through to 9, the LOs are assessed by means of a number of Assessment Standards that become progressively more complex with each grade. The Learning Outcomes for Grades 7 to 9 are as follows:

Learning Outcome 1: Health Promotion: *The learner will be able to make informed decisions regarding personal, community and environmental health*.

> The Senior Phase learner is exposed to a wider range of risky situations. The health and safety issues encountered are still affected by the physical and socio-economic environment. The learner should acquire the skills to make informed choices. The learner needs to develop a healthy lifestyle, informed by environmental awareness and by other health and safety aspects. Lifestyle choices related to

> sexuality are crucial at this age and should be dealt with sensitively (Department of Education, 2002, p.37).

Learning Outcome 2: Social Development: *The learner will be able to demonstrate an understanding of and commitment to constitutional rights and responsibilities, and to show an understanding of diverse cultures and religions.*

> The Senior Phase learner is increasingly influenced by peers, while the family continues to play an important role. The learner is engaged in a variety of social activities and should be encouraged to participate in civic and human rights programmes. Knowledge of diverse cultures and religions will also contribute to the learner's own orientation in the world, an enable the making of informed decisions on human rights, social relationships and moral issues (Department of Education, 2002, p.38).

Learning Outcome 3: Personal Development: *The learner will be able to use acquired life skills to achieve and extend personal potential to respond effectively to challenges in his or her world.*

> Adolescence is marked by emotional and physical changes. The learner needs to continue the formation of a positive self-concept. Acceptance by the peer group is still very important. The learner needs opportunities to develop further life skills. It is necessary to develop emotional intelligence, to power the learner in order to cope with challenges (Department of Education, 2002, p.37)

Learning Outcome 4: Physical Development and Movement: *The learner will be able to demonstrate an understanding of, and participate in, activities that promote movement and physical development*.

> The Senior Phase learner is entering adolescence and experiences rapid physical change. The refinement of movement is aimed at developing precision and agility. These are to be emphasised in different situations. Life long participation in physical activities promoting fitness needs to be encouraged (Department of Education, 2002, p.38)

Learning Outcome 5: Orientation to the World of Work: *The learner will be able to make informed decisions about further study and career choices.*

> While study skills and work ethics are addressed in the earlier phases, in the Senior Phase the learner needs to make choices for further study or the world of work. In order to achieve this successfully, the learner needs a realistic understanding of own abilities, interests and aptitudes. The learner should be aware of various career options and implications of choices. The learner needs to be informed about a range of options for further study, and be oriented to the world of work (Department of Education, 2002, p.38).

From the above quotes one can clearly ascertain the scope of what is required to be taught by the Life Orientation educator of grades 7 to 9.

While there are many Assessment Standards set out within the Revised National Curriculum Statement Grades R-9 Policy (Department of Education, 2002) for each Learning Outcome, for the purposes of this study, the researcher has extracted just those Assessment Standards that are pertinent to the study, i.e., those that highlight the emphasis placed on health, body concept and diet within the Life Orientation curriculum. Examples include the following outcomes that learners should be able to demonstrate by the end of the year:

1. "Proposes ways to improve the nutritional value of own personal diet" (Grade 7, Assessment Standard, Learning Outcome 1) (Department of Education, 2002, p.40).
2. "Discusses the personal feelings, community norms, values and social pressures associated with sexuality" (Grade 7, Assessment Standard, Learning Outcome 1) (Department of Education, 2002, p.40).
3. "Describes what a healthy lifestyle is in own personal situation, as a way to prevent disease" (Grade 8, Assessment Standard, Learning Outcome 1) (Department of Education, 2002, p.41).
4. "Illustrates and evaluates the influence of ecological, social, economic, cultural and political factors on own personal choice of diet" (Grade 9, Assessment Standard, Learning Outcome 1) (Department of Education, 2002, p.41).
5. "Critically evaluates changes in cultural norms and values in relation to personal and community issues" (Grade 8, Assessment Standard, Learning Outcome 2) (Department of Education, 2002, p.43).

6. "Reports on the implementation of strategies to enhance own and other's self-image through positive actions" (Grade 7, Assessment Standard, Learning Outcome 3) (Department of Education, 2002, p.44).
7. "Evaluates media and other influences on personal lifestyle choices and proposes appropriate responses" (Grade 7, Assessment Standard, Learning Outcome 3) (Department of Education, 2002, p.44).
8. "Analyses and discusses factors which influence self-concept formation and self-motivation" (Grade 8, Assessment Standard, Learning Outcome 3) (Department of Education, 2002, p.45).
9. "Analyses and reflects on positive personal qualities in a range of contexts (Grade 9, Assessment Standard, Learning Outcome 3) (Department of Education, 2002, p.45).
10. "Responds appropriately to emotions in challenging situations (Grade 9, Assessment Standard, Learning Outcome 3) (Department of Education, 2002, p.45).
11. "Assesses own physical wellness level and sets personal goals for improvement (Grade 9, Assessment Standard, Learning Outcome 4) (Department of Education, 2002, p.47).

While the Assessment Standards do not specifically highlight the need to address eating disorders in the classroom, the learners are required to demonstrate 'appropriate' attitudes and knowledge with regards to diet and self concept, and are required to be able to place diet and self concept within ecological, social, economic, cultural and political contexts in order to analyse the effects of these. In order to competently achieve such outcomes, these learners would need to be guided by educators who have accurate personal knowledge on subject matter such as self-concept formation, physical wellness, healthy diet, and healthy lifestyle, and the effects of dominant social and cultural discourses on these concepts.

Certain Life Orientation textbooks, developed according to the National Curriculum Statement, have interpreted a need to teach specifically on eating disorders, and have devoted learning units to eating disorders. One such example is the Grade 9 Life Orientation text book edited by Panel (2003). The Grade 9 Common Tasks of Assessment (Department of Education, 2003), Section A, 2003, required the learners to describe symptoms of anorexia, to list possible causes of anorexia, and to highlight what treatment is required for anorexia, and why.

Thus, it becomes evident that the Life Orientation educator is expected not only to deal with health, diet, self-concept and body image, but is also required to give direct instruction with regards to eating disorders. This would therefore naturally require the Life Orientation educator to possess accurate and relevant knowledge regarding eating disorders, health, diet, self-concept formation and body image. Their position as the Life Orientation educator requires them to "empower learners" with regards to their "social, personal, intellectual, emotional and physical growth" (Department of Education, 2002, p.4). This places enormous pressure on the educators to act as positive socializing agents, thus requiring them to be role models of healthy attitudes and behaviours with regards to, amongst other things, body image and diet.

While international studies (O'Dea & Abraham, 2001; Price & Desmond, 1990; Smolak, Harris & Levine, 2001) have reflected varied findings with regards to the effectiveness of educators and school counsellors as prevention agents, the researcher could not locate any such South African study. While Life Orientation educators are being expected to play an important role in health promotion and prevention of eating disorders in South African schools, little is known as to their effectiveness within this role. As has been outlined within this chapter, these educators may do more harm than good when educating learners about healthy diet and eating disorders if unaware of effective teaching practices or if they possess incorrect knowledge. It is therefore imperative that these educators be provided with the support required to perform their roles effectively. As O'Dea and Abraham (2001, p.339) assert,

> teachers who are required to teach about weight control, eating disorders, and other body image issues need an accurate knowledge of eating disorders and weight issues from both a personal and a professional perspective. In order to teach about weight, body image, or eating disorder issues in the classroom, teachers need information and training to enable them to develop a good knowledge of food and nutrition as well as appropriate beliefs, attitudes, and behaviours related to body image, weight control, and eating disorders.

4.6. Conclusion

As discussed in Chapter 3, educators as women live within a society that endorses and legitimises certain ways of being and looking. When not actively aware of the

dominant discourses that shape many of their ideas of what it means to be healthy, beautiful and successful, it would be very difficult for these educators to question such ideals, the very ideals that create vulnerability in women to the development of eating disorders. Educators may therefore possess many of the unhealthy ideals and may in fact practise many of the unhealthy behaviours which they are supposed to discourage in their learners. Education within South Africa is currently undergoing a transition from the old apartheid driven curriculum to the new Outcomes Based curriculum. This transition, along with its new curriculum, has not come, however, without its own challenges, including a concern as to the qualification and preparedness of educators to accurately facilitate learning based on the new curriculum.

The assessment of the knowledge of Life Orientation educators with regards to eating disorders and its prevention, as well as an assessment of their attitudes and behaviour towards their own body image and weight control practices, is seen, therefore, as crucial. This is based on, amongst other factors, the potentiality of school-based eating disorder prevention programs doing more harm than good, the possibility of negative body attitudes being unwittingly transferred to the school learners in Life Orientation educator's care and the question surrounding the qualification and preparedness of South African Life Orientation educators to perform their roles effectively.

Before moving to the discussion of the methods used to conduct the present study, a review of the preceding chapters is deemed necessary.

In Chapter 2 a study of theory regarding eating disorders revealed that, while anorexia nervosa and bulimia nervosa are well publicised disorders, they are understood by some as extreme end products of a continuum of unhealthy eating behaviours and attitudes, many of which are endorsed by society. According to the eating disorder continuum men and women may be displaying dysfunctional eating patterns and attitudes that are not recognised as such and that may lead to the development of a diagnosable disorder.

Chapter 3 sought to highlight some of the societal discourses that create vulnerability in women to develop unhealthy eating behaviours and attitudes. It was noted that, due to the dominance of such discourses, most, if not all women found themselves positioned within such expectations. While it was shown that women

could resist such discourses, it was noted that being unaware of the effects of these could result in them being disempowered to take up new positions in relation to them.

Chapter 4 examined the effectiveness of eating disorder prevention programmes in schools. While these programmes had the potential to be of much value when well implemented, many researchers cautioned the introduction of such programmes in schools particularly by those with little knowledge regarding what to include and what to exclude in such programmes. As important role models in the lives of the learners, certain researchers also recommended the importance of allowing educators the opportunity to examine their own views on body ideals and healthy eating so as to prevent the endorsement of unhealthy views and attitudes. Included in this chapter was also a study of the changes within the structures of South African education. As those given the responsibility of guiding the learner's knowledge and attitudes surrounding healthy body concepts, diet and eating disorders, an examination of the role of the Life Orientation educators was included.

The conclusion was reached that, due to the lack of research into whether Life Orientation educators were in fact adequately trained to perform their roles effectively, and due to the importance of such roles in the lives of the learners within their care, an examination of the Life Orientation educator's knowledge, attitudes and behaviours with regards to eating disorders, diet and body concept was seen as vital.

The following chapter will outline the primary aims of the current research study and discuss the methodology that was used.

CHAPTER 5
RESEARCH METHODOLOGY

5.1. Introduction

The preceding four chapters have sought to lay a foundation and a rationale for the current research study. This chapter provides a description of the research design and methodology employed in this study. A description of the participants and sampling procedure is provided and a brief overview of the measures used to gather the data is included. Lastly, the process of the research and the data analysis of the study is explained.

5.2. Aims of the Study

The primary objective of the present study is, therefore, to explore and describe the knowledge, attitudes and behaviours related to eating disorders, body image and weight control of a group of female Life Orientation educators. More specifically, the study aims to:

1. Explore and describe the knowledge of Life Orientation educators with regards to eating disorders and healthy diet.
2. Explore and describe the attitudes held by Life Orientation educators with regards to their own body image.
3. Explore and describe the behaviour of Life Orientation educators with regards to eating habits, dieting and exercise.

5.3. Research Design

According to Thyer (1993), a research design can be described as being a "blueprint or detailed plan for how a research study is to be conducted – operationalising variables so they can be measured, selecting a sample of interest to study, collecting data to be used as a basis for testing hypotheses, and analysing the result" (p.94). As such, choosing an appropriate design is an integral part of any study and should be approached with care.

The current study makes use of a quantitative design. In social research, quantitative research is "a form of conclusive research involving large representative samples and fairly structured data collection procedures" (Struwig & Stead, 2001, p.4). An advantage of quantitative studies is that they allow the researcher to present

the multiplicity of the collected data in a coherent and functional way (Bless & Kuthuria, 1993; Struwig & Stead, 2001). A disadvantage of this type of method is that detailed insight into the research problem may be compromised.

This current study can also be classified as exploratory-descriptive in nature. Exploratory-descriptive research involves the systematic examination and organisation of carefully observed information about the constructs under study (Cozby, 1989; 1993; Dane, 1990), in this case the knowledge, attitudes and behaviour related to eating disorders, body image and weight control of a group of Life Orientation educators. As no previous research has been conducted on the constructs of the proposed study within a South African context, an exploratory approach is recommended (Pennock-Roman & Seo, 1999).

As stated earlier, this study is also descriptive in that it will attempt to describe the phenomenon under study using descriptive statistics (Bailey, 1987). Descriptive studies are structured, focussing on relatively few dimensions of a well-defined entity and measuring these dimensions systematically and precisely, usually with detailed numerical descriptions (Singleton, Straits & Straits, 1993). There are a number of descriptive methods which can be employed to gather data, for example, field observation, systematic observation, case studies, survey research and archival research (Cozby, 1993). According to Fox (1969), if one "wanted to know what someone thought, the best way to find out was to ask him" (p.525). Consequently, this current study has asked participants certain questions by utilizing a self-report survey technique, namely questionnaires.

While interviews have been shown to have some advantages over questionnaires, for example, questions can be clarified and the strength of an attitude or opinion assessed, interviews are time consuming, and consequently reduce the size of the sample under consideration. In addition, the interviewer has been shown to have a profound effect on the outcome of the interview, by many subtle or not so subtle ways (Henerson, Morris, & Fitz-Gibbon, 1987). Questionnaires have therefore been chosen for the current study as they can be administered in a group context, they are cost-effective and are less time-consuming than interviews (Babbie, 1990). Interview bias is also reduced when using questionnaires since participants complete identically worded self-report measures (Bailey, 1987; Dane, 1990; Salkind, 2003). A weakness of surveys, however, is their susceptibility to reactivity, which introduces systematic measurement error. Most notably, the possibility exists for respondents to give

socially desirable answers to sensitive questions. Another inherent weakness is that surveys rely almost exclusively on reports of behaviour rather than observations of behaviour (Singleton, Straits & Straits, 1993). As a consequence, measurement error may be produced by respondents' lack of truthfulness, misunderstanding of questions and by the instability of their attitudes. Exploratory-descriptive research is however advantageous in that it increases the researchers understanding of a particular field or construct and allows for the development of theory.

5.4. Participants and Sampling

As mentioned earlier the current study aims to explore and describe the knowledge, attitudes and behaviours related to eating disorders, body image and weight control of a group of Life Orientation educators. As such the target population was Life Orientation educators within the Nelson Mandela Metropole (NMM). A non-probability purposive sampling procedure was used to select the participants. The non-probability method of sampling is based on the fact that the principle of randomisation is not implemented when selecting the participants (De Vos, 1998) and therefore the probability of selecting participants is unknown by the researcher (Bailey, 1987). Purposive sampling refers to procedures directed toward obtaining a certain type of participant (Dane, 1990). The advantage of purposive sampling is that the researcher uses his/her own judgement and chooses only those participants who will best meet the purpose of the study. The disadvantage of non-probability sampling is that, since the probability that a person will be chosen is not known, the investigator generally cannot claim that his or her sample is representative of the larger population (Bailey, 1987).

Participants for the proposed study were selected from schools represented by the School Counsellor's Forum and included educators who attended the ACE Life Orientation training at the Nelson Mandela Metropolitan University. The School Counsellor's Forum is comprised of a group of high school Life Orientation educators and School Counsellors who meet quarterly from within the Nelson Mandela Metropole (NMM). At present the Forum represents approximately 30 schools from within the metropole.

The inclusion criteria for the sample of the current study was that all participants were female High School Life Orientation educators currently teaching Grade 8 and/or Grade 9 Life Orientation. All participants had a minimum of Grade 12

qualification in which English was passed as either a first or second language. While many symptoms pre-empting eating disorders can have their origins in children as young as 9, eating disorders such as anorexia and bulimia nervosa usually have their beginnings in the teenage years (Robert-McComb, 2001). Thus the sample was restricted to those educators working with adolescents. As the study utilised a *feminist* post-structuralist discourse perspective, the researcher was only interested in the experiences of female Life Orientation educators. In general, it has been found that women show greater body dissatisfaction than men, and are ten times more likely than men to suffer from an eating disorder (Ogden, 2004; Robert-McComb, 2001). For these reasons, the sample was limited to female Life Orientation educators.

While all 30 schools of the School Counsellors forum were approached to participate in the current study, only 6 schools indicated a willingness and provided consent to participate in the study. A total of 120 questionnaires were delivered to Grade 8 and/or Grade 9 Life Orientation educators attending the ACE Life Orientation training and to those 6 participating schools from the School Counsellors Forum. Only 50 questionnaires were completed in full, however, thus limiting the sample to 50 participants. The researcher collected the remainder of the questionnaires.

The biographical details of the sample will be discussed in detail in Chapter 6.

5.5. Measures

A biographical questionnaire and a self-administered research questionnaire, specifically constructed for the purpose of the proposed study, as well as two standardised self-report measures were used to assess educators' knowledge of eating disorders, their level of body satisfaction and their eating behaviour.

5.5.1. Biographical Questionnaire

A biographical questionnaire was constructed to elicit information regarding specific participant characteristics (refer to Appendix B). Data obtained from this questionnaire allowed for the exploration of factors such as age, gender, race, educational qualification and teaching experience.

5.5.2. Research Questionnaire

The research questionnaire aimed to assess the Life Orientation educators' knowledge of eating disorders and healthy diet, as well as their knowledge regarding safe and effective teaching practices regarding eating disorders and healthy diet. The items of the self-administered research questionnaire (refer to Appendix C) were generated from five sources: the Survey for Trainee Teachers, developed by O'Dea and Abraham (2001); the Questionnaire on Eating Disorders developed by Price and Desmond (1990) used to assess the School Counsellors' knowledge of adolescent eating disorders; the Revised National Curriculum Statement Grades R-9 Policy (Department of Education, 2002); the Questionnaire on Sexual Abuse developed by McGregor (1999) for the assessment of school educators' knowledge of sexual abuse; as well as a broad literature review. During the construction of the research questionnaire, an expert panel was consulted, including a clinical psychologist working in private practice and specialising in the field of eating disorders, a clinical psychologist trained and employed as a School Counsellor at a high school, a group of dieticians working in a variety of settings within the Nelson Mandela Metrapole, and a research psychologist employed by the Nelson Mandela Metropolitan University. This expert panel assessed both the content validity and the ease of understanding of the questionnaire. The accessibility of the research questionnaire was further assessed by a group of high school educators in the form of a pilot study. Suggestions were noted and changes to the questionnaire were made. The questionnaire was scored by calculating frequency distributions for each question across the sample.

The first part of the questionnaire was designed to survey educators' knowledge regarding the specifics of eating disorders, the type of advice given to adolescents regarding healthy dieting and the specifics of teaching eating disorders within the classroom. Each section was consisted of a number of items. The questions were closed ended, with educators having to choose one out of two possible responses.

The second section of the questionnaire was designed to assess the needs of Life Orientation educators regarding training and support. The questions were closed ended, with educators having to choose one out of two possible responses, and at other times from a choice of four possible options.

As well as using a questionnaire developed for the use of the current study, two standardised measures were used in order to meet aims two and three of the current

study. These measures included the Eating Attitudes Test (EAT-40), and the Body Shape Questionnaire (BSQ). These will each be discussed briefly below.

5.5.3. The Eating Attitudes Test (EAT-40)

The Eating Attitudes Test (EAT-40), developed by Garner and Garfinkel (1979), consists of 40 items using a 6-point Likert scale, forced choice, self-report format (refer to Appendix D, 160). A shortened version of the EAT, consisting of 26 items, was developed in 1982 by Garner, Olmstead, Bohr and Garfinkel. The longer version will however be used in this current research study. The EAT is designed to measure abnormal eating behaviour and abnormal attitudes to food, body image, shape and weight. It is easily administered and scored and is an objective instrument for symptomology in anorexia nervosa as well as being a useful screening instrument for identifying actual or incipient cases of anorexia nervosa in an undiagnosed population (Garner & Garfinkel, 1979). It is suggested that the EAT is more accurately viewed as a measure of concern about weight and food intake, rather than exclusively being a measure of the symptoms of anorexia nervosa (Button & Whitehouse, 1981).

The validity and reliability of the EAT–40 in both clinical and non-clinical samples has been successfully demonstrated (Garner & Garfinkel, 1979; Garner, Olmsted, Bohr, Garfinkel, 1982). The total EAT-40 score was shown to have a high level of concurrent validity. In addition, measures of internal consistency ($\alpha = .94$, Garner & Garfinkel, 1979; $\alpha = .95$, Bittinger & Smith, 2003) and test-retest reliability ($r = .84$, $N = 56$, 2-3 weeks, Carter & Moss, 1984) are both high.

There are currently no available norms for the EAT-40 or EAT-26 for a South African population. This measure has, however, been used in a number of South African studies (Jacobson, 1992; le Grange, Mintz & O'Halloran, 2000; Tibbs & Selibowitz, 1995; Shefer, 1987; Szabo, 1997), and has specifically been used in cross-cultural studies within South Africa (Caradas, Lambert & Charlton, 2001; Senekal, Steyn, Mashego & Nel, 2001; Szabo, 1999). The EAT has also been used extensively to identify the possible presence of eating disorders and symptoms in non-Westernised populations (Choudry & Mumford, 1992; Fisher, Pastore, Schneider, Pegler & Napolitano, 1994; Lee, 1993).

Robert-McComb (2001) suggests, however, that the EAT be used with its limitations in mind. While the EAT has been shown to distinguish individuals with anorexia nervosa and bulimia nervosa from control subjects (Gross, Rosen, Leitenberg & Willmuth, 1986) there is little evidence to say that the EAT

discriminates between individuals with anorexia nervosa and persons with bulimia nervosa (Mintz, O'Halloran, Mulholland & Schneider,1997). Other research has also cautioned that the EAT yields a high false positive rate for anorexia and bulimia nervosa among non-clinical samples (Carter & Moss, 1984; Johnsone-Sabine, Wood, & Patton, 1988; Meadows, Palmer, Newball, & Kenrick, 1986). The EAT is, however, considered to be the most widely used instrument in the epidemiological study of eating disorders (Button & Whitehouse, 1981; Johnsone-Sabine, Wood & Patton, 1988) and was deemed the most suitable measure for the current study.

The result of the EAT-40 is a single composite score which indicates an overall level of symptoms. Possible scores on the EAT-40 range from 0 to 78. A cut-off score of 30 or more points is indicative of pathological eating behaviour. Scores greater or equal to 20 are generally considered characteristic of subclinical eating disorder pathology (Caradas, Lambert & Charlton, 2001). The factors of the EAT-40 Factor Structure devised by Garner, Olmstead, Bohr and Garfinkel (1982) were not used in this study. This was due to the fact that no correlation studies were performed.

5.5.4. The Body Shape Questionnaire (BSQ)

The Body Shape Questionnaire (BSQ) is a self-report questionnaire developed by Cooper, Taylor, Cooper and Fairburn (1987). This measure is a widely used tool on an international level in research regarding eating disorders (Rousseau, 2005) and is argued to have the greatest utility for patients with eating disorders (Rosen & Srebnik, 1990). It comprises 34 questions measuring the extent of psychopathology around concerns about body shape and in particular the phenomenal experience of 'feeling fat' (refer to Appendix E, p.162). The questionnaire includes questions that refer to the subject's state over the past four weeks and is answered in a 6-point Likert scale, forced choice, self-report format (Ghaderi & Scott, 2004).

According to Cooper, Taylor, Cooper and Fairburn (1987), the BSQ has been discriminately validated on a clinical population of bulimia nervosa patients and non-clinical community populations. The BSQ has been shown to have good concurrent and discriminative validity (Cooper, Taylor, Cooper & Fairburn, 1987). Significant correlations between the BSQ and the total score of the EAT-40 indicate concurrent validity, and the EAT-40 and BSQ have been shown to correlate significantly (Cooper, Taylor, Cooper & Fairburn, 1987).

As with the EAT-40, while there are no norms available for a South African sample, the BSQ has nevertheless been utilized in a number of South African studies (Caradas, Lambert & Charlton, 2001; Colborn, 1994; le Grange, Tibbs & Selibowitz, 1995). Due to it being shown that severe concern about body shape constitutes a risk factor for the later development of eating disorders among young women in the general population, the BSQ has been used for detecting at risk groups in the prevention of eating disorders (Ghaderi & Scott, 2004).

The questionnaire has a possible range of 34-204. A score of 120 and over indicates significant concerns about body shape and feeling fat. Cooper, Taylor, Cooper and Fairburn (1987) found that a mean score of greater than 136 was achieved by patients with bulimia nervosa and a mean score of 129 by probable cases. Average scores of 71.9 (SD = 23.6) for nonclinical college females and 136.9 (SD = 22.5) for individuals diagnosed with BN have been reported by Cooper, Taylor, Cooper and Fairburn (1987).

5.6. Procedure

A research questionnaire was constructed for the purposes of the study. In order to increase the validity of the questionnaire, a panel of experts was consulted and a pilot study conducted.

The researcher submitted the research proposal to the Human Ethics Committee at the Nelson Mandela Metropolitan University (NMMU) and subsequent changes were made in order to ensure that the research was carried out in an ethical manner. Permission to conduct the research was then obtained from the Eastern Cape Department of Education. The names of the schools and contact individuals were obtained from the chairperson of the School Counsellors Forum. Thereafter contact was made with the relevant school principals via a letter and telephonically in order to obtain permission to approach the Life Orientation educators at their school. Suitable times were arranged with the individual participants for the administration of the questionnaires. The lecturer of the ACE programme offered at the Nelson Mandela Metropolitan University (NMMU) was approached and permission was granted to conduct the research with the educators attending this course. Participants were approached and selected.

A covering letter (refer to Appendix F, p.164) describing the research was given to the principles of participating schools, the lecturer of the ACE programme, as well as

each participant. The nature, procedure and outcome of the research, as well as the rights of the participants, were explained. Participants were also informed that their involvement within the study was voluntary, and that they could participate anonymously. They were reassured that all information provided by them would be treated as highly confidential. The consent form (refer to Appendix G, p.168) was prepared in compliance with the latest guidelines stipulated by the Medical Research Council. Participants were asked to give consent for participation in this study.

The participants were subsequently asked to complete the biographical questionnaire, the research questionnaire, the Eating Attitudes Test (EAT-40), and the Body Shape Questionnaire (BSQ). Questionnaires were collected and placed into individually sealed envelopes in order to ensure confidentiality. Participants were informed that individual feedback would not be provided, but that the results of the group as a whole would be disclosed to them in the form of a brief report. Finally, the data was captured and analysed according to the aims of the study.

5.7. Data Analysis

Due to the exploratory-descriptive nature of the proposed study, the researcher has used descriptive statistics to describe the data. This allows for the organisation and interpretation of the data recorded (Myers, 1989). Descriptive statistics include finding measures of central tendency as well as measures of variation or spread (Cozby, 1993; Dane, 1990). The remainder of the data analysis will be discussed according to the aims of the proposed study.

Aim one, which is to explore and describe the knowledge of Life Orientation educators with regards to eating disorders and healthy diet, was investigated using the Research Questionnaire and by calculating frequency distributions. A frequency distribution is an arrangement of the scores collected in a research study that indicates how often each possible score occurred (Harris, 1998). In the case of the proposed study, the frequency of True/False, Yes/No and Very Confident/Not Confident scores were calculated. The frequency distributions were then converted into percentages for further descriptive analysis.

Aims two and three are to explore and describe the attitudes held by Life Orientation educators with regard to their own body image, and to explore and describe the behaviour of Life Orientation educators with regard to eating habits, dieting and exercise respectively. These were analysed using frequency distributions

and the computation of measures of central tendency of scores obtained on the Body Shape Questionnaire and the Eating Attitudes Test. Finding the measures of central tendency included the computation of the mean, mode and standard deviation of the scores for each questionnaire. The mean can be defined as the sum of the scores divided by the number of scores for the questionnaires and the mode simply refers to the score with the highest frequency for each measure. The standard deviation uses the mean of the distribution as a reference point and measures variability by considering the distance between each score and the mean (Gravetter & Wallnau, 1999). The range was calculated as a measure of variability to describe the distance between the highest and lowest score in the distribution (Harris, 1998).

5.8. Ethical Considerations

Harvey and MacDonald (1993) have pointed out that there are ethical considerations to be borne in mind when undertaking research. They emphasise the importance of researchers taking into consideration the well-being of their participants and the need to never abuse their trust. As stated earlier, permission for the proposed research study was obtained from the Ethics Committee at the Nelson Mandela Metropolitan University (NMMU), the Eastern Cape Department of Education, the Chairperson of the School Counsellors Forum, the ACE Life Orientation Lecturer at the Nelson Mandela Metropolitan University (NMMU) and the principals of schools involved. The participants' informed consent was also obtained.

Another ethical concern is that of coercion (Cozby, 1993, Leary, 1991). Coercion refers to whether the participants were forced or pressurised by a researcher or someone that has authority or influence over them to participate in a study (Leary, 1991). The cover letter for the present research simply requested that prospective participants considered participating in the research study. When the researcher contacted the participants, they were asked whether they were interested in completing the questionnaires and if so, when she could meet with them. The prospective participants were thanked for their time regardless of whether they had decided to participate.

The maintenance of privacy and confidentiality are also among the ethical guidelines suggested in literature. As the information that was elicited from the participants was extremely sensitive in nature, the researcher took precautions to ensure the anonymity of the research participants.

Lastly, group feedback will be provided to the participants in the form of a written report of the research findings once the study has been completed. Participants will be provided with contact details of eating disorder support resources at this stage.

5.9. Conclusion

The research methodology and design used in this study was chosen on the basis of the aims and purpose of this research. An exploratory-descriptive research design was used in the study. The data was gathered using a biographical questionnaire, a self developed Research Questionnaire, the Eating Attitudes Test (EAT-40) and the Body Shape Questionnaire (BSQ). A non-probability convenience sample of female grade 8 and 9 Life Orientation educators in the Nelson Mandela Metropole was sampled in order to collect the data. The ethical guidelines outlined above were taken into consideration for the purposes of this study. After the necessary permission was obtained, the questionnaires were personally hand delivered to each participant, collected on completion, scored and the data analysed using descriptive statistics to describe the participant's knowledge, attitudes and behaviour related to eating disorders, body image and weight control. The results obtained are reported and discussed in the following chapter.

CHAPTER 6
RESULTS AND DISCUSSION

"Common sense is the collection
of prejudices acquired by age eighteen"
-Albert Einstein-

6.1. Introduction

It is important to revisit the aims of this research before discussing the results obtained from the data collection and analysis. The first aim was to explore and describe the *knowledge* of female Life Orientation educators in the Nelson Mandela Metropole with regards to eating disorders and healthy diet. The second aim was to explore and describe the *attitudes* held by female Life Orientation educators within the Nelson Mandela Metropole with regards to their own body image. The third aim was to explore and describe the *behaviour* of female Life Orientation educators within the Nelson Mandela Metropole with regards to eating habits, dieting and exercise.

The results obtained from the data analysis are discussed in this chapter. The biographical details of the sample obtained from the biographical questionnaire are described first, in order to obtain a comprehensive picture of the sample. Thereafter, the results of the three questionnaires, namely the Research Questionnaire, the Eating Attitudes Test (EAT-40) and the Body Shape Questionnaire (BSQ), are presented individually in response to the three aims respectively.

6.2. Biographical Description of the Sample

The biographical variables that are discussed in this section pertain specifically to the information obtained from the biographical questionnaire completed by the respondents. These variables include age, race, marital status, socio-economic status, qualifications, years of service in education, grades taught, weight, desired weight, dieting status, and history of eating disorders. It must be noted that the small sample size and unequal groupings do not allow for the investigation of possible statistical relationships between biographical variables and the results of the measures. While the data related to the biographical variables cannot on the whole be linked to the measures, it is important to report the biographical data in order to provide a context for the findings related to the measures.

A total of 50 female Life Orientation educators participated in this study. The subjects represented a total of 39 high or senior secondary schools within the Nelson Mandela Metropole. Six of the schools were drawn from those schools that form part of the School Counsellors Forum, and the remaining came from those attending the ACE Life Orientation training at the Nelson Mandela Metropolitan University. The sample was limited to female Life Orientation educators currently teaching either grade 8 and/or 9 Life Orientation. All participants had a minimum Grade 12 qualification in which English was passed as either a first or second language.

6.2.1. Age

The ages of the respondents ranged from 25 to 60 with an average age of 31.29 years. One participant did not report on her age, and therefore the frequency distribution was calculated on a total of 49.

Table 1: Age Distribution of the Sample

Age in Years	N	Percentage
25-34	18	36
35-44	17	34
45-54	13	26
55-60	1	2
Unknown	1	2
Total	(N) = 50	100

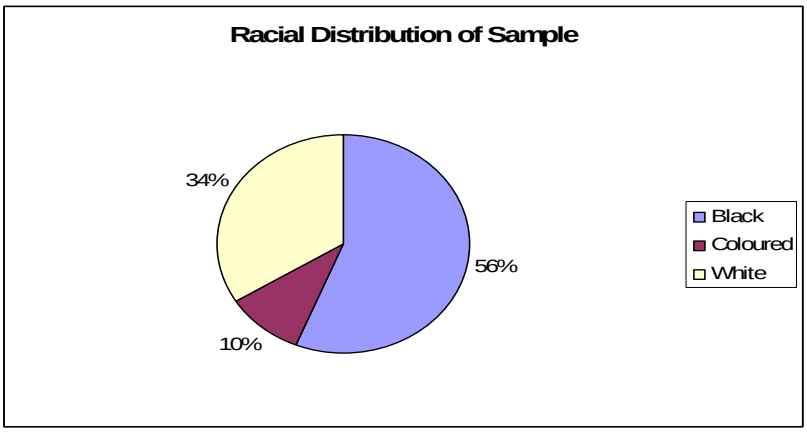
From the above table it is clear that 36 % (n = 18) of the sample fell within what Havinghurst (1972) outlined as the early adulthood stage of life. Those within this age category would be more likely, according to Kaplan and Saddock (2003), to show signs of the development of an eating disorder than those within the older age group categories. It is also noteworthy to highlight that many within this group would have had the opportunity of being trained specifically in the area of Life Orientation within their post graduate education qualification, as they would have been trained post 1997. The remaining 62% (n = 31) of the participants fall within Havinghurst's (1972) middle adulthood developmental stage. These participants would have been trained according to the old education system, prior to 1997, and as such, would not

have been formally trained in Outcomes Based Education during their tertiary studies. The only form of training in Life Orientation that they would have obtained, therefore, would have been through courses offered to them via the government's education departments and tertiary institutions. These participants would therefore be likely to experience the greatest need for support in making the transition between the previous teaching syllabus and methods, and those of Outcomes Based Education.

6.2.2. Race

The racial distribution of respondents is indicated in figure 1.

Figure 1: Racial Distribution of the Sample



The majority of the sample was made up of black participants, with about a third being made up of white participants. The remainder were coloured educators. No other racial groups featured in the sample. While eating disorders were almost unheard of in the black population before the 1980s in America (Garfinkel & Garner, 1982; Silber, 1986) and before 1994 in South Africa (Szabo, Berk & Allwood, 1994), changes have begun to occur. According to various authors (Edwards & Moldan, 2004; Senekal, Steyn, Mashego & Nel, 2001), there are definite signs of assimilation of Western cultural norms concerning body shape and an associated link of increased eating disorders amongst black males and females in South Africa. This is most likely due to the urbanisation process currently occurring in South Africa post Apartheid (Senekal, Steyn, Mashego & Nel, 2001). While there is an increase in eating disorder pathology, White females continue to exhibit greater body image concerns and body image dissatisfaction than mixed race or black individuals (Caradas, Lambert & Charlton, 2001; Senekal, Steyn, Mashego & Nel, 2001), a construct measured in this research. Due to the unequal numbers of participants across the above mentioned

racial groups, this study will not attempt to make any correlations between racial groups and eating disorder pathology. It is worthy to note, however, that the majority of the participants within this study come from a racial group that, up until 10 years ago, showed little to no body dissatisfaction linked to eating disorder pathology.

6.2.3. Marital Status

The marital status of the sample is presented in Table 2.

Table 2: Marital Status Distribution of the Sample

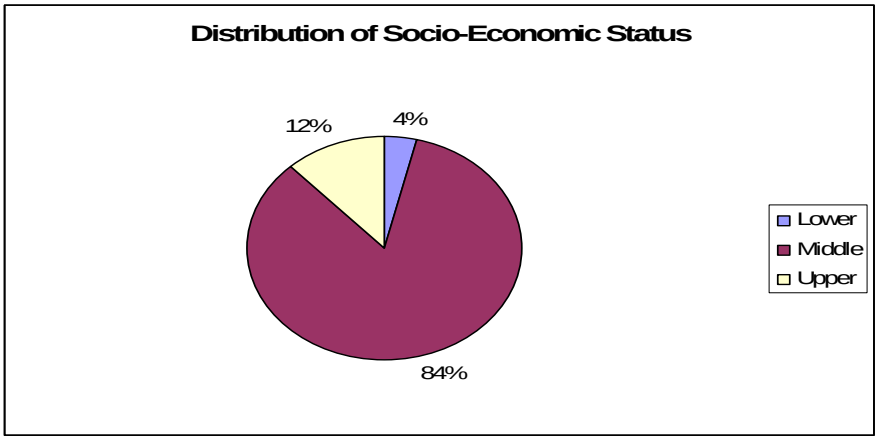
Marital Status	N	Percentage
Single	16	32
Married	21	42
Divorced	9	18
Widowed	4	8
Total	(N) = 50	100

The marital status of the participants in the sample varied between being married, single, widowed and divorced, with the majority of the sample being married. No significant correlation has been found between eating disorders and marital status, that is, being married, separated, divorced or widowed (Garfinkel & Garner, 1982).

6.2.4. Socio-Economic Status

The distribution of the socio-economic status of the participants is presented in Figure 2.

Figure 2: Distribution of Socio-Economic Status of Participants



The majority of the sample (84%, n = 42) placed themselves within the middle income bracket, with only 4% (n = 2) indicating that they were within the lower socio-economic bracket. A further 12% (n = 6) indicated that they fell within the upper income bracket. Clinical studies have described a higher incidence of anorexia nervosa in middle to upper socio-economic classes (Bruch, 1973). This was confirmed by Askevold (1982) who found that, compared to patients with other health problems, patients with anorexia nervosa were more likely in families with a higher socioeconomic status. Herzog (1982) found that patients with bulimia come from families with higher income levels than patients with anorexia. It is important to note, however, that eating disorder cases have been noted beyond the traditional risk groups, and are now spanning socio-economic boundaries (Caradas, Lambert, & Charlton, 2001; Lee, 1996; Ogden, 2003). While the majority of the sample placed themselves within the middle to upper income bracket, we are unaware of what socio-economic bracket the respondent's families of origin were. While they may have a higher risk for the development of an eating disorder at present due to their current socio-economic status, the participants may have grown up in very different circumstances during their adolescent years, that is, the years during which they would be most likely to develop attitudes and behaviours that would influence eating disorder pathology.

6.2.5. Qualification

While all the participants were currently teaching grade 8 and/or 9 Life Orientation, the respondents qualified as high school educators via a number of different pathways. Those wishing to qualify as high school educators can do so by completing a diploma in education, a degree in education, or a combination of a degree and a diploma. These can be completed in various tertiary institutions including Technikons and Universities. The qualification pathways noted amongst the participants appear in Table 3.

Table 3: Distribution of Types of Qualification per Participant

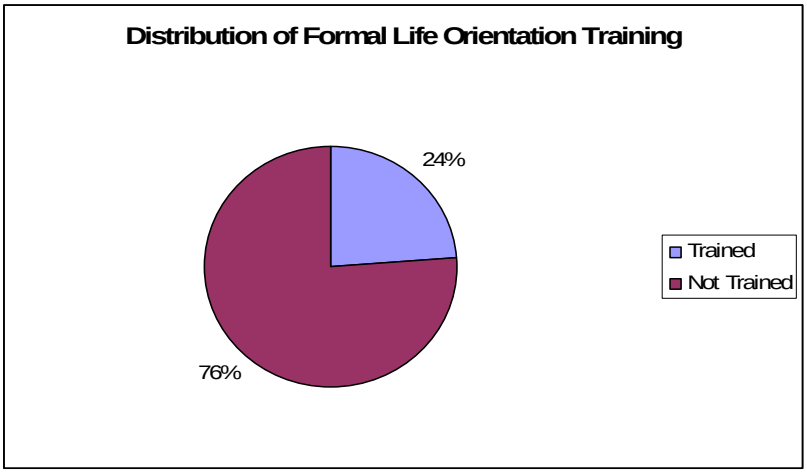
Qualification	n	Percentage
Matriculation Certificate	1	2
Diploma in High School Education only	18	36
Degree in High School Education only	5	10
Non-Education Degree only	1	2
Non-Education Degree and Diploma in High School Education	20	40
Diploma in High School Education and Degree in High School Education	1	2
Non-Education Degree and Degree in High School Education	2	4
Diploma in High School Education, Non-Education Degree and Education Degree in High School Education	2	4
Total	(N) = 50	100

While all participants were employed as high school educators, 4% (n = 2) of these participants were not qualified as educators at all, with one of these participants having no qualification beyond her matriculation certificate. The rest of the respondents qualified via different pathways by obtaining a mixture of diplomas and degrees. One must question as to the consistency in content and quality across these different qualification pathways. While they are all being expected to perform as educators on the same competency level, the possibility exists that they are not being equally qualified to do so. As such, even amongst those who were trained in Life Orientation, some might be better equipped that others to interpret the requirements of the curriculum and have more accurate knowledge regarding the content of the learning area, simply due to the nature of their qualification. One must question whether it would not be of value to streamline the qualification pathways in order to bridge the inequalities in teaching practise that might arise.

6.2.6. Formal Training in Life Orientation

As mentioned, due to Outcomes Based Education only having being launched in 1997, not all of the participants would have had specific training in Life Orientation during their tertiary qualification. The distribution of those trained and not trained appears in figure 3.

Figure 3: Distribution of Formal Life Orientation Training of the Sample



As expected, the majority of the participants (76%, n = 38) were not formally trained in Life Orientation as the majority of the participants have worked for more than 11 years, and therefore qualified before 1997. The remaining 24% (n = 12) had been formally trained in Life Orientation. The majority of the respondents that were not trained would therefore rely on training offered by the government education departments or tertiary institutions to competently perform the teaching roles they fill.

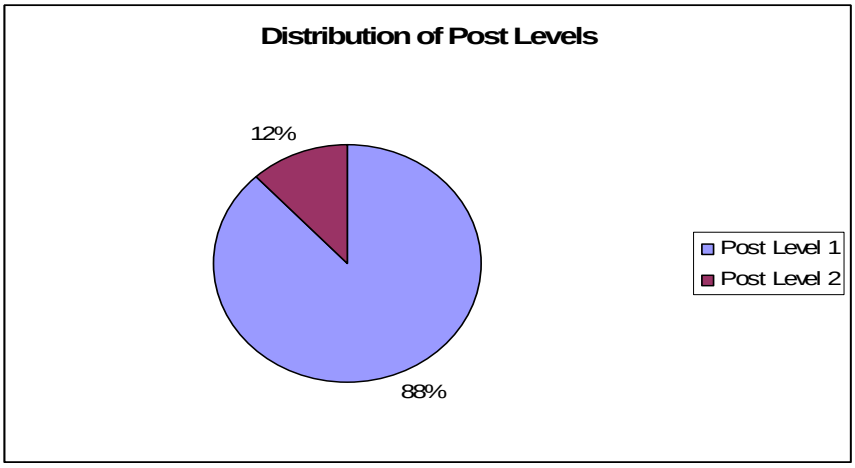
6.2.7. Teaching Posts Occupied by Participants

While all participants were currently teaching grade 8 and/or 9 Life Orientation, the type of post they occupied and the teaching subjects they taught varied. Sixteen percent (n = 8) of the participants taught Grade 8 Life Orientation only, while 32% (n = 16) taught only Grade 9 Life Orientation. The remaining 52% (n = 26) taught both Grade 8 and 9 Life Orientation.

The participants within this study occupied two different Post Levels. While some participants held 'Head of Department' positions and therefore were 'Post Level 2' educators, the majority of the respondents were employed as level 1 educators. Those educators who are employed at the Post Level 2 position are generally given more

responsibility within their departments and school and are given more financial remuneration for doing so. The distribution of Post Levels appears in Figure 4.

Figure 4: Distribution of Post Levels of Participants



As mentioned, the learners within the sample of this current study were involved in teaching a variety of subjects other than Life Orientation. While not in all cases, the majority of these learners would have originally qualified as learners of subjects other than Life Orientation and would have more recently begun teaching LO. The distribution of subjects taught appears in Table 4.

Table 4: Distribution of Subjects Taught by Participants

Subjects Taught	N	Percentages
Life Orientation only	32	64
Life Orientation and Languages	9	18
Life Orientation and Guidance	3	6
Life Orientation and Librarian	2	4
Life Orientation and Natural Science	1	2
Life Orientation and Home Economics	1	2
Life Orientation and Accountancy	1	2
Life Orientation, Natural Science and Human Social Sciences	1	2
Total	(N) = 50	100

The majority of the sample (64%, n=32) were employed solely as Life Orientation educators, while the rest of the educators taught at least one other subject area.

The biographical questionnaire also requested the participants to indicate the number of years spent in their teaching profession. The number of years ranged from less than 3 years to more than 11 years, with the majority of the sample (58%, n = 29) having taught for more than 11 years. The distribution of years in teaching service is indicated in Table 5.

Table 5: Distribution of Years of Service of Participants

Years of Service	n	Percentage
Less than 3 years	3	6
3 to 5 years	2	4
6 to 8 years	10	20
9 to 10 years	6	12
More than 11 years	29	58
Total	(N) = 50	100

6.2.8. Weight of Participants

The biographical questionnaire requested the participants to indicate their current weight and their height. From this the Body Mass Index (BMI) was calculated for each participant. The participants were also requested to indicate their desired weight. Not all participants indicated their weight and height or what they desired to weigh. The personal nature of this information was taken note of and may have contributed to participants not being willing to report on this information, in spite of the anonymity that was agreed upon at the start of the study. The distribution of current weight and desired weight, height and BMI scores for each participant is indicated in Tables 6, 7 and 8 respectively.

Table 6: Distribution of Current Weight and Desired Weight of Participants

	Current Weight		Desired Weight	
Weight Category	N	Percentage	n	Percentage
45kg to 54kg	3	6	7	14
55kg to 64kg	12	24	19	38
65kg to 74kg	11	22	13	26
75kg to 84kg	9	18	7	14
85kg to 95kg	12	24	1	2
85kg to 94kg	2	4	0	0
Unknown	1	2	3	6
Total	(N) = 50	100	(N) = 50	100

Table 7: Distribution of Height Categories of Participants

Height	N	Percentage
1.1m to 1.29m	2	4
1.3m to 1.39m	3	6
1.4m to 1.49m	1	2
1.5m to 1.59	9	18
1.6m to 1.69m	14	28
1.7m to 1.79m	9	18
1.8m to 1.9m	3	6
Unknown	9	18
Total	(N) = 50	100

Table 8: Distribution of actual and desired Body Mass Index (BMI) of Participants

Body Mass Index (BMI)	Actual BMI		Desired BMI	
	N	Percentage	N	Percentage
Underweight (<20)	1	2	6	12
Normal Weight (20-26)	19	38	20	40
Overweight (27-32)	13	26	7	14
Obese (>32)	8	16	5	10
Unknown	9	18	12	24
Total	(N) = 50	100	(N) = 50	100

Almost half of the sample (38%, n = 19) fell within a normal weight category, with 26% (n = 13) being overweight. One participant (2%) was noted as being underweight, and eight (16%) as obese.

It is noteworthy to highlight that, while almost half of those who indicated their current weight had no weight problems according to the Body Mass Index scale, 86% (n = 43) of the participants indicated that they desired to lose weight. The desire to lose weight occurred across the weight ranges, therefore, with the only difference being the amount of weight that the participants wanted to lose. While those within the normal weight range desired to lose on average 5.44kg, those within the obese group wanted to lose 12.11kg on average. The average amount of weight that participants wanted to lose across the weight ranges was 10.73kg. It is clear from the above that, even though the majority of the sample had no significant weight problems, all but five of the participants were dissatisfied with their current weight and desired to weigh less than they currently did. Twelve percent (n = 6) of the sample were not only dissatisfied with their weight, but indicated a desire to lose weight to the point of being underweight, according to the calculation of the BMI for their desired weight. A further 8% (n = 4) wanted to weigh at the lowest end of what would be healthy for them to weigh. One participant indicated a desire to lose weight to the point of placing her BMI below 17.5, that is, below the cut-off point used by the DSM-IV-TR to indicate anorexia nervosa.

6.2.9. Dieting Status of Participants

Apart from indicating their current weight and desired weight, the participants were asked in the biographical questionnaire to indicate whether they were currently dieting to lose weight or to gain weight. None of the participants indicated that they were currently dieting to *gain* weight. Those who indicated a desire a *lose* weight are indicated in Table 9. The participants were also asked to report on their usual eating habits throughout the day.

Table 9: Distribution of Dieting Status of Sample

Dieting to Lose Weight	N	Percentage
Yes	16	32
No	34	68
Total	(N) = 50	100

Almost a third of the sample indicated that they were currently dieting in order to lose weight. This is contrasted, however, with the 85.58% of the participants that indicated that they desired to weigh less than they currently weighed. While research agrees that dieting has become common place in women's lives (Brownell, 1991), the incidence of this weight loss technique appears to vary across time and populations. The 1985 American National Health Survey indicated that 46% of women and 24% of men were dieting (National Center for Health Statistics, 1985). Lowe, Gleaves and McKinney (1996) found that 19% of female learners were currently dieting, while Gruber, Pope, Lalonde and Hudson (2001) reported 58% of female college learners being involved with the practices of dieting. No statistics could be found indicating the incidence of dieting practices in female educators.

Participants were requested to indicate the pattern of their eating habits on an average week day. The distribution of their eating habits is indicated in Table 9.

Table 10: Distribution of Eating Habits for Sample

Eating Habits	Yes		No	
	n	Percentage	n	Percentage
Breakfast	34	68	16	32
Morning Snack	26	52	24	48
Lunch	37	74	13	26
Afternoon Snack	24	48	26	52
Eat Dinner	39	78	11	22
Evening Snack	21	42	29	58
Total	(N) = 50	100	(N) = 50	100

Most educators within the sample indicated that they ate regular meals at breakfast, lunch and supper. While more than half of the sample tended to have a

morning snack, less than half of the participants indicated having afternoon or evening snacks. As the educator's morning is typically broken up by two break times, they may be more likely to have a morning snack. Twenty eight percent (n = 14) of the sample indicated they usually only ate two main meals during the day, with some having in between snacks. Eighteen percent (n = 9) of these did not eat breakfast. Eighteen percent (n = 9) of the total sample tended to only eat one main meal during the day. This meal varied between breakfast, lunch or supper. These participants again ate snacks in between. One participant (2%) indicated that she did not participate in any main meals during the day. This individual reportedly only snacked three times a day.

6.2.10. History of Eating Disorders

The biographical questionnaire required the participants to indicate whether they had ever been diagnosed or treated for an eating disorder in the past, and whether they either were currently receiving treatment for an eating disorder or believed that they might have an eating disorder. The results of the participant's responses are recorded in Table 11.

Table 11: Distribution of Eating Disorder History of Participants

Disorder	Diagnosed				Treated				Receiving Treatment				Suspect a Disorder			
	Yes		No		Yes		No		Yes		No		Yes		No	
	n	%	n	%	n	%	n	%	n	%	n	%	n	%	n	%
Anorexia Nervosa	0	0	50	100	0	0	50	100	0	0	50	100	0	0	50	100
Bulimia Nervosa	0	0	50	100	0	0	50	100	0	0	50	100	0	0	50	100
Other Eating Disorder	1	2	49	98	1	2	49	98	1	2	49	98	3	6	47	94
Low Weight Problem	1	2	49	98	1	2	49	98	0	0	50	100	0	0	50	100
Exercise Disorder	1	2	49	98	0	0	50	100	0	0	50	100	2	4	48	96

None of the participants within the sample indicated that they had been diagnosed or treated for anorexia nervosa or bulimia nervosa in the past or that they were either currently receiving treatment or suspected that they might have one of these disorders. One participant indicated that she had been diagnosed and was currently receiving treatment for an eating disorder other than those mentioned in the questionnaire. This particular participant was measured as 'obese' according to the BMI. Three other participants further indicated that they believed that they may have had a disorder other than those mentioned in the questionnaire. One participant reported that she had been both diagnosed and treated for a low weight problem in the past, but that she was no longer being treated for this. One participant indicated that she had been diagnosed with an exercise disorder but had received no treatment for it. Two further participants indicated that they suspected that they may have an exercise disorder.

6.3. Results of the Measures

The following subsections will focus specifically on the aims of this study, which are to explore and describe the knowledge, attitudes and behaviours related to eating disorders, body image and weight control of a group of female Life Orientation educators.

6.3.1. Aim 1: The Research Questionnaire

The Research Questionnaire was designed to assess the accuracy of the Life Orientation educator's knowledge regarding healthy body weight, eating behaviour, eating disorders and healthy diet, and their knowledge regarding the effective and safe teaching practices of eating disorder pathology. The questionnaire also assessed the educator's confidence levels regarding their ability to competently identify and report eating disorders in their learners and their needs in terms of training in the area of eating disorders. The results of questionnaire are outlined below and will be discussed under each subsection of the questionnaire.

6.3.1.1. Educator's knowledge regarding body weight, eating behaviour and eating disorders

The participants were requested to indicate whether they felt statements presented in the first part of the questionnaire were either true of false. These statements were designed to assess the accuracy of their knowledge pertaining to body weight, eating

behaviour and eating disorders. As was pointed out in Chapter 5, the statements were derived from an extensive literature review, and although any single statement could generate considerable discussion, each question is essentially either true or false. The results of this subsection are outline in Table 12. Correct responses are indicated in italics in the table.

Table 12: Educator's knowledge regarding body weight, eating behaviour and eating disorders

Knowledge Question		True		False	
		n	%	n	%
1.1.	Anorexia Nervosa is characterised by an intense fear of becoming fat, even when underweight (*True).*	48	96	2	4
1.2.	Overweight teenagers should go on strict weight-reducing diets (*False).*	17	34	33	66
1.3.	Girls begin their growth spurt before boys *(True).*	49	98	1	2
1.4.	Overweight teenagers usually eat more food than thin teenagers *(False).*	30	60	20	40
1.5.	Those with anorexia nervosa refuse to maintain their body weight at or above what is expected for their age and height *(True)*	44	88	6	12
1.6.	Teenagers should be encouraged not to eat any junk-food *(False).*	33	66	17	34
1.7.	It is normal for teenage girls to put on fat around their thighs and hips *(True).*	37	74	13	26
1.8.	Thin people are generally happier than their overweight counterparts (*False).*	19	38	31	62
1.9.	Eating disorders such as anorexia nervosa only occur in females in upper and middle class families *(False).*	19	38	31	62
1.10.	All those who have suffered from an eating disorder never fully recover *(False).*	14	28.57	35	71.43
1.11.	People with anorexia nervosa lose their appetite	32	65.31	17	34.69

Knowledge Question		True		False	
		n	%	n	%
	(False).				
1.12.	People with bulimia nervosa are usually within the normal weight range for their age and height *(True).*	25	50	25	50
1.13.	People with bulimia nervosa always induce vomiting *(False).*	38	76	12	24

Note: Frequencies do not always add up to the sample total due to non-responses on some items.

It is noteworthy to highlight that not one respondent was able to give correct responses to all statements. This must be seen as problematic, for it means that there are a number of educators within this sample who hold incorrect views about body weight, eating behaviour and eating disorders, views that could, at the least result in them passing on incorrect information while teaching, and at worse, result in serious harm in those within their care.

Of the 13 statements, 11 were answered incorrectly by 12% or more of the respondents. Four of the questions were answered incorrectly by 50% or more of the participants. These figures generally indicate a problem of some magnitude. A consideration of each of the statements individually will clearly demonstrate this point.

Statement 1: *Anorexia Nervosa is characterised by an intense fear of becoming fat, even when underweight.*

This statement is true. The DSM-IV-TR (American Psychiatric Association, 2003), outlines an "intense fear of gaining weight or becoming fat, even when underweight" as Criterion B in the diagnosis of anorexia nervosa. This question taps a fundamental concept regarding anorexia nervosa as it speaks of a desire to lose weight due to a fear of becoming fat even though the person is already thin.

The majority of the participants (96%, n = 48) scored this item correctly. Only two respondents (4%) indicated that the statement was false. This is cause for concern, however, as it indicates a lack of knowledge regarding an essential feature of anorexia

nervosa and brings up questions regarding the ability of these educators to recognise a learner who may be developing anorexia nervosa.

Statement 2: *Overweight teenagers should go on strict weight-reducing diets*.

According to Mahan and Escott-Stump (2000), children should not be put on 'diets'. The treatment goal for the child who is overweight should be weight maintenance or a slowing of weight gain. According to Mahan and Escott-Stump (2000), this gives the child time to "grow into" his or her weight. Children who have already exceeded their adult optimal weight may need to reduce their weight slowly until the optimal adult weight is reached. Attention, in these cases, should be directed towards the modification of family eating habits and increased physical activity. As discussed, dieting is a strong precursor for eating disorders, with dieters being eighty times more likely than non-dieters to develop an eating disorder (Wilson, 1995). It would therefore be concerning for educators to endorse such dieting practices, particularly when they are needing to act as buffers against the dominant societal discourses that endorse a body ideal that is unhealthy for most learners. It would therefore be important for educators to have knowledge regarding what healthy and unhealthy eating practices are for teenagers.

Sixty-six percent of the sample agreed that overweight teenagers should not go on strict weight-reducing diets, while 34% felt that they should. This later statistic is worrying as it suggests that 34% of the participants might be endorsing the practises of dieting, either through direct or indirect practices. As discussed, the Life Orientation curriculum requires the Life Orientation educators to teach on issues relating to healthy diet. The concern here would be how the learners understand the concept 'diet', particularly if educators are endorsing the practices of dieting for weight loss. Without accurate knowledge in this regard, educators could inadvertently endorse the very practices that create vulnerability in their learners for the development of eating disorders.

Statement 3: *Girls begin their growth spurt before boys.*

During adolescence there is a very pronounced and sustained growth spurt. Adolescent girls tend to increase in height (on average 23cm) and weight (on average 21kg) between the ages of 10 and 15 years. Adolescent boys, on the other hand, tend to increase in height (around 26 cm) and weight (around 26kg) between the ages of 12

and 17 years (Mahan & Escott-Stump, 2000). It is important for high school educators to understand the normative difference between girls' and boys' weight in the early years of high school. Due to the earlier growth spurt, girls may be on average taller and heavier than the boys. As this may be a difficult period for teenage girls, the support and formative knowledge of the high school educator is seen as necessary.

Only one participant (2%) scored this item incorrectly, with the remaining 98% (n = 49) scoring it correctly.

Statement 4: *Overweight teenagers usually eat more food than thin teenagers*.

Ogden (1992) suggests that overweight people do not necessarily eat more food than thin people, but are simply predetermined to use their food differently and to store it as fat. This view is supported by Miller (1994), who adds that the obese person often eats less than the thin person. According to Mahan and Escott-Stump (2000), the number and size of fat cells, regional distribution of body fat, and the Resting Metabolic Rate (RMR) are determined genetically. It is suggested, therefore, that genes provide the susceptibility for obesity. The belief that the overweight adolescent eats more food that their thin counterparts may support the idea that fat people have little self-control or will-power, and that they tend towards being greedy (Ogden, 1992). Obese children are often the targets of discrimination and teasing from other learners. It is important, therefore, for the high school educator to act as a buffer against the stereotypes associated with being fat.

A concerning 60% of the participants felt that this statement was true, i.e. that overweight teenagers do usually eat more food than thin teenagers. With the majority of the sample believing that overweight children are 'fat' due to their own unhealthy eating patterns, one must question as to the messages that are being endorsed in the classroom. As discussed in Chapter 3, the discourse of body ideal and healthism has encouraged an idea that those who are 'fat' are so because of their own lack of willpower and their 'gluttonous' way of eating. Thus, the message given is that the overweight children in these educators' classrooms simply need to 'take control' of their eating habits and show more restraint and they will look the way they should. This demonstrates the underlying assumption (as discussed in Chapter 2) that Brownell (1991) highlighted regarding dieting that, the body is malleable and therefore with the 'right' combination of weight loss techniques one can look like the aesthetic ideal. Thus, if you do not look the way you should, you are doing something

'wrong'. The result of this question therefore appears to confirm what was discussed in Chapter 4, i.e. that it is not only peers who endorse prejudicial attitudes with regards to fat children, but that educators may too be endorsing the prejudicial ideas of weightism regarding people of heavier weight. Piran (2004) pointed out that a educator's ability to establish non-weightist norms within the classroom depends a great deal on their own prejudicial attitude.

Statement 5: *Those with anorexia nervosa refuse to maintain their body weight at or above what is expected for their age and height.*

The DSM-IV-TR (American Psychiatric Association, 2003), outlines a "refusal to maintain body weight at or above a minimally normal weight for age and height" as a diagnostic criteria for anorexia nervosa. This question was included within the questionnaire to assess the educators' knowledge of what constitutes anorexia nervosa.

The majority of the sample (88%, n = 40) scored this statement correctly, while 12% (n = 6) felt that it was false. Again, this question taps a fairly fundamental understanding of what constitutes anorexia nervosa, and educators who need to provide knowledge to learners regarding eating disorders would be expected to know this fact. Knowledge regarding this statement would also be important as it enables educators to correctly identify those who may have or potentially may develop anorexia nervosa. It is therefore concerning that 12% of the sample did not know that those with anorexia nervosa keep their weight below what would be expected for their age and height.

Statement 6: *Teenagers should be encouraged not to eat any junk-food*.

This statement was purposely written in the extreme form to highlight the rigidity of the concept. According to Mahan and Escott-Stump (2000), as with a growing infant, an adolescent whose diet is too low in energy density, e.g. a diet very low in fat and high in fibre, may limit his/her growth. It is important for educators to understand what a healthy diet is, specific to adolescence, and to encourage the idea of balance when approaching eating. Encouraging teenagers (overweight or not) to cut out all junk-foods may lead to the idea of some foods being 'bad' – the negative focus of which may contribute to an underlying fear of food, dietary fat, and weight gain, all of which may precipitate eating problems (O'Dea & Maloney, 2000). It may also

encourage a diet devoid of the nutrients adolescents need for growth and development. Ogden (1992) further suggests that that which is forbidden becomes all the more desirable. As such, one may actually increase the desirability of 'junk-food' through discouraging the consumption of it. The recommended daily eating guide for adolescents, as outlined in Mahan and Escott-Stump (2000), allows for "small amounts, perhaps once per day, of high-fat, high-sugar items, such as desserts, soda, candy, cookies, and pastries" (p.268). This is balanced with a healthy selection of dairy, protein, fruits and/or vegetables, as well as grains, breads and cereals.

The majority of the sample (66%, n = 33) felt that the statement was true, i.e. that teenagers should be encouraged not to eat any junk-food. This is disconcerting as it suggests that the majority of the sample are endorsing rigid thoughts around food, that is, that some foods are 'good' and others are 'bad'. This idea is similar to what is found in the thinking patterns of those with eating disorders, in which their diet generally consists of 'safe' foods, i.e. foods that can be consumed without weight gain (Robert-McComb, 2001). It also endorses the discourse of body ideal and healthism, as discussed in Chapter 3, as it may communicate a message that through 'controlling' one's intake of food and eliminating all 'bad' foods from the diet, one can have absolute control over one's weight and ultimately one's mortality. While eating a 'healthy' diet should be encouraged within the classroom, this should be communicated as being a balanced diet rather than one of extremes and in the context of health and not weight.

Statement 7: *It is normal for teenage girls to put on fat around their thighs and hips*.

Body changes in the adolescent period result from hormonal influences regulating the development of sex characteristics. For girls, there is an increasing amount of subcutaneous fat deposit, particularly in the abdominal area. The hip breadth increases, and the bony pelvis widens in preparation for reproduction (Hafen, 1981). This is often stressful for girls who have internalised society's value of thinness, particularly females who are involved in activities that reward thinness, e.g. gymnastics, dance, figure skating and athletics.

Seventy-four percent (n = 37) of the sample understood this statement to be true, while the remaining 26% (n = 13) felt that it was false. As discussed, in Chapters 3 and 4, adolescence can be a perilous time, particularly for females, as their normative developmental sex changes go against what the dominant societal discourses outline

as being acceptable for females to look like. As the educator acts as a socialising agent, it is vital for them to understand the normative placement of fat deposits in girls, and to counteract messages that encourage girls to be dissatisfied with what is a normal and necessary part of developing into a woman. Understanding the physical changes of puberty and the associated behaviours that adolescents exhibit is essential (Akos & Levitt, 2002).

Statement 8: *Thin people are generally happier than their overweight counterparts.*

Ogden (1992) suggests that, while some overweight people are depressed and show poor self-control, depression and poor self-control also commonly occur with those who are thin. She further suggests that "there are no overall differences between fatties and thinnies" in terms of mood (p.8). Clinical depression has been found in 45% of eating-disordered patients, many of whom are thin, and it is likely that many more women with eating disorders, although not clinically depressed, may experience symptoms of depression (Somer, 1995). Robert-McComb (2001) suggests that body image disturbance is so pervasive amongst women that it is normative rather than unusual for women to be unhappy with their bodies. The diet industry bombards men and women with messages endorsing the need to be thin. One such message is that those who are thin are happier. Again, the discourses of healthism and body ideal are endorsed by such a statement.

While 62% (n = 31) of respondents felt that thin people were not generally happier than their overweight counterparts, a surprising 38% (n = 19) felt that the statement was true. As the educator acts as a socialising agent, it is important for them to counteract the message that, 'in order to be happy, one must be thin'. If this truth is preferenced in the classroom, an overemphasis will be placed on the way the adolescent looks and success may be marginalised to this aspect of their lives.

Statement 9: *Eating disorders such as anorexia nervosa only occur in females in upper and middle class families.*

Literature suggests that cases of anorexia nervosa are most often found in females from upper and middle class families and those that have good education and knowledge of nutrition (Mahan & Escott-Stump, 2000). It is important to note, however, that eating disorder cases have been noted beyond the traditional risk

groups, and are now crossing socio-economic, cultural and gender boundaries (Caradas, Lambert, & Charlton, 2001; Lee, 1996; Ogden, 2003).

The majority of the sample (62%, n = 38) felt that this statement was false, while the remaining 38% (n = 19) felt that it was true. It would be necessary for those working with adolescents in the prevention and detection of eating disorders to be aware of who would be at risk. While eating disorders have traditionally been restricted to certain risk groups, it is seen as important for educators to be alerted to the vulnerability in all adolescents within their care, and not only those within these traditional risk groups.

Statement 10: *All those who have suffered from an eating disorder never fully recover*.

According to Becker (1994, sighted in Mahan & Escott-Stump, 2000), early detection and knowledgeable treatment of anorexia nervosa can lead to full recovery after treatment within 50% of patients. Thirty percent will have a partial recovery, while 20% will experience life-long problems with irrational dieting and food fears. Eating disorders are often coupled with an experience of fear and a sense of being overwhelmed. It is important for the educator, therefore, to promote the feasibility and success of treatment in order to encourage those who are experiencing an eating disorder to seek treatment.

The majority of the sample (n = 35, 71.43%) felt that this statement was false, while 14 participants (28.57%) felt that it was true. One participant left this question out, presumably due to not knowing the answer. While the majority of the sample answered the question correctly, it is concerning that 14 participants believed that those with eating disorders would never fully recover and one participant was not sure. One must question how this belief would impact on the educator's interaction with those who had developed eating disorders, either in a formal or informal manner. As discussed in Chapter 3, the discourse of schooling enables a power imbalance to occur between the educator and the learner. Thus, what the educator says becomes fact and is difficult to refute as mere opinion. If a learner who is suffering from an eating disorder hears the educator state that those with eating disorders never fully recover, this becomes fact and will shape to some extent the way the learner views their struggle with the disorder. These learners may never seek the help they require and may believe that they are helpless in the face of the disorder.

Statement 11: *People with anorexia nervosa lose their appetite*.

While the term anorexia may imply a loss of appetite, individuals with anorexia nervosa do not in fact experience a loss of appetite (Robert-McComb, 2001). According to Garner and Garfinkel (1997), those with anorexia nervosa possess good appetites, but are terrified of giving in to this impulse. Individuals may attempt to use the excuse of a lack of appetite in order to avoid undue attention aroused from their restricted eating behaviour. Educators should be alerted by a combination of restricted and ritualistic eating behaviours when attempting to identify those with anorexia nervosa.

The majority (65.31%, n=32) of the sample felt that this statement was true, while 34.69% (n=17) felt that it was false. Again, one participant left this statement out, presumably due to not knowing the answer. Thus, the majority of the sample held incorrect knowledge regarding the appetites of those with anorexia nervosa, and therefore may have difficulty in correctly identifying those with anorexia nervosa. This question also taps into the knowledge of the extreme measures of control that those with this disorder employ. While having an appetite of normal proportions, they will restrict their eating to the point of starvation. One might consider whether this restrictive pattern of behaviour is perhaps not linked to the same form of control that is endorsed through the discourses of body ideal and healthism in that, those with culturally ideal and healthy bodies demonstrate the willpower to deny themselves those things that are desirable in order that they may look the way they do. It would be important for educators to be aware, therefore, of the possible link between the control endorsed by societal discourses and that shown by those with eating disorders in order to highlight the dangers of dieting and other methods of control that bring about weight loss.

Statement 12: *People with bulimia nervosa are usually within the weight range for their age and height*.

Unlike anorexics, bulimics usually show no outward signs of their secret behaviour, making them difficult to identify. They are typically within the normal weight range, although some may be underweight or overweight (Mahan & Escott-Stump, 2000). It is important for educators to realise that eating disorders are not only associated with those who are underweight. Care is therefore required when dealing

with weight and diet issues in the classroom even when learners do not obviously appear to be struggling with an eating disorder.

The sample was divided in their response to this question. Half of the sample (50%, n=25) felt that the statement was true and the other half (50%, n=25) felt that the statement was false. This implies, therefore, that half of the sample may be misguided in what they are looking for when attempting to identify those who are struggling with bulimia nervosa. They may also be in danger of making comments regarding the need for overweight learners to lose weight when these very learners may already have an eating disorder. It is therefore understood as vital that these educators have accurate knowledge regarding the details of eating disorders in order that they may utilize the required sensitivity.

Statement 13: *People with bulimia nervosa always induce vomiting*.

As discussed in Chapter 1, The DSM-IV-TR (American Psychiatric Association, 2003) specifies two types of bulimia nervosa, i.e. purging type and non-purging type. People who practice the non-purging type of bulimia nervosa make use of other inappropriate compensatory behaviours, such as fasting or excessive exercise, other than engaging in self-induced vomiting. It is important to note, when attempting to identify those adolescents suffering from bulimia nervosa, that purging is not a central part of the diagnosis, but that it is the binge eating behaviour and a form of inappropriate compensatory behaviour that identifies those with bulimia nervosa (Mahan & Escott-Stump, 2000).

Seventy six percent (n=38) of the sample felt that it was true that those who have bulimia nervosa always induce vomiting. The remaining 24% (n=12) disagreed with the statement. This again suggests that these Life Orientation educators do not possess the knowledge that is required to accurately identify those who are struggling with bulimia nervosa. It may also suggest that incorrect knowledge is being transmitted to those within their classroom, providing an opportunity for learners who are binge eating and making use of a compensatory behaviour other than vomiting to be misled into believing that they do not have an eating disorder.

6.3.1.2. Educator's knowledge regarding appropriate statements of advice for over-weight adolescents

The second part of the Research Questionnaire focused on questions pertaining to the type of advice that Life Orientation educators may give to overweight adolescents within their care. These questions were included in order to assess the accuracy of the educator's knowledge regarding a healthy and appropriate diet specific to the adolescent developmental stage. The questions were also designed to tap the underlying attitudes of educators towards obesity in adolescence, i.e. a belief that those who eat too much are fat. For this reason, seven of the ten questions dealt with the concept of food restrictions and the withholding of something. The remaining questions dealt with popular but ineffective ideas held by those who diet, weight monitoring and the inclusion of exercise. Of the ten questions posed, the sample was divided in opinion for nine of the questions. The results of the questions are presented in Table 13 and will be discussed below.

Table 13: Educator's knowledge regarding appropriate statements of advice for over-weight adolescents

Knowledge Questions		Yes		No	
		n	%	n	%
2.1	Go on a strict weight-reducing diet in which little to no carbohydrates are consumed.	16	32	34	68
2.2	Increase daily exercise.	50	100	0	0
2.3	Aim to lose 1-2 kilograms per week.	24	48	26	52
2.4	Reduce their daily intake of food.	36	73.47	13	26.53
2.5	Weigh themselves every day	14	28	36	72
2.6	Choose only low-calorie foods.	40	80	10	20
2.7	Avoid going on a weight-reducing diet.	26	52	24	48
2.8	Avoid combining foods, e.g. eating fruit and protein together.	10	20	40	80
2.9	Eat two meals per day rather than three.	6	12	44	88
2.10	Avoid eating certain foods like chips, sweets, chocolate, pies, sausage rolls and fried foods.	47	94	3	6

Note: Frequencies do not always add up to the sample total due to non-responses on some items.

As discussed, literature recommends against strict weight reducing diets for children or adolescents. While low carbohydrate diets are popular, it is important for the educator to understand the dangers of such a diet. Mahan and Escott-Stump (2000) points out that, in order for the body to function properly, the body tissues require a daily dietary supply of carbohydrates providing 50% to 55% of the total kilocalories. It has been suggested (Ogden, 2004) that complex carbohydrates (such as bread, potatoes, pasta and rice) reduce hunger and cause reduced food intake due to their bulk and the amount of fibre they contain. Therefore, carbohydrates make you feel fuller faster. Due to the growth spurt that occurs during adolescence, teenagers are in particular need of energy providing foods. During the time of peak growth velocity, adolescents usually need to eat large amounts of food often. To place an adolescent on a restrictive diet could therefore potentially impair their development.

While obesity is widely understood as being a physical health risk, it is important for educators to point out that, restrained eating may promote weight cycling, which is also detrimental to health. Failed attempts to diet, which are very likely to occur when using the methods outlined in the above questions, may leave the adolescent feeling that they have failed, and thus leave them depressed and with a sense of being out of control (Ogden, 2004). It is also important to highlight that, as discussed in Chapter 2, the metabolic changes that occur as a result of dieting and the impact of cognitive restraint may lead to disordered eating (Pesa, 1999; Polivy & Herman, 1983;). In fact, as mentioned, dieters are eighty times more likely than nondieters to develop an eating disorder (Wilson, 1995).

Thus, according to Mahan and Escott-Stump (2000), the treatment goal for the child who is overweight should be weight maintenance or a slowing of weight gain rather than a formalised weight reducing diet. Exercise is seen as an extremely important part of any weight maintenance programme, particularly in children and adolescence. While promoting the use of fat as fuel for exercise, numerous other positive side effects of exercise include strengthening cardiovascular integrity, relieving boredom, and increasing a sense of control and well-being (Mahan & Escott-Stump, 2000).

The results of the statements, as outlined in Table 13, will be discussed according to the concept tapped by the statements.

Food Restrictions

Statements 2.1, 2.3, 2.4, 2.6, 2.7, 2.9, and 2.10 collectively tapped the concept of restricting the intake of food in order to lose weight. As discussed above, literature recommends against strict weight reducing diets that involve the restriction of food and calories. When considering the educators' responses to the above questions, we see that they are somewhat divided in their opinions regarding dieting or restricted eating in adolescence. While 68% (n = 34) of participants felt, in statement 2.1, that adolescents should not go on strict weight-reducing diets, 48% (n = 24) of the sample, indicated in statement 2.7 that these adolescents should not avoid going on some kind of weight-reducing diet. The participants were somewhat divided in their opinion of whether the overweight teenager should aim to lose 1-2 kilograms per week (statement 2.3) with 48% (n = 24) believing they should and 52% (n = 26) believing they should not. The majority of the sample (73.47%, n = 36) believed that overweight teenagers should reduce their daily intake of food (statement 2.4) as well as 80% (n = 40) indicating in statement 2.6 that they should choose only low-calorie foods. Similarly, the majority of the sample (94%, n = 47) felt that these adolescents should avoid eating certain foods like chips, sweets, chocolates, etc (statement 2.10). Only 12% (n = 6) endorsed the skipping of meals in statement 2.9 with 88% believing that they should partake in all three meals.

Fad Diet Techniques

As diets are advertised by magazine and television advertisements, many people have access to information regarding what one 'should' include exclude from one's diet. Although some of the programmes that are advertised are sensible and appropriate, most emphasise fast results with a lack of logical nutritional principles (Mahan & Escott-Stump, 2000). As such, one could suggest that women are often ill-informed as to what is accurate information regarding healthy dieting. Question 2.8 is one example of a dieting concept often used but not linked to logical nutritional principles. Eighty percent (n = 40) of the participants did not agree with this approach to weight loss, with the remaining 12% agreeing that this technique is advisable.

Weight Monitoring Techniques

As weight per say should not be the emphasis when encouraging a healthy way of living in adolescents, weight monitoring techniques should not be encouraged. The majority of the sample (72%, n = 36) believed that overweight adolescents should not

weigh themselves every day, while the remaining 28% (n = 14) felt that this technique should be employed in order to lose weight.

Exercise

As pointed out, exercise is understood to be highly effective in weight maintenance in adolescents as well as being effective in increasing a sense of control and well-being. All participants agreed that overweight teenagers should increase their daily exercise.

In looking at the overall responses, therefore, one could suggest that, while the majority of the sample do not suggest strict weight-reducing diets that cut out carbohydrates, they do suggest limiting their overall intake of food and carefully selecting the types of food they eat, for instance, eating only low calorie foods while avoiding 'junk foods'. They also felt that these adolescents should increase their daily exercise. The educators were somewhat divided, however, in whether they endorsed weight loss as apposed to weight management, with just under half endorsing the loss of 1-2 kg per week and 28% suggesting that these adolescents weigh themselves everyday. It would appear from this, therefore, that these educators would benefit from obtaining information specific to the dietary needs of adolescents and regarding appropriate advice that should be given to the adolescent and/or their parents regarding weight management as opposed to weight loss techniques.

6.3.1.3. Educator's knowledge of effective and safe teaching practice regarding eating disorder pathology

The participating educators were asked to indicate whether they would use the methods of instruction outlined in the table below. These questions were designed according to what literature suggests as the most effective teaching practices in the area of eating disorder pathology and those things that should be avoided when teaching children about eating disorders. The appropriate response is indicted in italics. The results of the questions appear in Table 14 and are discussed below.

Table 14: Educator's knowledge of effective and safe teaching practice regarding eating disorder pathology

Knowledge Question		Yes		No	
		n	%	n	%
3.1	Provide learners with the facts about eating disorders, e.g. the types of eating behaviour associated with bulimia (such as binging and purging), and anorexia (such as dietary restraint) *(No).*	50	100	0	0
3.2	Make use of case studies and media reports to highlight the dangers of eating disorders, e.g. speaking about the experience and showing pictures of celebrities with eating disorders *(No).*	50	100	0	0
3.3	Provide classifications of "good" foods and "bad" foods so as to encourage a healthy diet *(No).*	50	100	0	0
3.4	Use practical exercises to encourage the development of self-esteem within the learners *(No).*	49	100	0	0

Note: Frequencies do not always add up to the sample total due to non-responses on some items.

Teaching Method 1: *Provide learners with the facts about eating disorders, e.g. the types of eating behaviour associated with bulimia (such as binging and purging), and anorexia (such as dietary restraint).*

The information model is based on the theory that an increase in knowledge will change an individual's attitudes. The assumption is that more knowledge about the harmful consequences of behaviour will prompt a less positive attitude toward that behaviour and that a negative attitude will lesson chances of it occurring (Robert-McComb, 2001). This approach assumes that people are rational and do not want to suffer harm, and if they are told about the dangers of a behaviour, they will avoid it. Research suggests that this approach works to a limited degree with adults, but much less so with children and adolescents. Teaching the facts alone has not proven to be an efficient means of changing behaviours and attitudes in adolescents. As discussed in Chapter 4, various studies (Carter, Stewart, Dunn & Fairburn, 1997; Mann, Nolen-

Hoeksema, Huang, Burgard, Wright & Hanson, 1997; Russel & Ryder, 2001(b)) have indicated that school-based education programmes that provide information about eating disorders may increase participant's knowledge and symptoms of eating disorders such as dietary restraint and purging. In so doing, vulnerable children are provided with the means to achieve, or attempt to achieve, the weight loss they already desired. A review of the most effective eating disorder prevention programmes to date suggest that school-based interventions are most effective and safe if they avoid direct instruction about eating disorders and employ self-esteem development, the enhancement of life skills, e.g. problem-solving, decision making, communication and assertiveness training, as well as a critical examination of the westernised cultural ideal of being thin (O'Dea & Maloney, 2000; Robert-McComb, 2003; Vandereycken & Noordenbos, 1998).

As Table 14 reflects, all 50 participants (100%) believed that this method of instruction would be one that they would employ. Not only is this method of instruction ineffective, but it is hazardous as it may introduce the very behaviour that these educators are attempting to prevent in their learners. The participating educators are clearly ill informed in this regard.

Teaching Method 2: *Make use of case studies and media reports to highlight the dangers of eating disorders, e.g. speaking about the experience and showing pictures of celebrities with eating disorders*.

As stated in Chapter 4, prevention programmes that make use of case studies such as media reports, discussions led by recovered peers, or drama activities about sufferers of eating disorders may be counter productive. These methods tend to reduce the stigma of these extreme disorders, and in so doing tend to glamorise the problem. When using those celebrities who have eating disorders in order to highlight the dangers of the disorder, it must be kept in mind that the adolescent already admires and respects this person and so may be drawn into wanting to look like them. The celebrity's success may be linked to the way they look, and thus also to the practices they employ in order to look the way they do. Frequent coverage of eating disorders in school lessons may also produce a sense of normalization of the problem, where the adolescent begins to believe that practices such as starvation and vomiting are common and therefore appear to be normal and socially acceptable behaviours (O'Dea, 2000).

As with the previous statement, 100% (n = 50) of the sample felt that they would employ the practice of making use of case studies and media reports in the teaching of eating disorders. This is again disturbing as it suggests that all the educators within the sample are employing teaching methods that serve to normalise and glamorise the practices of eating disorders, and are possibly encouraging experimentation, at the very least, of eating disorder practices in their learners.

Teaching Method 3: *Provide classifications of "good" foods and "bad" foods so as to encourage a healthy diet.*

Those with anorexia nervosa and bulimia nervosa tend to divide food into 'good' and 'bad' categories, often on the basis of nutritional myths. Some of these ideas are extreme interpretations of sensible dietary guidelines. For instance, dietary fat and sugar are eliminated rather than reduced and only foods that are considered 'calorie-sparing' are permitted. The result is usually an unappealing dietary regimen, but one that allows the person to feel 'safe' (Garner & Garfinkel, 1997). According to Robert-McComb (2001), school-based eating disorder prevention programmes may treat food and nutrition issues negatively by referring to "good" foods, "bad" foods, and "junk" foods. This classification of foods into "good" and "bad" categories is reminiscent of the way that those with eating disorders perceive food. O'Dea and Maloney (2000) suggests that this negative focus may contribute to an underlying fear of food and weight gain, factors that precipitate eating problems.

As with the previous two teaching methods, all 50 participants (100%) indicated that they would make use of such a teaching method when teaching about 'healthy diet'. Once again, the lack of accurate knowledge of effective and safe teaching practices regarding eating disorder pathology and healthy diet is demonstrated. One must question where these educators obtained such knowledge, as the full sample were in agreement as to the usage of such teaching practices. As the majority of the sample was not trained in the methods of Life Orientation, how is it they came to such shared knowledge? It may be suggested that this idea is influenced by the discourse of healthism in that certain food must be avoided as it causes weight gain or disease and is therefore 'bad' for you, while other food can be eaten without concern as it is 'good' for you. Thus we see the development of local and shared knowledges pertaining to the classification of foods into categories, often based on hearsay rather than on scientific evidence. As stated in Chapter 4, Outcomes Based Education relies

on the knowledge and personal experience of the educator due to the lack of ordered content from which they are given to work. In light of the above findings, it is concerning that the educators within the sample may not only be endorsing classifications of food that contribute to an underlying fear of food and weight gain, but are most likely basing the content of their instruction on their personal knowledge and experience rather than on scientific dietary content.

Teaching Method 4: *Use practical exercises to encourage the development of self-esteem within the learners.*

According to Robert-McComb (2001), some behaviours and attitudes associated with anorexia nervosa are (a) fear of eating in public; (b) feelings of ineffectiveness; (c) need to control the environment; (d) inflexible thinking; (e) limited social spontaneity; and (f) overly restrained emotional expression. Bulimics engaged in binge eating and purging frequently experience increased shame, guilt, anger and self-disgust after binge eating and purging (Robert-McComb, 2001). Lowered self-esteem, feelings of ineffectiveness and even self-disgust can be seen, therefore, to underlie the behavioural component of eating disorders. Self-esteem development is therefore seen as one of, and perhaps the most effective of strategies, in the prevention of eating disorders in a school context. The educator could employ a number of different exercises within the classroom to develop the self esteem of his/her learners (Robert-McComb, 2001).

All participants who responded to this item scored it positively by indicating that they would use practical exercises to encourage the development of self-esteem in their learners. One participant did not respond to the item.

6.3.1.4. Educators' views on their ability to identify and report eating disorders in their learners.

Of interest for the current study was whether or not the participating educators were being approached by learners within their care to speak about concerns regarding eating disorder pathology and whether these educators felt that they knew how to handle such a situation effectively. They were also requested to indicate how confident they felt regarding their ability to recognise signs and symptoms of eating disorders and to again to know what to do if they did recognise these signs and symptoms. The results appear in Tables 15(a) and 15(b) and will be discussed below.

Table 15(a): Educator's views on their ability to identify and report eating disorders in their learners.

Educator's Views		Yes		No	
		n	%	n	%
4.1	Do you know what to do (i.e. what channels to follow) if you think a child in your class is developing or experiencing n eating disorder?	26	53.06	23	46.94
4.2	Have any learners ever spoken to you about difficulties they are experiencing with weight or an eating disorder?	19	38.78	30	61.22
4.2.1	If Yes, did you know what to do?	16	84.21	3	15.79
4.3	Have you ever had a suspicion that a learner within your class was experiencing an eating disorder?	22	44.90	27	55.10

Note: Frequencies do not always add up to the sample total due to non-responses on some items.

Table 15(b): Educator's views on their ability to identify and report eating disorders in their learners

Educator's Views		Confidence Level	N	%
4.4	How confident do you feel to be able to recognise signs and symptoms of an eating disorder in one of your learners?	Very Confident	4	8.16
		Somewhat Confident	15	30.61
		Not Very Confident	21	42.86
		Not At All Confident	9	18.37
4.5	How confident do you feel that you would know what to do if a learner told you that he/she experiencing an eating disorder?	Very Confident	2	4.08
		Somewhat Confident	16	32.65
		Not Very Confident	17	34.69
		Not At All Confident	14	28.57

Note: Frequencies do not always add up to the sample total due to non-responses on some items.

As seen in table 15(a), the sample was divided between those who believed they did know what channels to follow if they suspected a child in their class was experiencing an eating disorder (53.06%), and those who felt that they did not know what to do (46.94%). This difference was minimal, suggesting that almost half of the

sample did not feel they knew what channels to follow. The majority of the sample (61.22%, n = 30) reported that they had not had a learner approach them regarding difficulties they were experiencing with weight or an eating disorder, while the remaining 38.78% (n = 19) indicated that they had been approached in this regard. One must question whether those educators who were approached had ever been trained in effective counselling skills. With the majority of these Life Orientation educators never having been trained specifically in Life Orientation, it is questionable as to whether they were offered such training. Of these 19 participants, most (84.21%, n = 16) indicated that they had known what do when having been approached, with three participants (15.79%) indicating that they had not known what to do. The sample were somewhat divided between those that had been suspicious about the development of an eating disorder in one of their learners (44.90%, n = 22) and those that had not (55.10%, n = 27). In order to suspect the development of an eating disorder within a learner, however, the educator needs to be able to accurately recognise the signs and symptoms of eating disorders. It has been demonstrated in previous knowledge based questions of this study that there was a lack of knowledge regarding eating disorder pathology in the sampled educators. Due to this, one must question the accuracy of these educators' ability to recognise signs and symptoms of eating disorder pathology.

It would appear from Table 15(b) that these educators acknowledge their lack of confidence in being able to recognise the signs and symptoms of eating disorders in their learners and to know what to do if a learner told them they were experiencing an eating disorder. The majority (61.23%, n=30) of the sample indicated that they were either not very confident or not at all confident to recognise eating disorder signs and symptoms in their learners, with 63.26% (n=31) indicating being not very confident or not at all confident in their ability to know what to do if they were approached by a learner who was experiencing an eating disorder. It would appear from the above, therefore, that, while some educators within the sample have been approached by a learners with concerns regarding weight or an eating disorder and have felt confident to know what to do, the majority of the sample do not feel confident to accurately recognise the signs and symptoms of eating disorders and therefore have not suspected learners within their class as having an eating disorder. If these educators were approached, they indicated that they would not, on the whole, feel confident to know what to do.

6.3.1.5. The needs of educators within the sample regarding training in eating disorders.

From the responses to the above questions, it has become evident that there is a paucity of knowledge regarding eating disorder pathology, weight and healthy diet in the educators sampled. It is also evident that these educators lack knowledge regarding safe and effective teaching practices when dealing with eating disorder pathology in the classroom and that these educators do not, on the whole, feel confident to recognise signs and symptoms of eating disorders or to know what to do if these are recognised. This leads us to question the quality of the training these educators are exposed to, as their lack of knowledge and confidence appears to exist across the board, rather than occurring amongst just one or two educators. While it was evident from the biographical questionnaire that the majority of the participants were not trained specifically in Life Orientation teaching as they were trained prior to its inception, one might wonder whether these educators were provided with other forms of specific training in the form of courses offered to them as student teacher, or training workshops offered to them by their schools. The researcher was also interested to know whether these educators felt that they required further training and whether they would be interested to attend training workshops. The results of these questions appear in Table 16 and are discussed below.

Table 16: The needs of educators within the sample regarding training in eating disorders

Needs for Training Regarding Eating Disorders		Yes		No	
		n	%	n	%
4.6	When you were a student teacher, did you ever have any kind of training with regards to eating disorders?	7	14.29	42	85.71
4.6.1	If Yes, was the training worthwhile?	7	100	0	0
4.6.2	If Yes, was the training sufficient?	5	71.43	2	28.57
4.7	Has your school ever had any training courses with regard to eating disorders?	1	2.04	48	97.96
4.7.1	If Yes, was it worthwhile?	1	100	0	0
4.7.2	If Yes, was it sufficient?	1	100	0	0

Needs for Training Regarding Eating Disorders		Yes		No	
		n	%	n	%
4.8	Do you think Life Orientation educators should be responsible for teaching eating disorder prevention skills to their learners?	49	98	1	2
4.9	At this moment, do you feel you are adequately trained to teach such a programme?	16	32	34	68
4.10	Do you think you need some form of training with regards to eating disorders?	46	92	4	8
4.11	Would you be interested in a training workshop that dealt with the dominant societal influences associated with the development of eating disorders in order that you could be more aware of their potential influence in your classroom?	48	96	2	4

Note: Frequencies do not always add up to the sample total due to non-responses on some items.

Forty two (85.71%) of the sample indicated in question 4.6 that they had never, as student teachers, had any training with regards to eating disorders. Only 14.29% (n = 7) indicated that they had received such training. Of the 14.29% that had obtained training, 100% (n = 7) felt that the training was worthwhile (question 4.6.1) while 71.43% (n = 5) felt that it was sufficient (question 4.6.2). The results of Question 4.6.2 indicated that 28.57% (n = 2) felt that, while the training was worthwhile, it was not sufficient for their needs as a Life Orientation educator. Only one participant (2.04%) indicated in question 4.7 that her school, out of the 39 schools that were surveyed, offered a training course on eating disorders, with the remaining 97.96% (n=48) indicating that their school had never offered such a course. The one participant whose school had offered the course felt that the course was both worthwhile and sufficient (questions 4.7.1 and 4.7.2). While 98% (n = 49) of the participants felt that they, as Life Orientation educators, should be responsible for the teaching of eating disorder prevention skills at schools (question 4.8), 68% (n = 34) felt that they were not, at this point, adequately trained to teach such prevention programmes (question 4.9), with 92% (n = 46) indicating a need for further training in the area of eating disorder prevention (question 4.10). All but two of the educators,

i.e. 96% (n = 48), indicated in question 4.11 an interest in a training workshop that dealt with the dominant societal influences associated with the development of eating disorders to increase their awareness of the potential influence of these discourses in their classroom.

From the above it is evident that, while some training in the area of eating disorders had been available and sufficient for the minority of the sample, the majority had never received training either from their tertiary institution whilst training as an educator or subsequently in the form of in-service training. These educators indicated that, while they do not feel adequately trained to perform the tasks they believe they should be performing, i.e. eating disorder prevention, they would be interested in attending training workshops and workshops pertaining to the influence of dominant societal influences within their classrooms. It would appear, therefore, that these educators would welcome training in these areas as they wish to perform their tasks more competently.

This is a positive finding as it indicates that, while these educators are in need of further training in the area of eating disorder prevention, they are interested in such training and are willing to take up the responsibility of running such programmes in their schools. As described in Chapter 4, schools are seen to be particularly useful sites in the implementation of prevention programmes because they offer relatively easy access to large groups of adolescents. Educators are understood to be indispensable in the early identification of eating disorders and the prevention thereof. Thus, if it could be shown that Life Orientation educators generally hold the views as those indicated in this study, it would be of great benefit to offer such training workshops for Life Orientation educators in order to utilise their position of influence and commitment in the prevention of eating disorders.

6.3.2. Aims Two and Three

As has been explored in Chapter 4, knowledge can never be understood as a mere grouping of facts devoid of cultural meaning or personal experience, and the dissemination of such knowledge can never completely be separated from the social position of the educator. Thus, when exploring the effectiveness of an educator's role in the prevention of eating disorders, it was seen as important to understand the personal weight-related experiences of the educator, particularly in light of their social position as females within a westernised culture. While no direct inferences could be

made, one could, based on their personal attitudes and behaviours, question the meaning that these educators attribute to diet and weight-related issues both personally and in the classroom. The educators were requested to complete two standardised questionnaires, that is, the Eating Attitudes Test (EAT-40) and the Body Shape Questionnaire (BSQ). The results of these questionnaires and the discussions thereof appear below.

6.3.2.1. Aim Two: The Body Shape Questionnaire (BSQ)

The second aim of the current study was to explore and describe the attitudes held by Life Orientation educators with regards to their own body image. Data obtained from the Body Shape Questionnaire was used to explore and describe aim two. The BSQ is designed to measure concerns about body shape and in particular the experience of 'feeling fat' (Ghaderi & Scott, 2004). As such, it is a measure of dissatisfaction of body shape. As discussed in Chapter 2, body dissatisfaction is understood in terms of negative feelings towards and cognitions of the body's weight and shape (Ogden, 2004), and is reported by some to be the single strongest predictor of eating disorder symptomology (Caradas, Lambert & Charlton, 2001; Cooper & Fairburn, 1993; Ricciardelli & McCabe, 2003; Vervaet & Van Heeringen, 2000).

The descriptive statistics in terms of means and standard deviations obtained on the BSQ for the total sample are presented in Table 17.

Table 17: Frequency Distribution of BSQ Scores for Participants

	BSQ Scores	n	Percentage
No Significant Concerns Regarding Body Shape and Feeling Fat	40-119	41	82
Significant Concerns Regarding Body Shape and Feeling Fat	120-149	6	12
At Risk for Bulimia Nervosa	150-169	3	6
	Total	50	100
Mean for Total Sample	84.80		
Standard Deviation	33		
Range for Total Sample	40 - 167		

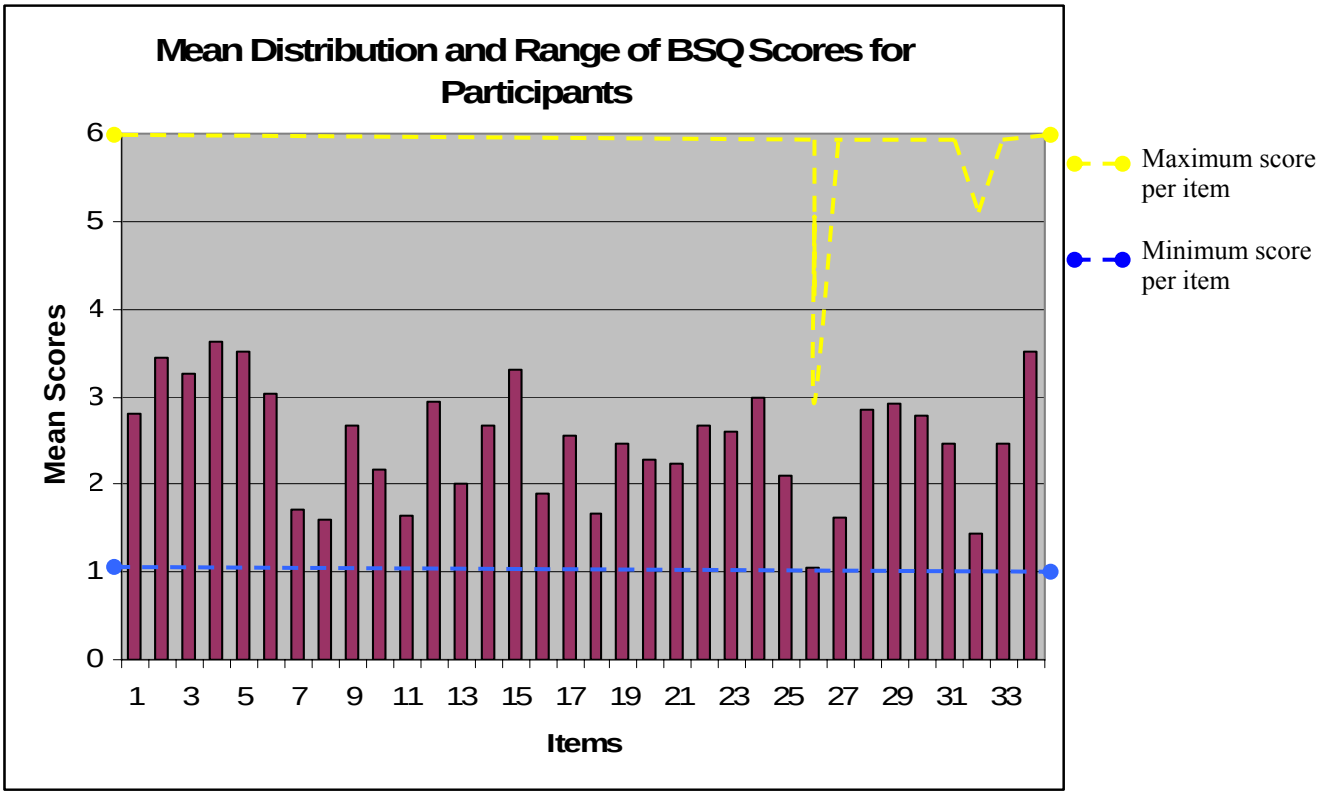
Table 17 depicts a range of scores obtained by the participating educators for the BSQ, and describes the majority of the sample as having no significant concerns regarding body shape and feeling fat, as would be expected for a non-clinical sample. Twelve percent of the sample, however, showed significant body dissatisfaction, with a further six percent displaying levels of body dissatisfaction indicative of those with bulimia nervosa. This therefore suggests that eighteen percent of the sample displayed body dissatisfaction of significant proportions, beyond that which would be expected as a 'normative discontent' with weight and body shape for females within a westernised culture. It is important, however, to apply caution to the interpretation of the above results due to there being no current South African norms available for the BSQ. In view of the fact that there are no such available norms, two standard deviations from the mean will be used as a cut-off point for abnormality (clinical conditions), as used in a study by Jacobson (1992), and one standard deviation as a cut-off point for subclinical conditions. While this is an acceptable statistical procedure in research, the fact that the BSQ is standardised on an American sample limits the confidence with which one can identify clinical disorders in a South African context. In other words, this will limit the researcher to identifying those who may have significant concerns regarding body shape and feeling fat rather than those who definitely do show such concern. When using this method, however, no changes arise in cut-off points, i.e. 12% of the sample still display possible significant body dissatisfaction (those with scores between one and two standard deviations) and 6% have possible body dissatisfaction indicative of those with bulimia nervosa (those with scores greater than two standard deviations from the mean).

Cooper, Taylor, Cooper and Fairburn (1987) found the average scores for nonclinical female college students to be 71.9 (SD = 23.6). This was lower than the mean obtained by Sheward (1995) for white South African students (95.7) and for black college students in the Western Cape (85). Senekal, Steyn, Mashego and Nel (2001), however, obtained a slightly lower mean (71.8) for black South African female students than obtained by Cooper, Taylor, Cooper and Fairburn (1987). The current sample was made up of 56% black, 34% white, and 10% coloured participants. The mean scores obtained for the BSQ for the current study (84.80) falls below that found by Sheward (1995) for white nonclinical South African students and above that found by Senekal, Steyn, Mashego and Nel (2001) for black nonclinical female students. This would be expected as the sample was made up of a mixture of

black, white and coloured individuals. Thus, we could suggest that the current sample of educators reflected body dissatisfaction within the range found by other South African studies of nonclinical populations. As discussed in Chapter 4, O'Dea and Abraham (2001) argue that, as role models in the lives of learners, educators should be expected to be able to cope more effectively with body and weight concerns than other women in the community. The educators within the current sample are displaying no greater adjustment to body and weight concerns than other women in the South African community, with 18% of the sample displaying significant concerns regarding their body shape and weight.

Looking at the individual items of the BSQ, it becomes evident that some items were scored higher by participants as a whole than other items. Figure 1 illustrates the mean distributions and the ranges across the items of the BSQ.

Figure 5: Mean Distributions and Ranges of Individual Items of the BSQ



The items of the BSQ can be divided into three categories according to the mean score for each item, as seen in Figure 1, i.e. those items whose mean score is between 1 and 2, those whose mean is between 2 and 3, and those whose is above 3. In so doing, one can reflect on the shared experiences of the educators, that is, those

statements that the participating educators were more likely to answer positively about and those they were least likely to answer positively about. The items whose mean is between 1 and 2 (the lowest scoring items) and those whose mean is above 3 (highest scoring items) are illustrated in Table 18.

Table 18: Individual items of BSQ according to the Mean Scores

	Item No.	Statement	Mean
Lowest Scoring Items (mean between 1 and 2)	7	Have you felt so bad about your shape that you have cried?	1.72
	8	Have you avoided running because your flesh might wobble?	1.60
	11	Has eating even a small amount of food made you feel fat?	1.64
	16	Have you imagined cutting of fleshly areas of your body?	1.90
	18	Have you not gone out to social occasions (e.g. parties) because you have felt bad about your shape?	1.66
	26	Have you vomited in order to feel thinner?	1.04
	27	When in company have you worried about taking up too much room (e.g. sitting on the sofa, or a bus seat)?	1.62
	32	Have you taken laxatives in order to feel thinner?	1.44
Highest Scoring Items (Mean above 3)	2	Have you been so worried about your shape that you have been feeling that you ought to diet?	3.44
	3	Have you thought that your thighs, hips or bottom are too large for the rest of you?	3.26
	4	Have you been afraid that you might become fat (or fatter)?	3.62
	5	Have you been worried about your flesh being not firm enough?	3.52
	6	Has feeling full (e.g. after a large meal) made you feel fat?	3.04

	Item No.	Statement	Mean
	15	Have you avoided wearing clothes which make you particularly aware of the shape of your body?	3.30
	24	Have you worried about other people seeing rolls of flesh around your waist or stomach?	3.00
	34	Has worry about you shape made you feel you ought to exercise?	3.52

When looking at the range of mean scores for the individual items of the BSQ, it is important to highlight that, while there were participants who scored on the upper extreme for questions, the majority of the sample tended to score on the lower extreme. As mentioned, this would be expected, as the sample is a non-clinical sample, and as such would be unlikely to generate high average scores.

In looking at those items that the educators collectively scored the lowest for, it is noteworthy to highlight that five out of the eight lowest scoring items had to do with a behaviour or action related to an attitude about their body shape and weight, e.g. have you *cried*, avoided *running*, not *gone out*, *vomited*, taken *laxatives*. In contrast to this, five out the eight highest scoring items used the word *worry* or *afraid* in the statement, but did not describe any action related to this concern. This would suggest that, while the educators collectively experience worry or concern about their body shape and weight, they do not generally act on this dissatisfaction. This would appear to correlate with the information obtained from the Biographical Questionnaire where, while 85.58% ($\underline{n} = 43$) of the participants indicated that they desired to lose weight, only 32% indicated that they were currently dieting.

Those items with mean scores of 3 and higher reflect what was described in Chapter 3 as the discourses of body ideal and healthism. Statement 3, for instance, refers to the experience of one's thighs, hips or bottom being too large for the rest of the body and Statement 24 refers to worrying about rolls of flesh around the waist and stomach. As explored in the Chapter 3, the ideal feminine form has changed over time from a heavier and more voluptuous figure to a thin and almost shapeless figure. Thus we see reflected in the current sample of educators the desire to fit the current beauty ideal of being 'skinny' and 'toned', a beauty ideal that rejects the biologically normative localisation of fat around the hips, thighs and buttocks. These statements

also reflect the 'anti-fat' messages of the discourse of body ideal and healthism in which fat is feared. Statements 4 and 6 refer to an experience of feeling fat and fearing becoming fatter. As discussed in Chapter 2, surveys of the views of young girls have indicated that they are more afraid of becoming fat than they are of cancer, nuclear war, or losing their parents (Berzins, 1999). The medical perspective and publicity surrounding exercise and working-out have strongly communicated messages of the dangers of fat and the need to eliminate fat from the diet and body. It is not surprising therefore that the educators within the current sample are communicating a fear of fat or of becoming fatter. Statement 34 reflects the link between exercise and weight loss as described in the discourse of healthism in Chapter 3. Forty eight percent of the sample indicated that they either 'often', 'very often' or 'always' feel they need to exercise when worrying about their shape. Arthurs and Grimshaw (1999) suggest that the discourses of health, fitness and beauty have become scarcely separable from each other, as the ideal female body is "fit, toned, lightly muscled and gleaming" (p.5). Therefore, while the health and fitness industry promotes exercise for health reasons, it is clear from the current sample that there is a strong link between the need or desire to exercise, and concern regarding body shape and weight outside of health reasons.

For the current sample of educators, therefore, it is evident that, while the majority of the sample shows normative discontent regarding their shape and weight, eighteen percent of the sample show possible significant concern regarding the shape and weight of their body. The mean scores of the BSQ indicate a level of body dissatisfaction across the sample that is within the range that has been found in other South African studies of nonclinical samples. The mean scores of the individual items of the BSQ highlight a fear of fat and weight gain, a desire to display a culturally acceptable body form, and a desire to exercise in order to attain this culturally accepted body ideal, factors that have been shown to be normative concerns for women in westernised cultures.

6.3.2.2. Aim Three: The Eating Attitudes Test (EAT-40)

The third aim of the current study was to explore and describe the behaviour of Life Orientation educators with regards to eating habits, dieting and exercise. Data obtained from the Eat-40 was used to explore and describe this aim.

It is, in reality, very difficult to separate one's attitudes around weight and food intake and one's behavioural responses to these attitudes. The EAT-40 measures both attitudes and behaviours characteristic of those with eating disorders, and is useful as a screening instrument for identifying actual or incipient cases of eating disorders in an undiagnosed population (Garner & Garfinkel, 1979; Garner & Garfinkel, 1997). It has been described more broadly by authors as being a measure of abnormal, disturbed, or exaggerated eating patterns in nonclinical samples (Carter & Moss, 1984; Koslowsky, Scheinberg, Bleich, Mark, Apter, Danon & Solomon, 1992). As such, while it does tap into the attitudes around weight and food of the participants, it is used extensively to distinguish between those with normal and abnormal eating behaviour, as described by the EAT-40 measure as those with healthy eating behaviour, subclinical eating behaviour and pathological eating behaviour. It will therefore be used to assess the eating behaviour of those Life Orientation educators assessed.

The descriptive statistics, in term of the means and standard deviations, obtained on the EAT-40 for the total sample are presented in Table 19 and Figure 6.

Table 19: Frequency Distribution of EAT-40 Scores for Participants

	Eat Scores	n	Percentage
Healthy Eating Behaviour	3 – 20	41	82
Subclinical eating disorder pathology	21 – 23	5	10
Pathological eating behaviour	30 – 38	4	8
	Total	(N) = 50	100

The following figure gives a graphic representation of the results of the EAT-40.

Figure 6: Frequency Scores for the Eating Attitude Test - 40

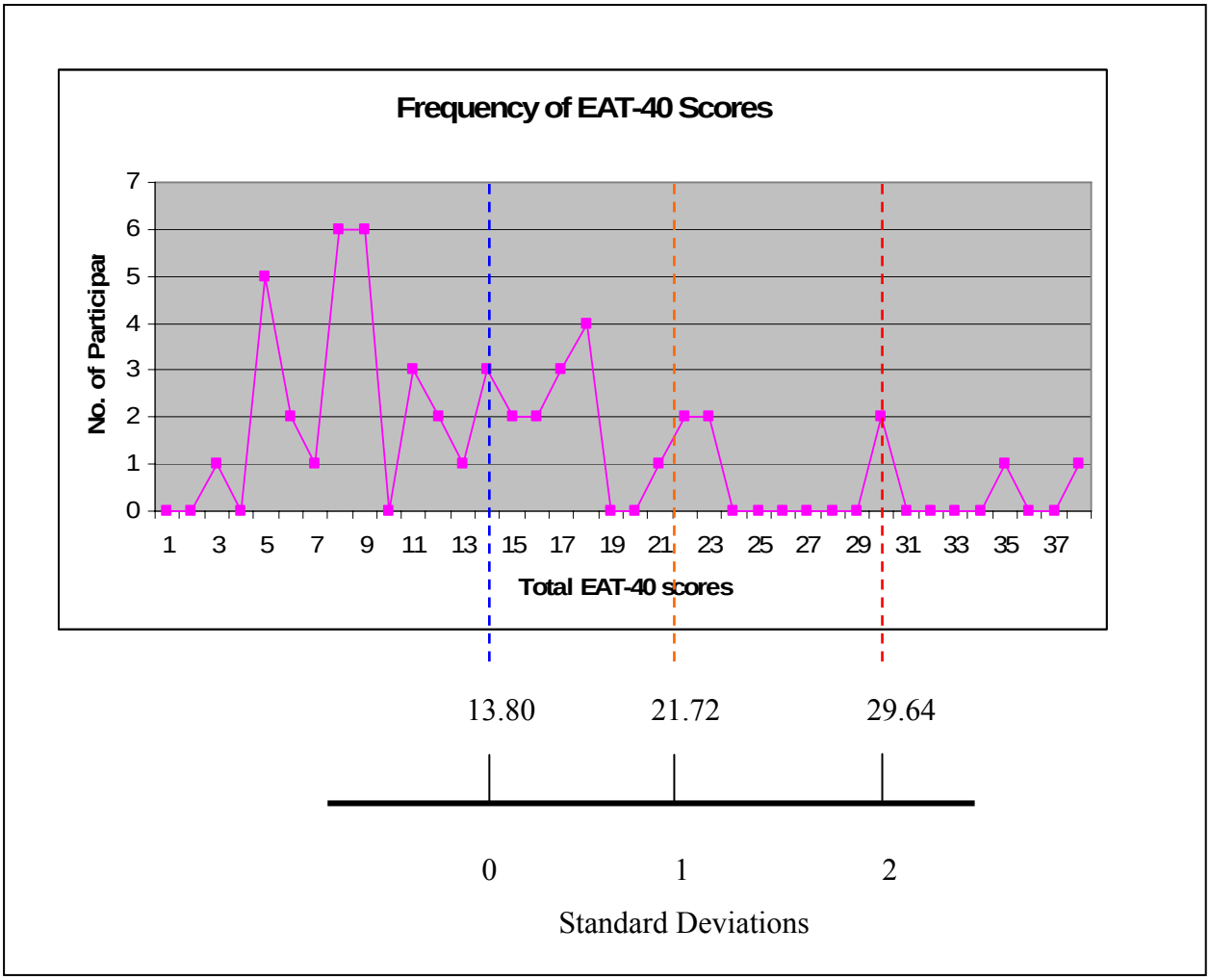


Table 19 and Figure 6 show that the sample was made up by those with both normal and abnormal eating behaviours. Those who showed normal eating behaviour made up the majority of the sample (82%, n = 41), with subclinical and clinical pathological eating behaviour being displayed in eighteen percent (n = 9) of the sample. Eight percent (n = 4) of the sample scored within the 'anorexic range' of the EAT-40. It is important to note the limitations of using the EAT-40 in a nonclinical sample and in a South African context for which there are no current norms. It has been shown that the EAT-40 yields a high false positive rate for anorexia and bulimia nervosa among nonclinical samples (Carter & Moss, 1984; Johnsone-Sabine, Wood, & Patton, 1988; Meadows, Palmer, Newball, & Kenrick, 1986) and therefore should be used with caution. In view of the fact that there are no available South African norms on the EAT-40, the same method used to delineate the cut-off points for the BSQ will be used for determining the cut-off points of the EAT-40, i.e. two standard deviations from the mean will be used as a cut-off point for abnormality (clinical

conditions) and one standard deviation as a cut-off point of possible subclinical conditions. While this is an acceptable statistical procedure in research, the fact that the EAT-40 is standardised on an American sample limits the confidence with which one can identify clinical disorders in a South African context. In other words, this will limit the researcher to identifying those who *may* have eating disorders rather than those who definitely *do* have these disorders. When using this method, 8% of the sample obtained scores above two standard deviations from the mean, and thus are suggestive of pathological eating behaviour. There is therefore no change when using this method to identify possible pathology. It does limit, however, those who show possible subclinical pathological eating behaviour to 8%.

The mean obtained by the current sample for the EAT-40 was 13.80 (SD = 7.92). Means obtained on other samples differ significantly across population groups. Only nonclinical samples will be looked at for the purposes of this study. Gross, Rosen, Leitenberg and Willmuth (1986) obtained a mean of 11.5 (SD = 7.5) for a nonclinical female population, while Mintz and O'Halloran (2000) obtained a mean of 13.17 (SD = 8.50) for a similar female population. A mean of 12.2 (SD = 12.6) was obtained by Caradas, Lambert and Charlton (2001) for a sample of South African schoolgirls, with white schoolgirls obtaining a higher mean score (12.5, SD = 11.6) than black (11.7, SD = 10.8) or mixed (11.5, SD = 11.2) racial groups. Jacobson (1992) obtained a mean of 14.9 (SD = 11.2) for South African nonclinical female psychology students. Colborn (1994) demonstrated that South African dance students (19.7, SD = 14.1) and South African medical students (15.9, SD = 13.0) have higher mean EAT-40 scores than social sciences students (12.7, SD = 10.6) at a South African university. When comparing the mean obtained for the current sample, it becomes evident that this sample obtained a higher mean score than those obtained in most nonclinical female samples sited above, other than the means obtained for so-called high risk groups (dance students and medical students) in which the prevalence of clinical eating disorders is high (Garner & Garfinkel, 1980; Herzog, Pepose, Norman & Rigottie, 1985) and for those obtained by South African psychology students. One could suggest, therefore, that the mean maladaptive eating behaviour is somewhat higher than what would be usual for a nonclinical sample, but is within an 'expected' range when calculating the standard deviation range.

Again, the important position of the educators as socialising agents and role models in the lives of the adolescents within their care may suggest that these

individuals should display more adaptive eating behaviour that those in the general public. As demonstrated above, the current sample is displaying no more adaptive eating behaviours than those within the general nonclinical public.

When adding the scores obtained on the BSQ to the above picture, we see in both measures that 82% of the sample demonstrated no clinical or subclinical attitudes or behaviours with regards to eating and weight management, when using the cut-off points as indicated by the authors of the measures. Both measures therefore suggested that only 18% of the sample demonstrated attitudes and behaviours that could be indicative of eating disorder pathology of either subclinical or clinical proportions. Results of the BSQ suggested that three participants were at risk of clinical eating disorder pathology, while the EAT-40 results indicated that four participants may be displaying clinical eating disorder pathology. This difference is slight and suggests that around 6% percent of the sample was possibly displaying eating disorder pathology of clinical proportions. According to the DSM-IV-TR (American Psychiatric Association, 2003), the lifetime prevalence of anorexia nervosa amongst females is approximately 0.5% while that of bulimia nervosa is 1% - 3% amongst women. It could therefore be suggested that the prevalence of possible clinical eating disorders within the sample was higher than that which would have been expected based on the DSM-IV-TR (American Psychiatric Association, 2003).

6.4. Conclusion

This chapter aimed at describing and discussing the results that were elicited from the four questionnaires completed by the participants. As this study is exploratory and descriptive in nature, no attempt has been made to draw conclusions regarding what has been found. The results of the study have, however, raised certain questions as to the effectiveness of those Life Orientation educators that were assessed regarding their role in eating disorder prevention in schools, as well the possible influence their own attitudes and behaviours may be having on the learners within their classroom.

CHAPTER 7
CONCLUSIONS, LIMITATIONS AND RECOMMENDATIONS

"Who dares to teach
must never cease to learn"
-John Cotton Dana-

7.1. Introduction

The main aim of this research was to explore and describe the knowledge, attitudes and behaviours related to eating disorders, body image and weight control of a group of female Life Orientation educators. It was argued that this information is essential to the implementation of effective eating disorder prevention strategies by Life Orientation educators within the school context. As the results of the current study's aims have been presented and discussed in the previous chapter, certain conclusions can now be drawn from these findings. This chapter provides a summary of the main findings of this study. The limitations and contributions of this study are also discussed. Lastly, recommendations for future research are outlined.

7.2. Aims of the Study Revisited

Conclusions based on the results of the study will be structured according to the aims. The results obtained pertaining to each of the current study's aims are discussed below.

7.2.1. Description of the knowledge of the sample regarding eating disorders and healthy diet.

The first aim of the current study was to explore and describe the knowledge of Life Orientation educators with regard to eating disorders and healthy diet. This aim included assessing the educators' knowledge regarding body weight, eating behaviour and eating disorders; their knowledge regarding appropriate statements of advice for over-weight adolescents; their knowledge of effective and safe teaching practice regarding eating disorder pathology; their views on their ability to identify and report eating disorders in their learners; and finally, the needs of the educators within the current sample regarding training in eating disorder prevention.

It was pointed out that the level of incorrect responses on the Research Questionnaire is cause for concern. Not one participant was able to correctly answer

all the items within the first part of the questionnaire, suggesting an overall level of knowledge that can be described as poor. Eighty four percent of the items that assessed the participants' knowledge regarding body weight, eating behaviour and eating disorders were scored incorrectly by 12% or more of the participants. If it were to be shown that this study could be generalised to all Life Orientation educators in South Africa, this minimum 12% could indicate the possibility of vast numbers of Life Orientation educators possessing poor knowledge regarding the above mentioned factors. As demonstrated in the discussion, this paucity of knowledge could result not only in the learners having a lack of information regarding eating disorders and healthy diet, but could also impact negatively on an educator's ability to correctly identify vulnerable learners. Furthermore, the educators' lack of knowledge could negatively impact on learners who have developed an eating disorder, in terms of how they view their disorder and the treatment thereof.

As demonstrated in the discussion, it becomes apparent that the participating educators would benefit from obtaining information specific to the dietary needs of adolescents, and information regarding the appropriate advice that should be given to the adolescent and/or their parents with respect to weight management rather than weight loss techniques. While the provision of the appropriate information and advice can serve to guide educators in their work, the social context in which such information acquires meaning should be considered. As highlighted, the message that is intended by the educator may not always be the message that will be acquired by the learner. This is due to the social identity of both the learner and the educator. Thus, the meaning that the word 'diet' will come to have for learners is questionable when these Life Orientation educators address the requirements of a having a healthy diet on the one hand, and endorse weight reduction and restrictive calorie intake on the other. These educators may very well be endorsing the dominant societal discourses that encourage females to employ restrictive practices in their eating habits and within their lives as a whole. Thus, it is suggested that these educators receive training on how to effectively communicate the ideals around healthy eating without reinforcing and encouraging the ideas of restriction and diet in order to fit a socially constructed body ideal.

Perhaps most concerning was the incorrect knowledge that all educators within the sample possessed with regards to effective and safe teaching practices in the prevention of eating disorder pathology. As research has illustrated, educators can do

more harm than good when attempting to teach their learners regarding the perils of dieting and eating disorders. It would appear that the results of this research support the concerns raised by the aforementioned research. Explanations of how such incorrect knowledge has been acquired by educators remain an important area for further investigation. The results of the current study do highlight, however, the need for training that would limit the endorsement of those very issues that educators are attempting to prevent. The importance of such training cannot be overemphasised.

Not only was it demonstrated that the Life Orientation educators within the sample had a paucity of knowledge regarding eating disorders, causing one to question their ability to correctly identify vulnerable learners, but the educators themselves indicated their lack of confidence in correctly identifying such vulnerable learners and knowing what steps to take with those who were suffering from the disorder. As there were educators within the sample who had been approached by learners with dieting and eating disorder concerns, it may be important to consider training in the area of basic counselling skills to assist these educators in how to approach their conversations with these learners. These educators also communicated, almost unanimously, a desire for further training and workshops in order to better perform a task that they felt was their responsibility, i.e. eating disorder prevention.

It is suggested, therefore, that the first aim of the current study demonstrated a paucity of knowledge with regards to eating disorders and healthy diet within those Life Orientation educators assessed, as well as a need for further training in this regard. This lack of knowledge is concerning particularly in light of the lack of content within the Outcomes Based curriculum currently being employed in South African schools. As educators are not provided with much structure or content from which to work, they are forced to rely on their own knowledges and that which they ‘happen’ to acquire along the way. It is suggested that these educators be supported in the very difficult, but equally important, task of educating our children, particularly around the issues explored in this research study. Referring to the discourse of schooling discussed in this research study, it is important to keep in mind the imbalance of power that exists between the educator and the learner and thus the gravity given to what the educator states or inadvertently communicates within and outside the classroom. Learners may thus find it very difficult to question what the educator says or to consider that what the educator has told them may be grounded in personal experiences or knowledges that may be potentially harmful. Again, it

becomes vital to provide these educators with information and knowledge that has been researched so that they are not forced to rely solely on their personal experiences and knowledges when teaching about healthy eating and eating disorders.

7.2.2. Description of the attitudes of the sample regarding their own body image.

The second aim of the current research was to explore and describe the attitudes held by Life Orientation educators with regards to their own body image. This aim was assessed using the Body Shape Questionnaire. The majority of the sample was found to have no significant concerns regarding their body shape, with the majority of the participants experiencing 'normative' discontent with their bodies. Just under a fifth of the sample, however, demonstrated significant concern regarding body shape. It was demonstrated that the average body discontent measured by the BSQ in this research study was consistent with what had been found to be average in other research studies conducted on similar South African populations. While this may appear encouraging, it is important to keep in mind that these educators are being required to buffer dominant societal ideals in order to prevent the learners within their care from accepting these ideals as their own. Thus, while these educators may be demonstrating body shape and size discontent that is normative within the general public, it has been suggested that they should be demonstrating less discontent than the general public. Those items that the educators felt were, on the whole, more true to their experiences, reflected an internalisation of the dominant cultural ideals of the feminine body. These items also reflected the link between exercise and weight loss rather than exercise being seen purely in the light of health.

It was also shown that the majority of the sample desired to weigh less than what they currently were weighing, with one sixth of the sample not only being dissatisfied with their weight, but indicating a desire to lose weight to the point of being underweight. It has been suggested by a number of authors (Boskind-Lodahl & Sirlin, 1977; Bruch, 1978; Fairburn & Garner, 1986; Polivy & Herman, 1987, Scarano & Kalodner-Martin, 1994; Russell & Ryder, 2001(a)) that eating disorders are at the extreme end of a continuum of behaviours and attitudes. Based on the results of the current sample, one could suggest that many of the women assessed fall within Scarano and Kalodner-Martin's (1994) category of weight-preoccupied individuals. These women, while perhaps not practicing weight loss techniques at present, are vulnerable to the development of unhealthy eating practices and attitudes, as body

dissatisfaction has been reported by some to be the single strongest predictor of eating disorder symptomology (Caradas, Lamber & Charlton, 2001; Cooper & Fairburn, 1993; Ricciardelli & McCabe, 2003; Vervaet & Van Heeringen, 2000).

7.2.3. Description of the behaviour of the sample regarding their eating habits and exercise.

The third aim was to explore and describe the behaviour of Life Orientation educators with regards to eating habits, dieting and exercise. This aim was assessed by using the EAT-40. As with the BSQ, the EAT-40 demonstrated that the majority of the sample was implementing healthy eating behaviours. Just under a fifth of the sample was shown, however, to be displaying subclinical or pathological eating behaviour. It was demonstrated that the mean of the EAT-40 found in this research study was consistent with that found in other samples of similar non-clinical proportions. It was suggested, however, that due to the role of these educators as socialising agents in the lives of learners, they should be demonstrating eating behaviour that is not consistent with that of the general public. Their behaviours should in fact reflect a buffering of the dominant societal ideals and messages.

While the majority of the sample demonstrated some dissatisfaction with their weight, reflected through their desire to lose weight, less than a third of the sample was currently implementing a weight loss technique in the form of a diet. It was suggested that many of these dieting participants may fall within the 'chronic dieters' category of Scarano and Kalodner-Martin's (1994) Continuum Model of Bulimia Nervosa, thus increasing their vulnerability to the development of an eating disorder.

It is suggested that aims two and three have demonstrated how many women within the sample have struggled to perceive themselves outside of those ideals that the dominant societal discourses invite. These educators, like the majority of women within the westernised culture, have been positioned within a dominant societal discourse that informs them as to how they should look to be truly feminine and successful. It thus becomes difficult to have views of oneself that are not formed by these ideals or to avoid comparing oneself with the ideal and thus evaluating one's success in this regard. It also becomes difficult to avoid assessing others by this same critique. This therefore raises the question as to the effect that the participating educators' personal experiences may be having on the learners within their care, as

the learners may also be evaluated by these same educators according to the criteria for success dictated by the dominant societal discourses.

To reject such a critique, these women would need to be aware of the dominant ideals, the alternatives to such ideals and the effect that these ideals have on their relationships with themselves and others. It is therefore suggested that these educators be given the opportunity to examine the expressions of these social ideals in their own lives and in the lives of their learners. They may further wish to examine the norms and policies operating within their schools that serve to reinforce or regulate issues such as weightism. It was indicated that the educators within the current sample are interested and willing to participate in such workshops. It is therefore suggested that the voices of these educators be heard and that supportive and training workshops be provided for them and the many thousands of educators in South Africa in similar positions.

7.3. The Value of the Research

The current study contributes to the growing body of research that focuses on eating disorder prevention. Research has shown that whilst eating disorders have had a reputation of being difficult to treat, the prognosis of treatment increases when the disordered habits have been identified and treated in their early stages. Thus schools are understood to be ideal sights for the implementation of prevention programmes. After an extensive research review, however, the current researcher demonstrated that very little research had been conducted into the effectiveness of educators in the implementation of such prevention programmes within their schools. This current study therefore contributes to the small body of research that assesses the effectiveness of educators in their roles as prevention agents.

South African education has seen many changes within the last decade, with the introduction of Outcomes Based Education being one such change. The introduction of this new curriculum has not been a smooth process, however, with the inadequate training of educators to teach in an outcomes-based manner being arguably one of the most significant problems noted. When expecting largely untrained educators to educate learners regarding the perils of dieting and eating disorders, one must question as to how effective these educators are in this regard. No research could be located to indicate whether those being expected to teach on such topics possessed adequate knowledge regarding eating disorders and healthy diet. There was similarly

no research located that assessed the personal attitudes and behaviours of educators with regards to their own body image and eating habits. This current research therefore provides important information regarding the knowledge, attitudes and behaviours of educators in South Africa with regards to eating disorders, body image and weight control, where there had previously been a lack of research.

When looking specifically at the role of the Life Orientation educator in South African education, this research arguably contributes to an awareness of the need for further training and workshops that support these educators in an awareness of the dominant societal discourses and how these may be impacting on their education of learners. The developers of curricula aimed at the training of Life Orientation educators, both at the tertiary education level and those involved with the training of existing educators, could benefit from the results of the current research. This research outlines the gaps in knowledge pertaining to healthy diet and eating disorders of Life Orientation educators and the need for opportunities for these educators to reflect on their own body images and eating behaviour so as to limit the impact these may have on the learners within their classrooms. The results of this study, if shown to be generalisable, could therefore serve to guide curriculum developers.

In essence, therefore, the value of this study lies in the information it provides those who are involved in the training of South African Life Orientation educators to better prepare and support this group of educators in the prevention of eating disorders within the school context.

7.4. Limitations of the Research

There are various limitations to this research. One of the methodological shortcomings of this study pertains to the fact that non-probability purposive sampling was used in the selection of the participants. With non-probability sampling, the probability that a person will be chosen is not known, and as such, one cannot claim that the sample is representative of the larger sample (Bailey, 1987). The ability to generalise the current study to all Life Orientation educators is therefore limited, and inferences which have therefore been drawn about educators in general can best be described as speculative.

Despite the fact that 120 questionnaires were delivered to potential participants, only 50 participants responded. This low response rate resulted in a small sample size and thus impacted on the type of statistics that could be applied to the results of the

study. If the sample had been larger, applying cluster analysis to the research results would have allowed for an exploration of the possible relationships between the variables of the EAT-40 scale, the BSQ scale, the Research Questionnaire and the Biographical Questionnaire, thus demonstrating patterns regarding the knowledge, attitudes and behaviours of the educators with regards to their body image, eating habits, dieting and exercise. This type of statistical analysis was however not possible to perform due to the small sample size. While the sample represented different cultural groupings, these groupings were uneven, each being represented by a different number of participants. Due to this, no correlation could be drawn between racial groups and eating disorder pathology. These might have provided richness to the study and added to the growing body of research into the relationships between eating disorders and culture.

A further limitation of the study pertains to the measures that were used. As it has been pointed out, both the EAT-40 and the BSQ were not normed on South African populations, and as such the confidence with which one could identity those with clinically significant attitudes and eating behaviours was limited. An attempt to increase this confidence was made by using the standard deviations as cut-off points. It was still necessary, however, to apply caution to the resulting inferences that were made.

As highlighted in Chapter 5, a disadvantage of using questionnaires is that one cannot ascertain how the respondents interpreted the questions. For example, in this survey, a number of respondents did not answer some items on the questionnaire. The reason for this lack of response may differ from person to person, but may be indicative of the respondent not understanding the language or the specific concept to which the question refers. On the other hand, the respondent may possibly have left out the question accidentally. Fortunately, in this survey, the number of unanswered items was few and thus this does not cast serious doubt on the validity of the findings.

It should also be highlighted that the language of the questionnaires may have introduced further limitations to the study. While the questionnaires were presented in English, the majority of the participants were black and as such were unlikely to have had English as a first language. The inclusion criteria for the sample, however, was that the participants had to have had a minimum Grade 12 qualification with English having been passed as either a first or second language. It could be assumed from this, therefore, that the participants possessed an adequate level of comprehension of the

English language. Despite this, one may suggest that the study may have been more efficient if the questionnaires had been presented in the first language of all participants.

While it has been suggested in literature that educator's personal attitudes and behaviours influence those attitudes and behaviours of the learners within their care, little research has been conducted to demonstrate this effect. Thus, while this study has questioned the effect of a educator's paucity of knowledge, attitudes, and behaviours regarding eating and weight on their learners, the exploratory and descriptive nature of this study does not allow us to predict what this relationship might look like.

These limitations indicate in general, therefore, that the results of this study must be interpreted with some care, particularly when generalisations to the larger educational situation are concerned.

7.5. Recommendations

Firstly, it is recommended that this study be replicated in the future with larger and more representative samples, so that the results can be made more generalisable to Life Orientation educators within the entire South African educational system. The paucity of existing research in this regard indicates a need for South African research in the field of eating disorder prevention in the context of schools.

It has also been recommended that the results of this study, if shown to be generalisable, be considered by those who are involved in the training of present and future Life Orientation educators. The study has demonstrated gaps in knowledge and a dire need for further training in the prevention of eating disorders, and thus could be used when developing training curricula for the education of Life Orientation educators in this regard.

Workshops that allow for the exploration of the educator's personal attitudes and behaviours with regards to eating and weight should be provided. It has been recommended that educators be given the opportunity to examine their own views and behaviours in order to consider the impact that these may be having in their classrooms and schools.

7.6. Conclusion

While schools have been identified as particularly useful sites for the implementation of programmes aimed at the prevention of eating disorders, this research study has echoed the concerns raised by other researchers regarding the effectiveness of those within the school system to run such programmes.

Schools have come to embody far more than the mere transmission of knowledge to learners who have been considered as clean slates eager to absorb what is given to them. Knowledge is understood by certain theorists to be reflective of those things that culture and society hold to be 'truth'. It has been shown, however, that it is these very 'truths' of society that bind people into believing that they have to be, believe and feel a certain way in order to 'be' at all. As schools are institutions that are motivated and constructed around many of these socially created 'truths', e.g. 'I must perform to be acceptable', those within these institutions come to view themselves according to these 'truths'. We therefore see how schools may endorse many of those societal ideals that lead to disordered ways of seeing oneself and behaving, those very things that may underlie disorders of eating.

To live outside this 'truth' requires an awareness of its construction and an active choice to be and feel otherwise. It requires those who are aware and bold enough to resist and to proclaim their resistance to the learners within their care as a way of presenting an alternative to the dominant 'truths' of society. This research study demonstrated that the majority of those educators who were assessed had, to some extent, internalised the expectations of looking a certain way and thus behaving in ways in order to fit the ideal of body weight and shape. The need for workshops that create opportunities to increase these educators' awareness of the dominant discourses and the impact on their ways of seeing themselves and behaving has been highlighted.

The purpose of this study was by no means to point out the faults of those educators who are working to educate and shape the views of our children, but to highlight the need for these educators to be supported in their endeavours. School can be a difficult time for adolescents as they form views of the world and ways of seeing themselves within it. Much of how they see the world is shaped by what is presented to them by those who are esteemed to 'know'. Let us support these 'knowers' by finding helpful ways of standing with them, so that schools can work to protect those young lives within the schools' care rather than to perpetuate the societal ideals that create vulnerability.

It is perhaps fitting to conclude with the words of one who experienced school to be a place that created vulnerability towards the development of an eating disorder, rather than being a place that supported and protected. Carrie, age 17:

> I've been to several different schools, since I've become ill this is, trying to get away from the illness at school…I have actually just been trying to find alternatives to go back to because I know that I can't go back to that school for my health, if you know what I mean…but in terms of whether school actually started the illness, I really don't know whether it did. All I know was that before I became ill I was immensely, immensely depressed, and I think the depression came from the school…because I've always been a very insecure person and school provided me with no security whatsoever (Evans, Rich & Holroyd, 2004, p.136).

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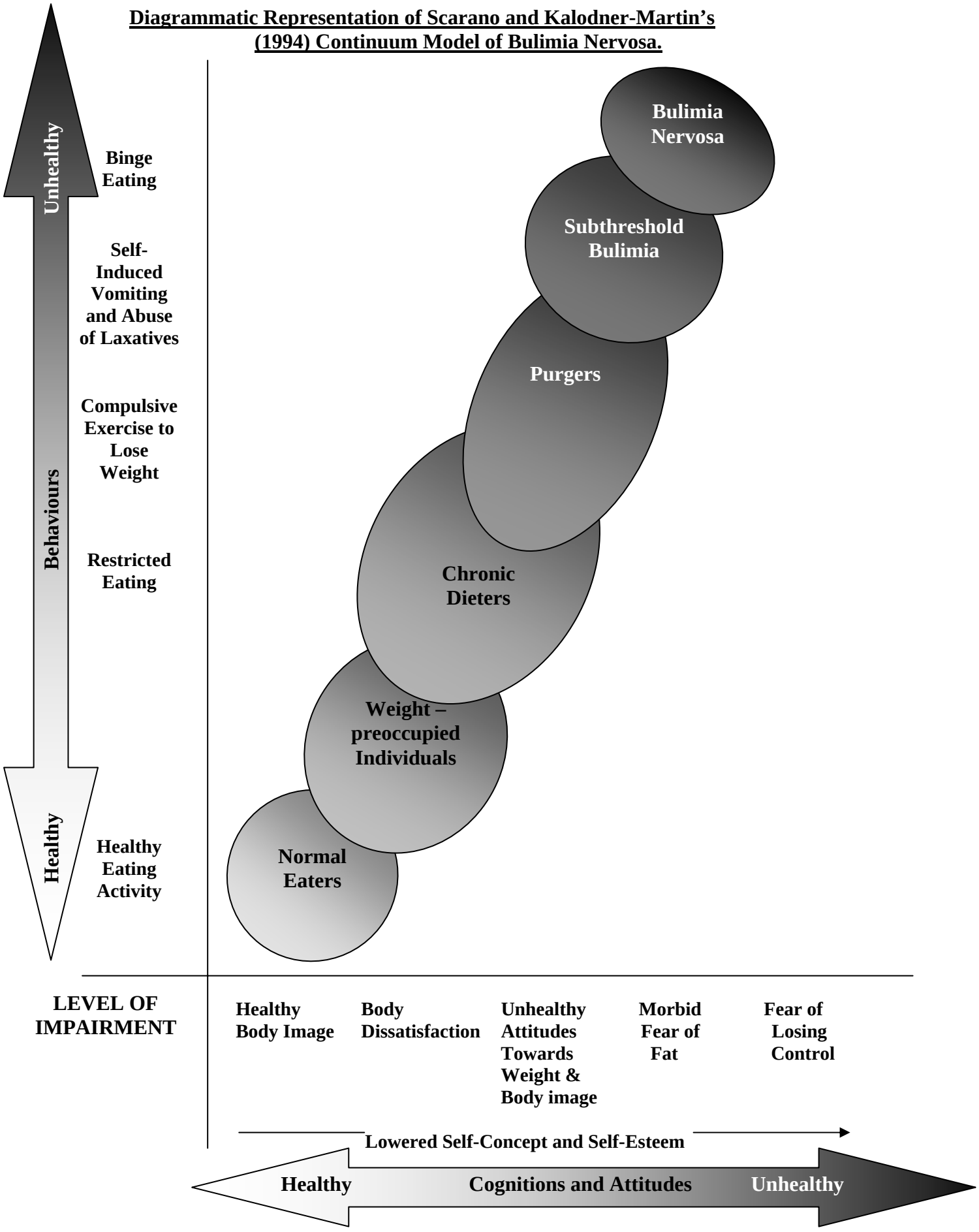
APPENDIX A

Diagrammatic Representation of Scarano and Kalodner-Martin's (1994) Continuum Model of Bulimia Nervosa.



APPENDIX B

BIOGRAPHICAL QUESTIONNAIRE

Please read the following statements and place an X in the appropriate box or answer in the space provided.

1. Date of Birth (yy/mm/dd): 19…./…../…..
2. Home Language: …….
3. Marital Status:

3.1. Single	
3.2. Married	
3.4. Divorced	
3.5. Widowed	

4. How would you describe your socio-economic status?

4.1. Lower	
4.2. Middle	
4.3. Upper	

5. Please list all your educational qualifications (include undergraduate degrees/diplomas as well as post graduate degrees/diplomas).

_____

_____

6. Did you receive formal training specifically in the Learning Area of Life Orientation during your tertiary education?

6.1. Yes	
6.2. No	

7. What is your current post (e.g. Life Orientation teacher, head of department, etc.)?

_____

_____

8. What is your current post level?

_____

_____

9. Indicate your length of service within the Education Department.

9.1. Less than 3 years	
9.2. 3 to 5 years	
9.3. 6 to 8 years	
9.4. 9 to 10 years	
9.5. More than 11 years	

10. Which grade(s) of Life Orientation do you currently teach?

10.1 Grade 8	
10.2. Grade 9	

11 Current Weight _____kg

Current Height _____m

Desired Weight _____kg

12. On week days, do you:

	YES	**NO**
12.1. Usually eat breakfast		
12.2. Usually have a morning snack		
12.3. Usually eat lunch		
12.4. Usually have an afternoon snack		
12.5. Usually eat dinner?		
12.6. Usually have an evening snack?		

13. Do you diet to lose weight?

13.1. Yes	
13.2. No	

14. Do you follow a planned diet in order to gain weight?

14.1. Yes	
14.2. No	

15. Have you ever been *diagnosed* by a health professional (Doctor, Dietician, Psychologist, Psychiatrist or other health professional) for any of the following?

15.1. Anorexia Nervosa	
15.2. Bulimia Nervosa	
15.3. Any other Eating Disorder	
15.4. A Low Weight Problem	
15.5. An Exercise Disorder	

16. Have you ever been *treated* by a health professional (Doctor, Dietician, Psychologist, Psychiatrist or other health professional) for any of the following?

16.1. Anorexia Nervosa	
16.2. Bulimia Nervosa	
16.3. Any other Eating Disorder	
16.4. A Low Weight Problem	
16.5. An Exercise Disorder	

17. Are you currently *receiving treatment* from a health professional (Doctor, Dietician, Psychologist, Psychiatrist, or other health professional) for any of the following?

18.1. Anorexia Nervosa	
18.2. Bulimia Nervosa	
18.3. Any other Eating Disorder	
18.4. A Low Weight Problem	
18.5. An Exercise Disorder	

18. *Do you believe* that you currently have any of the following?

18.1. Anorexia Nervosa	
18.2. Bulimia Nervosa	
18.3. Any other Eating Disorder	
18.4. A Low Weight Problem	
18.5. An Exercise Disorder	

Thank you for completing this questionnaire

APPENDIX C

RESEARCH QUESTIONNAIRE

KNOWLEDGE OF EATING DISORDERS AND HEALTHY DIET

1. The following statements are about body weight and eating behaviour.
   Please consider each statement carefully and indicate whether you believe the statement to be true or false by placing an X in the appropriate column.

		TRUE	FALSE
1.1.	Anorexia nervosa is characterised by an intense fear of becoming fat, even when underweight.		
1.2.	Overweight teenagers should go on strict weight-reducing diets.		
1.3.	Girls begin their growth spurt before boys.		
1.4.	Overweight teenagers usually eat more food than thin teenagers.		
1.5.	Those with anorexia nervosa refuse to maintain their body weight at or above what is expected for their age and height.		
1.6.	Teenagers should be encouraged not to eat any junk-food.		
1.7.	It is normal for teenage girls to put on fat around their thighs and hips.		
1.8.	Thin people are generally happier than their overweight counterparts.		
1.9.	Eating disorders such as anorexia nervosa only occur in females in upper and middle class families.		
1.10.	All those who have suffered from an eating disorder never fully recover.		
1.11.	People with anorexia nervosa lose their appetite.		
1.12.	People with bulimia nervosa are usually within the normal weight range for their age and		

	height.		
1.13.	People with bulimia nervosa always induce vomiting.		

2. Which of the following statements of advice would you give to an overweight student who has asked you for advice on weight reduction? Please consider each statement carefully and indicate whether you would give the following advice by placing an X in either the Yes or No column.

		YES	**NO**
2.1.	Go on a strict weight-reducing diet in which little to no carbohydrates are consumed		
2.2.	Increase daily exercise		
2.3.	Aim to lose 1-2 kilograms per week		
2.4.	Reduce their daily intake of food		
2.5.	Weigh themselves every day		
2.6.	Choose only low-calorie foods		
2.7.	Avoid going on a weight-reducing diet		
2.8.	Avoid combining foods, e.g. eating fruit and protein together		
2.9.	Eat two meals per day rather than three		
2.10.	Avoid eating certain foods like chips, sweets, chocolate, pies, sausage rolls and fried foods		

3. The following questions deal with teaching about eating disorders and dietary health within the classroom context. Please indicate whether you would use the following methods of instruction by placing an X in either the 'Yes' or the 'No' column.

		YES	**NO**
3.1.	Provide learners with the facts about eating disorders, e.g. the types of eating behaviours associated with bulimia (such as binging and purging), and anorexia (such as dietary restraint).		
3.2.	Make use of case studies and media reports to highlight the		

	dangers of eating disorders, e.g. speaking about the experiences and showing pictures of celebrities with eating disorders.		
3.3..	Provide classifications of "good" foods and "bad" foods so as to encourage a healthy diet.		
3.4.	Use practical exercises to encourage the development of self-esteem within the learners.		

4. The following questions are about your experiences of dealing with eating disorders within the school context. Please consider the questions carefully and respond by placing an X in the appropriate column.

		YES	**NO**
4.1.	Do you know what to do (i.e. what channels to follow) if you think a child in your class is developing or experiencing an eating disorder?		
4.2.	Have any learners ever spoken to you about difficulties they are experiencing with weight or an eating disorder?		
4.2.1	If Yes, did you know what to do?		
4.3.	Have you ever had a suspicion that a learner within your class was experiencing an eating disorder?		

		Very Confident	**Somewhat Confident**	**Not Very Confident**	**Not At All Confident**
4.4.	How confident do you feel to be able to recognise signs and symptoms of an eating disorder in one of your learners?				
4.5.	How confident do you feel that you would know what to do if a learner told you that he/she is experiencing an eating disorder.				

		YES	NO
4.6.	When you were a student teacher, did you ever have any kind of training with regard to eating disorders?		
4.6.1.	If yes, was the training worthwhile?		
4.6.2.	If yes, was the training sufficient?		
4.7.	Has your school ever had any training courses with regard to eating disorders?		
4.7.1.	If yes, was it worthwhile?		
4.7.2.	If yes, was it sufficient?		
4.8.	Do you think Life Orientation teachers should be responsible for teaching eating disorder prevention skills to their learners?		
4.9.	At this moment, do you feel you are adequately trained to teach such a programme?		
4.10.	Do you think you need some form of training with regards to eating disorders?		

Thank you for completing this questionnaire

APPENDIX D - EATING ATTITUDES TEST

Please place an (X) under the column which applies best to each of the numbered statements. All of the results will be strictly confidential. Most of the questions directly relate to food or eating, although other types of questions have been included. Please answer each question carefully. Thank you.

Always	Very Often	Often	Sometimes	Rarely	Never	
( )	( )	( )	( )	( )	( )	1. Like eating with other people.
( )	( )	( )	( )	( )	( )	2. Prepare food for others but do not eat what I cook.
( )	( )	( )	( )	( )	( )	3. Become anxious prior to eating.
( )	( )	( )	( )	( )	( )	4. Am terrified about being overweight.
( )	( )	( )	( )	( )	( )	5. Avoid eating when I am hungry.
( )	( )	( )	( )	( )	( )	6. Find myself preoccupied with food.
( )	( )	( )	( )	( )	( )	7. Have gone on eating binges where I feel that I may not be able to stop.
( )	( )	( )	( )	( )	( )	8. Cut my food into small pieces.
( )	( )	( )	( )	( )	( )	9. Aware of the calorie content of foods that I eat.
( )	( )	( )	( )	( )	( )	10. Particularly avoid foods with a high carbohydrate content (e.g. bread, potatoes, rice, etc).
( )	( )	( )	( )	( )	( )	11. Feel bloated after meals.
( )	( )	( )	( )	( )	( )	12. Feel that others would prefer if I ate more.
( )	( )	( )	( )	( )	( )	13. Vomit after I have eaten.
( )	( )	( )	( )	( )	( )	14. Feel extremely guilty after eating.
( )	( )	( )	( )	( )	( )	15. Am preoccupied with a desire to be thinner.
( )	( )	( )	( )	( )	( )	16. Exercise strenuously to burn of calories.
( )	( )	( )	( )	( )	( )	17. Weigh myself several times a day.
( )	( )	( )	( )	( )	( )	18. Like my clothes to fit tightly.
( )	( )	( )	( )	( )	( )	19. Enjoy eating meals.
( )	( )	( )	( )	( )	( )	20. Wake up early in the morning.
( )	( )	( )	( )	( )	( )	21. Eat the same foods day after day.
( )	( )	( )	( )	( )	( )	22. Think about burning up calories when I exercise.

Always	Very Often	Often	Sometimes	Rarely	Never	
( )	( )	( )	( )	( )	( )	23. Have regular menstrual periods.
( )	( )	( )	( )	( )	( )	24. Other people think that I am too thin.
( )	( )	( )	( )	( )	( )	25. Am preoccupied with the thought of having fat on my body.
( )	( )	( )	( )	( )	( )	26. Take longer than others to eat my meals.
( )	( )	( )	( )	( )	( )	27. Enjoy eating at restaurants.
( )	( )	( )	( )	( )	( )	28. Take laxatives.
( )	( )	( )	( )	( )	( )	29. Avoid foods with sugar in them.
( )	( )	( )	( )	( )	( )	30. Eat diet foods.
( )	( )	( )	( )	( )	( )	31. Feel that food controls my life.
( )	( )	( )	( )	( )	( )	32. Display self control around food.
( )	( )	( )	( )	( )	( )	33. Feel that others pressure me to eat.
( )	( )	( )	( )	( )	( )	34. Give too much time and thought to food.
( )	( )	( )	( )	( )	( )	35. Suffer from constipation.
( )	( )	( )	( )	( )	( )	36. Feel uncomfortable after eating sweets.
( )	( )	( )	( )	( )	( )	37. Engage in dieting behaviour.
( )	( )	( )	( )	( )	( )	38. Like my stomach to be empty.
( )	( )	( )	( )	( )	( )	39. Enjoy trying new rich foods.
( )	( )	( )	( )	( )	( )	40. Have the impulse to vomit after meals.

APPENDIX E - BODY SHAPE QUESTIONNAIRE

We should like to know how you have been feeling about your appearance over the PAST FOUR WEEKS. Please read each question and circle the appropriate number to the right. Please answer all the questions.

OVER THE PAST FOUR WEEKS:	Never	Rarely	Sometimes	Often	Very Often	Always
1. Has feeling bored made you brood about your shape?	1	2	3	4	5	6
2. Have you been so worried about your shape that you have been feeling that you ought to diet?	1	2	3	4	5	6
3. Have you thought that your thighs, hips or bottom are too large for the rest of you?	1	2	3	4	5	6
4. Have you been afraid that you might become fat (or fatter)?	1	2	3	4	5	6
5. Have you worried about your flesh being not firm enough.	1	2	3	4	5	6
6. Has feeling full (e.g. after a large meal) made you feel fat?	1	2	3	4	5	6
7. Have you felt so bad about your shape that you have cried?	1	2	3	4	5	6
8. Have you avoided running because your flesh might wobble?	1	2	3	4	5	6
9. Has being with thin women made you feel self-conscious about your shape?	1	2	3	4	5	6
10. Have you worried about your thighs spreading out when sitting down?	1	2	3	4	5	6
11. Has eating even a small amount of food made you feel fat?	1	2	3	4	5	6
12. Have you noticed the shape of other women and felt that your own shape compared unfavourably?	1	2	3	4	5	6
13. Has thinking about your shape interfered with your ability to concentrate (e.g. while watching television, reading, listening to conversations)?	1	2	3	4	5	6
14. Has being naked, such as when taking a bath, made you feel fat?	1	2	3	4	5	6
15. Have you avoided wearing clothes which make you particularly aware of the shape of your body?	1	2	3	4	5	6

	Never	Rarely	Sometimes	Often	Very Often	Always
16. Have you imagined cutting of fleshly areas of your body?	1	2	3	4	5	6
17. Has eating sweets, cakes or other high calorie food made you feel fat?	1	2	3	4	5	6
18. Have you not gone out to social occasions (e.g. parties) because you have felt bad about your shape?	1	2	3	4	5	6
19. Have you felt excessively large and rounded?	1	2	3	4	5	6
20. Have you felt ashamed of your body?	1	2	3	4	5	6
21. Has worry about your shape made you diet?	1	2	3	4	5	6
22. Have you felt happiest about your shape when your stomach has been empty (e.g. in the morning)?	1	2	3	4	5	6
23. Have you thought that you are the shape you are because you lack self-control?	1	2	3	4	5	6
24. Have you worried about other people seeing rolls of flesh around your waist or stomach?	1	2	3	4	5	6
25. Have you felt that it is not fair that other women are thinner than you?	1	2	3	4	5	6
26. Have you vomited in order to feel thinner?	1	2	3	4	5	6
27. When in company have you worried about taking up too much room (e.g. sitting on the sofa, or a bus seat)?	1	2	3	4	5	6
28. Have you worried about your flesh being dimply?	1	2	3	4	5	6
29. Has seeing your reflection (e.g. in a mirror or shop window) made you feel bad about your shape?	1	2	3	4	5	6
30. Have you pinched certain areas of your body to see how much fat there is?	1	2	3	4	5	6
31. Have you avoided situations where people could see your body (e.g. communal changing rooms or swimming baths)?	1	2	3	4	5	6
32. Have you taken laxatives in order to feel thinner?	1	2	3	4	5	6
33. Have you been particularly self-conscious about your shape when in the company of other people?	1	2	3	4	5	6
34. Has worry about your shape made you feel you ought to exercise?	1	2	3	4	5	6

APPENDIX F

(*Date*) 2005

Dear (*name of School Principle*)

The apparent increase in the incidence of both anorexia nervosa and bulimia nervosa worldwide has resulted in a surge of interest in effective treatment methods, prevention programmes and mental health promotion. Eating disorders usually have their origin during the teenage years, but can develop as early as around 10 years of age. As such schools provide useful sites for the implementation of prevention programmes. With the introduction of Curriculum 2005, the responsibility of life skills education in general and eating disorder education and prevention, in particular, has fallen largely on the shoulders of the Life Orientation teacher.

I am currently studying towards a Masters degree in Clinical Psychology and as part of my qualification I am required to complete a treatise. Upon reviewing the research on eating disorder prevention within the South African context, it became obvious that, while Life Orientation teachers have been given the responsibility of acting as prevention agents, little to no research had been conducted in this area of their work. The study I will be conducting will explore and describe Life Orientation teachers' knowledge, attitudes and behaviours related to eating disorders, body image and weight control. It is with this goal in mind that I would like to enlist the participation of the Life Orientation teachers within your school in this study. The teachers may participate anonymously, and all information provided by them will be treated with confidentiality.

The information for the study will be gathered in the form of four questionnaires. These will take approximately 45 minutes to complete. One questionnaire gathers biographical information. The Research Questionnaire measures one's level of knowledge with regard to eating disorders and a healthy diet. The Eating Attitudes Test (EAT) measures one's eating behaviour and attitudes to food, body image, shape

and weight. Lastly, the Body Shape Questionnaire (BSQ) will be used to assess one's levels of body satisfaction.

Permission to conduct this research within your school will be most appreciated. Individual contact and permission will be gained from the Life Orientation teachers at (*name of school*) subsequent to gaining your permission. Should you have any queries, I can be contacted on the following number: 084 823 6183.

Thanking you in advance.

Ms. Alison Hardie
Intern Clinical Psychologist

Dr. Di Elkonin
Research Supervisor

Ms. Lynn Markman
Co-supervisor

(*Date*) 2005

Dear Participant

The apparent increase in the incidence of both anorexia nervosa and bulimia nervosa worldwide has resulted in a surge of interest in effective treatment methods, prevention programmes and mental health promotion. Eating disorders usually have their origin during the teenage years, but can develop as early as around 10 years of age. As such schools provide useful sites for the implementation of prevention programmes. With the introduction of Curriculum 2005, the responsibility of life skills education in general and eating disorder education and prevention, in particular, has fallen largely on the shoulders of the Life Orientation teacher.

I am currently studying towards a Masters degree in Clinical Psychology and as part of my qualification I am required to complete a treatise. Upon reviewing the research on eating disorder prevention within the South African context, it became obvious that, while Life Orientation teachers have been given the responsibility of acting as prevention agents, little to no research had been conducted in this area of their work. The study I will be conducting will explore and describe Life Orientation teachers' knowledge, attitudes and behaviours related to eating disorders, body image and weight control. It is with this goal in mind that I would like to enlist your participation in this study. You may participate anonymously, and all information provided by you will be treated with confidentiality.

The information for the study will be gathered in the form of four questionnaires. These will take approximately 45 minutes to complete. One questionnaire gathers biographical information. The Research Questionnaire measures one's level of knowledge with regard to eating disorders and a healthy diet. The Eating Attitudes Test (EAT) measures one's eating behaviour and attitudes to food, body image, shape

and weight. Lastly, the Body Shape Questionnaire (BSQ) will be used to assess one's levels of body satisfaction.

Your assistance will be much appreciated. Should you have any queries, I can be contacted on the following number: 084 823 6183.

Thanking you in advance.

Ms. Alison Hardie
Intern Clinical Psychologist

Dr. Di Elkonin
Research Supervisor

Ms. Lynn Markman
Co-supervisor

APPENDIX G

EATING DISORDERS, BODY IMAGE AND WEIGHT CONTROL: LIFE ORIENTATION TEACHERS' KNOWLEDGE, ATTITUDES AND BEHAVIOURS

Consent Form

Researcher: Alison Hardie
P.O. Box 1600
Psychology Department
Nelson Mandela Metropolitan University
PORT ELIZABETH
6000
Tel: 041 – 5012354

DECLARATION BY PARTICIPANT	
I, the undersigned, _____ (name) (I.D. No: _____) the participant of _____ _____ (address).	Please initial against each paragraph
A. HEREBY CONFIRM AS FOLLOWS:	
1. I was invited to participate in the abovementioned research project which is being undertaken by Alison Hardie of the Department of Psychology in the Faculty of Health Sciences, Nelson Mandela Metropolitan University.	_____
2. This research project aims to explore and describe the knowledge, attitudes and behaviours related to eating disorders, body image and weight control of South African Life Orientation teachers. The information will be used as part of the requirements for a MA Clinical Psychology degree. The results of this study may be presented at scientific conferences or in specific publications.	_____
3. I understand that I need to complete the four questionnaires as well as this consent form and return it to the researcher or research assistant on completion. If I am unable to participate in the study, I will return all questionnaires and letters to the researcher or research assistant.	_____
4. My identity will not be revealed in any discussion, description or scientific publication by the researcher.	_____

5. My participation is voluntary. My decision whether or not to participate will in no way affect my present or future employment/lifestyle/medical care.	_____
6. No pressure was exerted on me to consent to participation and I understand that I may withdraw at any stage without penalization.	_____
7. Participation in this study will not result in any additional cost to myself.	_____
B. I IDENTIFY CONSENT VOLUNTARILY TO PARTICIPATE IN THE ABOVE-MENTIONED PROJECT.	
I grant this as a voluntary contribution in the interest of training and knowledge.	_____
Signed at _____ on _____ 2005.	
Signature of participant _____	