COLLEGE WOMEN: EATING BEHAVIORS
AND HELP-SEEKING PREFERENCES

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ABSTRACT

Late adolescent women at a large, mid-Atlantic university were surveyed. Of the 578 who completed the survey, 17% were found to have eating disorders as defined by a score of 20 or above on the Eating Attitudes Test (EAT-26; Garner, Olmstead, Bohr, & Garfinkel, 1982). Participants who scored 20 or above were younger and more likely to be white, in a sorority, and Christian than were those who scored below 20 on the EAT-26. No correlation was found between EAT-26 scores and participation in organized athletics. In addition, the participants were asked about their choice of help and support should they have any worries about their eating. They were most likely to say that they would prefer a close friend to support them when dealing with disordered eating, followed by their parents and their significant other. In terms of professional services, most women reported that they would prefer individual assistance such as a consultation with a physician, a nutritionist, or a therapist, followed by family therapy, if they ever had questions about eating or thought they needed professional help with disordered eating.

More and more women are struggling with eating disorders, and they are doing so at younger and younger ages, often starting at puberty (Bruch, 1981; Garner & Garfinkel, 1980; Mitchell & Eckert, 1987; Shisslak, Crago, Neal, & Swain, 1987; Striegel-Moore, 1995). Nattiv and Lynch (1994) estimated that one to three percent of the general Western female population meet formal criteria for disordered eating, with a higher prevalence among adolescent and young adult women. It has been documented that a majority of American college women exhibit at least a few of the symptoms of disordered eating (Hesse-Biber, 1989, Protinsky & Marek, 1997), and prevalence studies have shown that it is common for fifteen percent or more of college campus women to meet diagnostic criteria for anorexia nervosa or bulimia nervosa (e.g., Borgen & Corbin, 1987; Heatherton, Nichols, Mahamedi, &

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Keel, 1995; Hesse-Biber, 1989; Ratcliff, 1986). Other researchers have documented that the most common onset of eating disorders is around age 18 (Thelen, Mann, Pruitt, & Smith, 1987). In addition, some research has shown that belonging to certain groups (for example, participating in sports or being a member of a particular religious faith) can increase a woman’s likelihood of disordered eating (Rosen, McKeag, Hough, & Curley, 1986; Sykes, Gross, & Subishin, 1986; Sykes, Leuser, Melia, & Gross, 1988). The present study was conducted to answer three questions: (1) What percentage of college women would be diagnosed with disordered eating at a large, mid-Atlantic university? (2) Would the women who were diagnosable differ from those who were not on a variety of demographic variables? (3) What types of support services for disordered eating do these college women want?

By doing this research, we hoped to gain insight not only into the numbers and demographic characteristics of college women with and without disordered eating, but also to learn what kinds of services students thought would be most helpful. Thereby, we would provide an up-to-date picture of both the state of the problem and its potential solution from the students’ perspectives.

METHOD

Sample and Data Collection

A random sample of 10% (1,066) of the female students enrolled in a large, public, mid-Atlantic, rural university were chosen from university registrar enrollment data. The stratified sample was proportional to the actual number of women in each year of study, undergraduate freshmen through graduate students. Surveys were distributed via the mail, and due to the anonymous protocol, no follow-up contact was possible. Participation was voluntary, and the study was approved by the university’s human subjects review committee.

Instruments

The demographic questionnaire asked women to identify their age, race, college class level, whether they were in a sorority or participated in organized sports, their religious background, their current level of religiosity and which religion (if any), their relationship status, and their parents’ relationship statuses. This questionnaire also asked the following: if they were concerned about their weight or eating habits to whom would they most likely go for help; if they had an eating problem from whom would they seek help; and who would be their first and second choices for support if they chose to go to therapy.
Although no self-report instrument alone can diagnose an eating disorder, the abbreviated Eating Attitudes Test (EAT-26; Garner et al., 1982) is a widely used self-report screening measure for the symptoms of anorexia nervosa and bulimia nervosa and has been used in multiple studies in North America and Europe (e.g., Nelson, Hughes, Katz, & Searight, 1999; Ratcliff, 1986; Williams, Schaefer, Shisslak, Gronwaldt, & Comerci, 1986). The EAT-26 contains twenty-six items with six possible answers ranging from never (0) to always (3).

Reliability estimates were run to reassess the EAT-26 for its appropriateness for use with this more modern population of young women. Alpha coefficients for the present study's total sample were as follows: Factor I (diet) = .88, Factor II (bulimia) = .78, Factor III (oral) = .60, which compared favorably against Garner et al.'s (1982) university control group (Factor I = .86, Factor II = .61, Factor III = .46), and therefore support the use of the EAT-26 with the current sample of female college students.

The possible scores on the EAT-26 range from 0 to 53. A score of 20 on the EAT-26 (Garner et al., 1982) was used as the cutoff. Women in this study who scored 20 or above were placed in the “probable diagnosis” (Dx) category, and those below were placed in the “non-probable diagnosis” (Ndx) category.

RESULTS

Sample Characteristics

In all, 589 women responded to our survey out of 1,066 women who were contacted. Of the 589, 578 respondents' data were completed and used in the analyses, giving a return rate of 54.2%. Ten of the 578 respondents chose not to answer three or fewer of the demographic form questions. We chose to use their cases, but these omitted data account for the changing Ns in the results.

Women’s ages were collected as categorical data on the demographics form. Most (238) reported that they were late adolescent, falling into the age range of 18–19, with 199 being 20–21, and 141 being 22 years or older. Reflective of this university’s population, the sample contained more undergraduates, with 152 freshmen, 133 sophomores, 105 juniors, and 99 seniors; 89 were graduate students. Most women (496) identified their race as white, but there were 82 women of color who identified themselves as Asian (46), American Indian (1), black (21), Hispanic (7), or other (7). We asked students to describe both their religious background (RB) and their own current religious orientation (CR). A majority reported being Protestant (335 RB, 274 CR) or
Catholic (139 RB, 98 CR). Other faiths and perspectives were represented as well, including Jewish (10 RB, 7 CR) and Muslim (4 RB, 4 CR), with 47 women describing their religious background as “other,” and 42 women saying they had grown up agnostic. One hundred forty-nine women reported that religion was currently not important for them. A large majority did not belong to a sorority (471), and a majority of women reported not being involved with any type of organized athletics (346). There were slightly fewer women living on-campus (243) than in off-campus (311) housing, with only nine of the latter living with their parents. When asked about their current relationship status, the largest group of students said that they were currently seriously, romantically partnered (355), with a minority married (35) or cohabiting (16). We also asked about their parents’ relationship statuses. A majority reported their parents to be currently married to each other (420), 15 reported them to be separated, 54 reported them to be divorced, 55 said one or both were remarried, 29 reported that one or both were deceased, and 3 reported that their parents had never been married.

**Analyses of the EAT-26 Scores**

In this study, 17% (99 out of 578) of the women scored 20 or above on the EAT-26, which placed them in the positive category for an eating disorder (Dx group). The women’s demographic characteristics and their EAT-26 total scores were then analyzed. Chi-square tests showed that a college woman’s race, current religious affiliation, participation in organized athletics, class standing, residence, relationship status (partnered or alone), and parents’ relationship status were independent from diagnosis. Women in our sample did not significantly differ in these areas based on whether they had an eating disorder. However, there were significant differences between women who scored 20 or above on the EAT-26 compared with those who scored below 20 on the following demographic variables: age, religious background, and sorority affiliation.

*Age.* A chi-square test of the independence of age and diagnosis showed that they were not independent, $\chi^2(6, N = 578) = 13.83, p < .05$. Women who scored 20 or above on the EAT-26 (and hence were in the Dx group) were more likely to be late adolescent (ages 18–21) than were women who scored below 20. Seventy-eight of the 99 women who scored 20 or above on the EAT-26 were in the 18–21 age range.

*Religious background.* A chi-square test of independence showed that a woman’s religious background and her EAT-26 score were not independent, $\chi^2(5, N = 577) = 12.51, p < .05$. Eighty-one of the 99 women who scored 20 or above on the EAT-26 identified themselves
as either Catholic (31) or non-Catholic (50) Christian. Five women were Jewish, 1 was Muslim, and 12 defined themselves as atheist, agnostic, or other. Christians seemed to have a higher likelihood of having an eating disorder than did women from other religions. However, due to the very low numbers of women who did not identify themselves as Catholic or non-Catholic Christian, these results should be interpreted with caution.

Sorority affiliation. Again, a chi-square test of independence showed that whether a woman belonged to a sorority and her EAT-26 score were not independent, \( \chi^2(1, N = 578) = 7.56, p < .01 \). In addition, all of the women in the Dx group who said they belonged to a sorority were white.

Conception of Eating Disorders and Choices of Helpers and Support

We asked the women for their opinions about whom they would look to for guidance and support if they were worried about an eating disorder. In these questions we were interested in how they would conceptualize disordered eating: would they more likely see it as a medical, spiritual, or mental health issue? Through such clarification, universities may be more informed about how to build student-friendly services and how to market these services. We also wanted to know to whom young women would most likely go for support when dealing with an eating disorder because these supporters may also need information on the subject and the services universities provide.

If you were concerned about your weight or eating habits, to whom would you most likely go for help? This question was phrased to not necessarily be about an eating disorder and we provided five kinds of helpers from whom the participants could choose: clergy, dietitian, friend, physician, or counselor/therapist. The chi-square test of independence showed that diagnosis and a woman's first choice for a support person were not independent, \( \chi^2(4, N = 569) = 12.33, p < .05 \). Although women in both groups (Dx and Ndx) chose to talk to a friend first, the differences between the two groups were in their second choices. Women in the Ndx group chose physicians, and women in the Dx group chose dietitians.

If you decided that you did indeed need help with an eating problem, which of the following do you think would be most beneficial? This question was phrased with the intention of having participants think about more severe disordered eating than in the previous question and then they were provided with five choices: individual therapy, group therapy, family therapy, consultation with a dietitian, and consultation with a physician. A chi-square test of independence showed that
a woman’s choice of professional helper and her EAT-26 score were not independent, \( \chi^2(4, N = 571) = 10.10, p < .05 \). Although women in both groups (Dx and Ndx) chose individual therapy first, again the differences between the two groups were in their second choices. Women in the Ndx group chose dietitian and women in the Dx group chose group therapy.

*If other people were going to support you in your work in therapy, who would be your first choice?* The chi-square test of independence showed that diagnosis and a woman’s first choice for a support person were independent; there were no differences based on EAT-26 scores. Women in both groups (Dx and Ndx) said that if they thought they needed help with an eating disorder they would first choose “a close friend.” A significant other and one or both parents tied for second, followed by a sibling.

**DISCUSSION**

**Demographics**

It is significant that the younger women (ages 18–21) in the sample were more likely than the older women to have an eating disorder. This questionnaire was administered during the second semester, in late March, so that the students would have had time to acclimate to the university culture. However, it may be that late adolescent women are both bringing disordered eating with them from home and high school, and are developing disordered eating at college. Heatherton, Mahamedi, Stripe, and Field’s (1997) longitudinal study of women’s eating patterns found that a wide variety of subclinical disordered eating in college-aged women was positively correlated with disordered eating in later adulthood. It is possible that college may serve as not only a time and place to develop disordered eating, but a time and place to learn how to have a healthy relationship with food and one’s own body (Martz, Graves, & Sturgis, 1997).

It is interesting that race, current religious affiliation, participation in organized athletics, residence (on campus versus off campus), own relationship status, and parents’ relationship were found to be independent of eating diagnosis grouping (Dx or Ndx). In regard to race, unlike Nielsen’s (2000) survey of a college campus similar to ours, our results seem to signify that disordered eating does not discriminate. However, it is also possible that our sample was not diverse enough to provide a reliable representation of the relationship between eating disorders and race. Similarly, although our sample was probably repre-
sentative of our university's population, we did not obtain many women of religious affiliations other than Christian. In addition, for both race and religious background, oversampling for minority women may have provided more reliable comparisons among all women, especially since we were interested in hearing all of their opinions about what types of services they would find most helpful for disordered eating.

Our results were contrary to previous prevalence studies that have found a greater likelihood for athletes to have an eating disorder (Nattiv & Lynch, 1994) or a greater preoccupation with weight (Borgen & Corbin, 1987) than nonathletic women. Although the female athletic triad (disordered eating, amenorrhea, osteoporosis) should always be of concern to college officials (Nattiv & Lynch, 1994), the women athletes in our sample did not show a higher propensity than nonathletes to score 20 or above on the EAT-26. A similar study specifically aimed at women athletes compared to nonathletes yielded the same results (Kirk, 1999). In her study, Kirk noted that the college coaches, nutritionists, and physicians on this campus reported being very aware of the symptoms of eating disorders. Kirk’s and our study’s results could be a reflection of their success. It is also possible that the EAT-26, with its focus on body perception, food, and eating, is limited; hence, the instrument might not be sensitive enough to the long-recognized anorectic symptom of excessive exercise (Beumont, Beumont, Touyz, & Williams, 1997). This is an area in need of more research.

Young Women’s Perspectives

With the high number (17% of the women in this sample) of late adolescent and young adult women struggling with disordered eating on our college campuses, it is imperative that universities provide interdisciplinary teams specializing in eating disorders and student education focusing on body image, healthful eating, exercise, and the types of mental health and medical services available. Shisslak et al. (1987) pointed out the need for mental health professionals to provide accurate and accessible information to college students through presentations in dormitories, sororities, and dance and drama groups. Polivy and Herman (1987) stress that such presentations should help young people to understand that normal healthful eating does not require a restrictive diet, what constitutes a realistic food portion for an average woman and man, and why many Americans’ sense of a food portion has become exaggerated. However, regardless of what experts think young women need, it is imperative that potential helpers know how young women conceptualize disordered eating, who they think would be helpful to them, and the most likely place for them to seek help at their college.
Women in both groups (Dx and Ndx) conceptualized difficulties with weight and eating habits as a medical problem. They reported that they would confer with physicians and dietitians for answers to their questions. They believed problems with disordered eating were both a mental health and a physical issue since they thought individual therapy would be most helpful, followed by either group therapy or consultation with a dietitian. However, all the women said they would seek a friend's help first. Therefore, in addition to employing physicians, dietitians, and psychotherapists who specialize in helping women with disordered eating (e.g., Clark, Levine, & Kinney, 1989; Crisp, 1988; Hotelling, 1989; Willard, Anding, & Winstead, 1983), it would be important to hire and train peer educators (e.g., Lenihan & Kirk, 1990; Sesan, 1989). According to the women in our sample, universities would best reach late adolescent women by incorporating peer educators, who would have better access and authority with their young peers in sororities, dormitories, gyms, social groups, classrooms, and other places that provide opportunities for women to learn about healthful and unhealthful relationships with food from people their own age. These data also suggest that all young women should be the target of this form of education, even if they are not struggling with an eating disorder, because it is likely that a woman who is struggling will come to them for support prior to or in conjunction with seeking help from a physician, dietitian, or psychotherapist.

It is significant that women in this sample said they would choose to go to a friend for information and support in dealing with disordered eating. Late adolescence and early adulthood are marked by the importance of one's peer group. However, if one's peers are also struggling with disordered eating, this source of support may not be a healthful one. It is significant that women in this study who were in sororities were more likely to have an eating disorder than those who were not. There may be a selection factor or a cultural emphasis within these peer groups that supports preexisting eating disorders or the development of such disorders. Peer intervention teams (Lenihan & Kirk, 1990; Martz et al., 1997) might have a unique ability to infiltrate these potentially rigid enclaves, being careful not to unintentionally glamorize disordered eating or educate their peers on how to do disordered eating "better."

Mental health issues are also important when working with a late adolescent who may be purging, restricting calories, or overexercising. Several studies have linked different forms of disordered eating with depression and addiction (e.g., Brisman & Siegel, 1984; Casper, Eckert, & Halmi, 1980; Garfinkel, Moldofsky, & Garner, 1980; Hatsukami,
Eckert, Mitchell, & Pyle, 1984; Walsh, Roose, Glassman, Gladis, & Sadik, 1985). Thus, the need remains for college medical staff working with late adolescent and young adult women to be trained to assess and work with eating disorders and potentially comorbid mental health issues. It may even be useful to include healthful eating units with campus education campaigns on responsible drinking and rape prevention. Our experience indicates that it is important to offer a wide range of services to young women on university campuses so that they feel they have access to the best therapy.

CONCLUSION

It is important to keep checking on the prevalence of eating disorders on our college campuses. This study showed that rates are still high, with 17% of our sample scoring above the cutoff score and, therefore, probably having an eating disorder. This percentage is consistent with the research findings over the past several years. College administrations need to recognize that young women will be turning to their friends and peers for help before turning to college mental and physical health professionals. Integrated teams, trained in the assessment and holistic treatment of disordered eating, need to be in place. Most importantly, these teams must be prepared to connect and interact with young women in ways the women themselves deem useful.

REFERENCES


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