

Health Championing of University Women Seeking Help from Eating Disorders

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Abstract

Eating disorders among university students can impede health and academic success. Social support may help improve symptoms. A mixed methods design was used to explore the meaning of social support in a non-clinical sample of female university students who self-identified as having issues with food or eating. Quantitative responses from 142 students enrolled in three universities in Eastern Canada were examined for eating attitudes, coping ability, and social support behaviours. From this sample, a subset of 22 women completed qualitative semi-structured interviews. Narrative analysis confirmed that women lacking readily accessible social support were more likely to have a high level of concern about body weight or eating behaviours. A typology of support-seeking behaviours was constructed based on health championing, a proactive process for achieving health and well-being. While lack of health championing fostered the concealment of illness, recovery was enhanced when women's self-championing efforts were mirrored by support from connected others. This finding may inform the design of an appropriate support intervention.

Keywords: *Championing, Eating disorders, Self-advocacy, Social support, University women*

1. Introduction

Eating Disorders (EDs) are so commonplace among female university students that some Canadian universities offer specific EDs services as part of their health and wellness programs [1]. The health consequences of EDs negatively influence physical, emotional, and social development, potentially impeding academic and future career aspirations. Although family and other supports may be vital for improving symptoms, students are often separated from families or friends and distanced by peers competing for grades, scholarships, and acceptance into professional programs. Understanding the meaning of social support to university women living with EDs and how they access support will contribute to effective recovery strategies.

2. Related works

Approximately 1 million Canadians meet the diagnostic criteria for an Eating Disorder (ED) [2]. More common among women than men [3], EDs are classified by body weight and by frequency and duration of eating and compensatory behaviours [Table 1]. The mortality

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rate associated with Anorexia Nervosa (AN) for females aged 15-24 years old is 12 times greater than that of all other causes of death combined [4]. 20% of those with AN and 25-35% with Bulimia Nervosa (BN) attempt suicide in their lifetime [5].

Eating disorders affect every body system, causing reversible and irreversible damage from restricting, purging, or binge eating [6]. The physical consequences of restricting behaviours may include cardiovascular changes (e.g., bradycardia, hypotension, loss of heart muscle, life-threatening arrhythmias), gastrointestinal complaints (e.g., slowed gastric motility, constipation, bloating, and abdominal discomfort), and endocrine system complications (e.g., euthyroid sick syndrome, amenorrhea in girls and low testosterone concentrations in boys, delayed puberty and growth retardation, osteopenia, and increased risk of stress fractures). Purging behaviours can induce fluid and electrolyte abnormalities (e.g., metabolic alkalosis, hypochloremia, hypokalemia, and metabolic acidosis) and esophageal tearing. Medical complications of binge eating include hypertension, dyslipidemia, type 2 diabetes, coronary artery disease, osteoarthritis, gallstones, and obstructive sleep apnea [10].

University students are at particular risk of developing Eating Disorders (EDs) given they often face separation from families, exposure to drugs and alcohol, and enormous expectations about grades. Many experience high-stress levels from attending school full-time, competing to enter professional programs, securing scholarships, and paying for books, computers, and tuition. Such concerns may trigger EDs as well as depression, bipolar disease, schizophrenia, and other mental illnesses, which generally surface in late adolescence or early adulthood [11][12]. Moreover, during the COVID-19 pandemic, the number of Canadians diagnosed with an ED increased [13]. This spike was attributed to social media messages about “undesirable” and “inevitable” weight gain related to isolation and lockdown restrictions [14][15].

A recent scoping review attributed seeking formal help for EDs to explicit support from close others [10]. Seeking help can be particularly difficult due to the limited availability of resources in Canada [2], stigma about mental illness and help-seeking [16][17][18], and dissatisfaction with treatment services [19][20]. Unfortunately, the majority of people experiencing EDs do not seek help, are never diagnosed, do not receive any treatment, and suffer significant distress [21][22]. The social and economic costs of untreated EDs are similar to those of depression and anxiety, with debilitating mental health effects comparable to psychosis and schizophrenia [23]. To ensure timely support, it was therefore necessary to more fully understand the specific support needs of women living with EDs and the pathways they use to access care and services.

Table 1. Classification of eating disorders

<p>Anorexia Nervosa (AN)</p> <p>Restricted energy intake leads to significantly low body weight regarding age, sex, development, and physical health.</p> <p>Intense fear of gaining weight, even though underweight</p> <p>Body image disturbance, undue influence of body weight or shape on self-evaluation, or denial of the seriousness of the current low body weight</p>
<p>Bulimia Nervosa (BN)</p> <p>Recurrent episodes of binge eating (eating large amounts of food within 2 hours and lack of control) followed by inappropriate compensating behaviours (e.g., vomiting, laxative misuse, excessive exercise, diet pills) to try to "purge" the body of the food.</p> <p>On average, binge eating and compensatory behaviours occur at least 1/week for three months.</p> <p>Self-evaluation unduly influenced by body shape or weight</p>
<p>Binge Eating Disorder (BED)</p> <p>Recurrent episodes of eating large amounts of food, more than most people would eat in similar</p>

circumstances in a short period, and/eating rapidly, and eating beyond fullness, eating in secret, and marked with distress around eating binges Sense of a lack of control over eating during the episode Binge episodes average at least 1/week for three months
Avoidant and Restrictive Food Intake Disorder (ARFID) Limited amount and types of food consumed No distress about body shape or size or fear of fatness Unable to meet appropriate nutritional needs, causing significant weight loss, nutritional deficiency, dependency on nutritional supplements, and impaired social functioning Problems with eating not related to beliefs about size, weight, and shape Not caused by a medical condition or another mental disorder
Other Specified Feeding or Eating Disorders (OSFED) Atypical AN – Meets criteria for AN and sustains significant weight loss but remains within or above normal weight range for height and gender BN of low frequency and limited duration – Meets criteria for BN, except the binge eating and compensatory behaviours occur less than 1/week or fewer than three months BED of low frequency and limited duration – Meets criteria for BED, except binge eating episodes occur no more than 1/week or last for fewer than three months Purging disorder – Engaging in purging behaviours (e.g., self-induced vomiting or laxative misuse), but no eating binges Night eating syndrome – Recurrent episodes of eating after awakening at night or after the evening meal. The eating episodes cause significant distress or impaired functioning
Other Eating Disorders Pica – Eating nonfood things that do not provide nutritional value Rumination disorder – Regurgitating food previously chewed and swallowed, re-chewing it, and then re-swallowing it or spitting it out Purging disorder – Purging behaviours such as using vomiting, laxatives, diuretics, or excessive exercising to control body weight or shape Unspecified feeding or eating disorder – Not meeting full criteria for any eating disorder Orthorexia – Obsessive focus on healthy eating to an extent that disrupts daily life

**Adapted from [7][8][9].*

3. Method

3.1. Study purpose

This study explored the meaning of social support in a non-clinical sample of female university students living with eating disorders. The objective was to describe and understand how women access social support when seeking help for issues with food or eating.

3.2. Design

A mixed methods design described by Creswell and Clark [24] combined the generalizability of quantitative methods with the in-depth understanding of a contextually influenced phenomenon gained from qualitative methods. The quantitative survey component included measures of eating attitudes, coping, social support, and support-seeking behaviours. Following this, qualitative narrative interviews took place with participants willing to discuss their experiences. Defining features of the qualitative approach involved eliciting stories from participants as experts of their own health experiences, in-depth collaboration between the interviewer and participant, and open-ended questions that let the participant control the direction and content of the interview. A narrative approach is often used in healthcare research to better understand the lives of those with life-limiting diseases [25]. Together, the mixed methods helped develop a fuller conceptualization of social support and help-seeking behaviours of university students struggling with Eating Disorder (ED) symptomologies.

3.3. Sample

Posters in three universities and an invitational letter via student listservs attracted 142 students to the study's online survey housed at the University of New Brunswick. Clinical diagnosis of an ED was not required to gain the broadest possible perspectives. Twenty-two participants completed interviews with graduate student research assistants.

3.4. Data collection

The study was outlined in detail, and participants were required to give consent before proceeding with the demographic questions, the EAT 26 [26], Social Provisions Scale [27], and Proactive Coping Inventory [28] Instrumental Support Seeking (ISS) and Emotional Support Seeking (ESS) subscales. Participants interested in being interviewed contacted the research assistant directly. Qualitative individual interviews via telephone gave participants the flexible space to elaborate on their experiences [29]. Each interview lasted approximately 40 minutes and was audio-taped, transcribed verbatim, and anonymized.

3.5. Data analysis

Quantitative data were analyzed via descriptive statistics, bivariate analysis, and logistic regression. Demographic information was presented using frequencies and percentages. The univariate analysis estimated the prevalence of having a high level of concern about eating attitudes (dieting, body weight, or problematic eating behaviours), as indicated by an EAT-26 score ≥ 20 . Bivariate analyses, chi-square tests, and logistic regression were used to investigate whether the likelihood of having a high level of concern about eating attitudes was significantly different among participants with and without perceived social supports and proactive coping behaviours, as assessed by the Social Provisions Scale (SPS) and Proactive Coping Inventory (PCI) measures. For all logistic regression models, odds ratios (OR) and 95% Confidence Intervals (CI) were reported. All analyses used Stata version 16 [30] and Microsoft Excel [31].

Qualitative data were examined for the study purpose of describing and understanding the meaning and access of social support to university women experiencing Eating Disorder (ED) symptoms. Making meaning from the qualitative data required re-reading interview transcripts to identify recurring and unique ideas. Patterns were compared and interpreted. Before and throughout data analysis, the researcher and research assistants clarified any biases they brought to the study by openly discussing their individual past experiences, assumptions, and emplacements that could influence interpretations. Quotes, in narrative form, provided evidence of findings. A typology was developed according to similarities and dissimilarities that hierarchically organized the ideas from the participants' stories into categories. The categories were inductively formed rather than formally deduced a priori—typologies group standard features to convey unique features of an individual's account about others [32].

As per the approach described by Creswell [24][37], this study's quantitative and qualitative data were collected and analyzed separately and then compared to see if the results confirmed or disconfirmed each other. The intentional process of integration [38] brought quantitative and qualitative findings together to address the research purpose interdependently.

4. Results and discussion

4.1. Descriptive statistics

The survey response rate was 80.6 % (N = 142). Participants ranged in age from 18 to 47 years, with an average age of 23.4 years (SD = 5.85). Most (76.1%, n=108) were from New Brunswick; 5.6 % were from other parts of Canada (4.2%, n=6) or international (1.4%, n=2); 18.3% (n=26) did not give their region. Most (93.7%, n=133) spoke English; 2.1% (n=3) spoke French; 2.8% (n=4) participants identified fluency in another language or did not identify their mother language. The majority of participants identified as Caucasian (90.1%, n=128), Black (2.1%, n=3), or Aboriginal (0.7 %, n=1); the remaining 7% identified their race as “other” (5.6 %, n=8) or did not state it (1.4%, n=2). Most (72%, n=122) were undergraduate students; 9.3% (n=1) were graduate students. Over 60% of participants were employed on a full-time (21.1%, n=30), part-time (39.4%, n=56), or casual (6.3%, n=9) basis; the rest were homemakers (4.2%, n=6), unemployed (23.9%, n=34), other (1.4%, n=2), or did not provide employment status (35%, n=5). Of the 81% who stated their incomes, 42.1% (n=60) stated incomes of less than \$35,999/year; 38.7% (n=55) earned above \$36,000/year. According to established body mass index (BMI) categories, just over half (52.8%) were classified as obese (BMI 30 and over) and 4.9% as overweight (BMI 25 – 29.9); 14.1% had BMIs 18.5 – 24.9 (normal), while the BMIs of 28.2% were < 18.5 (underweight). Weights and heights were self-reported.

4.2. Eating Attitudes Test (EAT 26) scores

The EAT-26 [25] uses a six-point scale based on how often the individual engages in specific behaviours. A score at or above 20 on the EAT-26 indicates a deep concern about dieting, body weight, or problematic eating behaviours. The average EAT-26 score in this study was 21.4 (SD=14.26). Seventy-two participants (50.7%) reported a high level of concern as indicated by an EAT-26 score ≥ 20 . Of these participants with an EAT-26 score >20 , 22.2% (n=16) had been previously treated for an Eating Disorder (ED). Of participants with EAT-26 scores <20 , 13% (n=9) had also been treated for an ED.

4.3. Social Provisions Scale (SPS)

The SPS [26] was used to assess perceived social support based on six core types of social provisions needed to avoid loneliness: attachment (intimacy), reassurance of worth (validation of competence), reliable alliance (perceived access to assistance), guidance (having others available when needed), social integration (belonging), and nurturance (caring for others). The Total Social Provisions Scale (SPS) scores ranged from 40 – 94, averaging 76.1 (SD: 11.47, n=123). The SPS Attachment subscale ranged from 5 – 16, with an average of 12.4 (SD: 2.70, n=138). The SPS Reassurance of Worth subscale ranged from 5 – 16, with an average of 12.0 (SD: 2.53, n=131). The SPS Reliable Alliance subscale ranged from 4 – 16, averaging 13.47 (SD: 2.52, n=142). The SPS Guidance subscale ranged from 4 – 16, averaging 13.2 (SD: 2.53, n=140). The SPS Social Integration subscale ranged from 6 – 16, with an average of 12.5 (SD=2.49, n=139). The SPS Nurturance subscale ranged from 6 – 16, with an average of 12.1 (SD: 2.48, n=137). As shown by the logistic regression results between SPS scores and high scores on the EAT-26, only the total SPS Nurturance subscale score was found not to be significantly associated with concern about dieting. The total SPS score and subscale scores for Attachment, Guidance, Reassurance of Worth, Reliable

Alliance, and Social Integration were all significantly and negatively associated with having a high level of concern about diet, body weight, or problematic eating behaviours on the EAT-26. Each 1-point increase in the total SPS score or total Attachment, Guidance, Reassurance of Worth, Reliable Alliance, and Social Integration subscale scores was associated with a decreased likelihood of scoring a high level of concern on the EAT-26. Thus, women lacking readily accessible social support were significantly more likely to have eating issues (EAT-26 greater or equal to 20).

Table 2. Odds ratios for SPS scores and having a high level of concern about diet, body weight, or problematic eating behaviours on the EAT-26 (reference group is EAT-26<20)

Score	OR	95% CI	P-value
Total SPS Score	0.80	0.70-0.92	0.001
Subscale Score Total:			
Attachment	0.80	0.70-0.92	0.002
Guidance	0.72	0.61-0.86	<0.001
Nurturance	0.96	0.84-1.10	0.62
Reassurance of Worth	0.76	0.64-0.89	0.001
Reliable Alliance	0.73	0.62-0.86	<0.001
Social Integration	0.82	0.71-0.95	0.011

Odds ratios were used to compare outcomes between those with EAT-26 scores<20 vs. those with EAT-26≥ 20. The odds ratio on Total SPS score was 0.80 (95% CI: 0.70-0.92), which means that each additional one-point increase in total SPS score is associated with a significant 20% reduction in the odds of having a high level of concern about diet, body weight, or problematic eating behaviours on the EAT-26. The SPS subscale analysis indicated that attachment, guidance, reassurance of worth, reliable alliance, and social integration were similarly associated with significantly reducing the odds of a high level of concern on the EAT-26. Each 1-point increase in these subscale scores significantly decreased the odds of having a high level of concern about diet, body weight, or problematic eating behaviours: attachment (20% reduction), guidance (28% reduction), reassurance of worth (24% reduction), reliable alliance (27% reduction), and social integration (16% reduction). The women’s responses to the nurturance questions of the SPS were not statistically significant. Furthering the analysis of the nurturance subscale using several different demographic groupings and chi-square tests for independence — (1) one with detailed marital status categories exactly as they appeared in the survey (e.g., married, common-law, single, boyfriend, other, etc.), (2) one with collapsed relationship categories (single/not in a relationship vs. in a relationship (married/common-law/ boyfriend/ girlfriend/other-engaged), and (3) one with more slightly less collapsed relationship categories (single/not in a relationship, boyfriend/girlfriend, married/common-law/engaged) showed no statistical significance ($\chi^2=3.7629$ p-value=0.584). A possible explanation for why the nurturance questions may not apply may relate to the demographics of the study population (e.g., mostly younger university students without dependents and likely not living for the school year with their families).

4.4. Proactive Coping Inventory (PCI) score

As a multidimensional instrument, the PCI [27] identifies and operationalizes seven dimensions of coping: Proactive, Reflective, Strategic, Preventive, Instrumental Support, Emotional Support, and Avoidance. The Emotional Support Seeking Scale (ESS) of the PCI measures emotional self-regulation with the assistance of significant others. The subscale

scores for ESS ranged from 6 – 16, with an average of 10.5 (SD=2.35, n=138). The ESS subscale score total was not statistically significantly correlated with having a high level of concern about diet, body weight, or problematic eating behaviours on the EAT-26. However, participants who did not report having a high level of concern about diet, body weight, or problematic eating behaviours were significantly more likely to respond "completely true" or "somewhat true" versus "barely true" or "not at all true" to know who to call to help them feel better, having people in their lives who help them feel cared for, having someone in their lives they can count on, and seeking others to talk to if feeling down or depressed.

Table 3. Odds ratios for the EAT-26 score and the emotional support-seeking subscale from the proactive coping inventory

Answered "Complete True" or "Somewhat True" vs. "Barely True" or "Not at All True"	EAT-26 Score	Odds ratio	P-value	95% CI
If I am depressed, I know who I can call to help me feel better	≥ 20 (ref)	1.00	--	--
	<20	5.00	<0.001	2.15-11.65
Others help me feel cared for	≥ 20 (ref)	1.00	--	--
	<20	4.41	<0.001	1.89-10.29
I know who can be counted on when the chips are down	≥ 20 (ref)	1.00	--	--
	<20	3.19	0.04	1.08-9.41
When I'm depressed, I get out and talk to others	≥ 20 (ref)	1.00	--	--
	<20	4.13	<0.001	2.00-8.51

In [Table 3], odds ratios compared outcomes between the two groups (i.e., those with EAT-26 scores <20 vs. those with EAT-26 ≥ 20). With odds ratios greater than one and the 95% confidence interval not crossing or equal to 1, those with EAT-26 scores <20 reported having close personal relationships with others, someone to turn to when distressed, and someone to depend on if needed. They also reported feeling part of a group of people who shared their attitudes and beliefs, had people who admired their talents and abilities, had close relationships that provided them with a sense of emotional security and well-being, and had a trustworthy person to turn to for advice if they were having problems.

To sum up, most participants were English-speaking undergraduate students engaged in outside employment while pursuing university studies. Over half were classified as obese or overweight. Most reported a high level of concern about diet, body weight, or problematic eating behaviours; 13-22% had been previously treated for an Eating Disorder (ED). The scores of participants who demonstrated high EAT-26 scores were significantly and negatively correlated with social support. Women lacking readily accessible social support, as measured by the attachment, guidance, reassurance of worth, reliable alliance, and social integration subscales of the SPS, were significantly more likely to be concerned about body weight or eating behaviours on the EAT-26. In terms of seeking emotional support, participants who did not report having a high level of concern about diet, body weight, or problematic eating behaviours were significantly more likely to report knowing who to call to help them feel better, having people in their lives who help them feel cared for, having someone in their lives who can be counted on, and seeking to talk to others if feeling down or depressed.

4.5. Qualitative findings on social support

The study's qualitative data complements the quantitative results by providing a rich understanding of the support perceived as helpful to women experiencing concern about weight or eating behaviours. University women define social support as including others who may not have initially been part of the women's prior social networks to gain emotional validation, connection, and belonging. Women access social support through health championing or efforts to attain optimal health without the negative effects of the disease. The concept of health championing has been used in public health, education, and healthcare literature to refer to providing sound educational and psycho-social, physical, and mental health opportunities that represent the interests of youth and others who have little or no voice in their care and that benefit society as a whole [32]. In healthcare settings, the literature reports championing by only formally appointed champions [33][34]. These healthcare champions are internal to an organization; have an intrinsic interest and commitment to implementing change; work diligently and relentlessly to drive implementation forward, even if those efforts receive no formal recognition or compensation; are enthusiastic, dynamic, energetic, personable, and persistent; and have strength of conviction [33]. Their championing activities include tenacious advocating, facilitating reflection, motivating others, and planning. Championing serves to overcome institutional siloing, build and leverage professional networks, create tension for change, cultivate positive learning climates, optimize compatibility with existing workflow, and engage key stakeholders. Key attributes associated with championing success in implementing new practices include influence, ownership, physical presence at the point of change, grit, persuasiveness, and participative leadership style [35].

In contrast to the above literature, championing the women participating in this study is an evolving and contextual process that women develop and is mirrored by support from connected others. Championing entails self-advocacy, self-efficacy, self-agency, assertiveness, self-actualization, and self-acceptance. A lack of championing fosters the concealment of illness. [Figure 1] depicts a typology of championing for women experiencing eating disorders (EDs) within their varying levels of social support. The typology captures different profiles of living with EDs. The columns convey the range of social support from no support to supporting self and others. The rows show the levels of championing as unchampioned, championed by others, self-directing self-care, and championing self. The typology does not convey lateral or vertical movement. For example, a woman who puts on a mask of pretending all is fine and uses defense mechanisms to push others away may not move into a position of getting help or speaking out. A woman may recover without social support (left, lower position in the typology).

4.6. No social support

Figure 1 (left column) shows women without social support have difficulty acknowledging the presence of an eating disorder (ED). They may feel thwarted trying to speak out and controlled and watched by others even if these others are attempting to champion. Passing off or hiding the eating disorder (ED), using defense mechanisms, and pushing others away help deflect intrusion. Women may overcome the ED on their own without social support.

Figure 1. Typology of recovery progress informed by championing and social support

Champion	Championing Self	No social support Learning to manage recovery on my own Views progress as an independent journey May see support as judgmental No one else is really helping Making progress on own at not letting food control life	Survival support Boundary setting Limits unhealthy relationships with food and others. Establishes healthy relationships with service providers while quitting unhealthy sports, dancing, and social activities	Supporting self Protecting progress Protects health progress through becoming authentic, living in the moment, asking for needed help, caring for self, and contracting with a mentor to prevent relapse	Supporting self & others Making wisdom public Speaks out, conducts anti-shame and anti-stigma campaigns, and demonstrates against fashion magazines. Regains what was lost to the ED and its antecedents
	Self-directed self-care	Putting on the mask Passes off or hides the ED by pretending all is fine May not see ED as a problem Uses defense mechanisms Pushes people away Uncomfortable with other's gazes Prefers anonymity to joining a group	Help-seeking without fully knowing the needs If available help is unacceptable, do not seek other help Passively accepts others' responses vs actively meeting needs Help-seeking is harder if seeing a different counselor each time, and the helping approach is non-individualized	Getting help Acknowledges the complexity of the problem Self-sufficient with eating and participating in support interventions Identifies the root cause of the ED Sees common threads and feels solidarity with others	Taking time for self & helping relationships Staying on top in the real world by prioritizing needs within life demands May still struggle to recognize own accomplishments Does things because wants to, not because told to Can limit/direct others' influence
	Championed by others	Feeling monitored by others Feels controlled and watched by others (even if these others are attempting to champion) Feels thwarted in trying to speak out	'Testing the Waters' Cryptic messages hinder problem recognition. Does not disclose the ED or engage in therapeutic alliance with care providers	Receptivity to role models Differentiates between positive and negative role models Enacts the behaviour of helpful role models	Helping others while helping self Attempts to help others and self through raising awareness, providing information, and participating in research
	Unchampioned	Denial Unable to acknowledge the presence of an ED Emotional Requires probing to share experiences	Dependent on limited informal support Feeling isolated It goes along with unwanted support interventions others do without asking	Connecting indirectly to others with similar issues Puts ideas out and looks for responses Reads accounts and journals to connect with self Is not fully engaged	Perceived connection with others unable to fully support Not comfortable with, but attempts to please others Cannot garner support, so stays unchampioned
			No support	Survival support	Supporting self

*ED = Eating disorder

4.6.1. Denial (no support/ unchampioned)

University women experience a period of not recognizing the presence of the ED. *“I think people know, but it's hard to admit to having an eating issue. Like, people just deny it.”*¹ Denial was first described by Freud [39] as refusing to acknowledge upsetting facts about external and internal events, including memories, thoughts, and feelings. The university women want control over unaccepted feelings related to stress from *“financial issues to relationship issues, to body image,”* moving and not knowing *“a single person there,”* being *“treated differently as the new girl,”* and academic program pressures. The women worry that others will see them as *“flawed”* or *“failing in one part of life.”* Denial provides emotional distance; it allows women time to keep the ED a secret as much as possible so they can try to deal with it on their own. *“Nobody knew I was losing weight. All my friends didn't live here; my mom didn't live here, and I didn't tell anybody.”* Eating or restricting food becomes *“the mechanism of choice to fend discomfort, to numb feelings.”*

Women may not see the ED as a problem if they consider it something they have control over and a source of pride. *“There are many things that I can't control, but I can control what I eat and how much I exercise. It was nice. I felt empowered and good and wouldn't tell anybody about that.”* Women maintain denial to protect the ED, which becomes *“kind of my identity and something I was so obsessed with weirdly... even though I know I was really unhealthy.”* The denial is reinforced by people complimenting the woman for losing weight.

Denial flourishes amid campus living where students often skip meals in confronting residence food options that involve long cafeteria lineups, limited salad and sandwich choices, inadequate vegetarian options, a predominance of deep-fried foods, and huge pasta servings of *“carbs, oil, and carbs!”* Fear of the freshman-15 (weight gain) also provokes restricting and excessive exercising to *“maintain a certain physique.”* Peers may promote denial of unhealthy eating practices, such as when watching a movie with *“everyone there eat[ing] junk food”* or when all the ballerinas in one participant's dance group ate only yogurt and water while not changing their activity level for over a month before performances, and afterward binge eating on chocolate until they got sick. *“You do what your friends are doing. I don't know if it (the ED) would have occurred had I not been in that environment.”*

The milieu of intense study and competition contributes further to denial and lack of support. University women often *“study until three o'clock every night,”* distract themselves with *“perfectionism,” “work way too much,”* and *“not treat [their] body well.”* Immersed in trying to get the best grades possible, they are oblivious to the concerns of those around them. *“I think I was too much in denial or something, or they didn't ask about it, I'm not sure.”* When the ED is *“pretty bad, and I'm still in denial,”* a woman does not want to talk. She may cry, withhold eye contact, and keep *“everything inside ... to maintain control.”* This perpetuates the denial, and the women remain unchampioned.

4.6.2. Feeling monitored by others (no support, being championed by others)

As the Eating Disorder (ED) continues, women feel controlled and judged by others. *“People stare at me when I walk around campus ... I kind of felt like there must be something wrong with me, like I look fat today.”* One participant did not *“have any issues when I'm super tiny.”*

In contrast, overweight women feel depersonalized, believing others see them as *“the fat person instead of a person.”* The watchfulness of others is so unsettling that women are terrified they will not arrive at class early enough to get a seat in the back row where *“nobody is looking at me.”*

Women find other students, start watching, and ask, “Why didn't you bring lunch today?” The woman replies, “No, I'm good,” “I eat,” and “I've never been diagnosed with an eating disorder.” Friends often break off the relationship after unsuccessfully encouraging the woman to “eat more, eat more.” Women also try to avoid other people monitoring their physical activity. “I don't need men staring at me as I run on the treadmill. I'm self-conscious enough that I don't want that.” Some women are scared that if they go home, their parents will closely monitor them and “be on my case about over exercising all the time” or “tell me I need to lose weight and stuff like that.” They perceive others as saying, “It's all about vomiting and starving, and they don't know everything else you're doing.” Women who “can't throw up,” “do eat,” or are not “stick thin” are monitored less because “nobody would think there's a problem.”

When monitoring by others is required, such as with routine weighing for athletic events (e.g., “If I'm like point one over, I have to wrestle a girl that's like five pounds heavier than me”) or for related health conditions (e.g., being diagnosed with diabetes and having to write down everything eaten to show their mothers/service providers), women may not recognize the underlying intent to support. They do not disclose the eating disorder (ED) because they think others will “force me to eat things I don't want to eat,” “do things I don't want to,” and “gain weight.” They dislike others “tell[ing]me about what my problem is because it's like my decision.” Even when a woman perceives others (e.g., parents, coaches, students) as attempting to champion her by showing positive regard for her and expressing hope that she will improve, the woman still regards others' monitoring as unwarranted, prohibitive, and unsupportive. To illustrate, several participants “couldn't say anything” in front of the family physician when their mothers entered the medical examining room with them.

Despite resenting being monitored by others, women monitor themselves via frequent self-weighing and tracking intake. They judge themselves based on the number on the scale. “When I stepped on the scale, it had to be like whatever. It didn't matter how great I felt or how great I looked. If it wasn't the number, it just wasn't right.” They want the calorie content listed next to every item in cafeteria foods so they can monitor their intake without others necessarily noticing them looking at the list. Women usually do not eat in front of friends because “it's pretty hard not to eat anything and still hang out with people.”

4.6.3. Putting on the mask (No support/self-directing self-care)

Women hide their eating patterns to avoid negative judgment from others, for example, staying home alone to throw up or taking the garbage out after ordering and eating an entire pizza so that others will not know. They wear “*baggier clothes*” and mask their true feelings to appear “*from the outside like I had everything together, and everything going for me.*” They try “*passing it [the ED] off*” by saying things like “*I went and had breakfast this morning...so like I didn't go to my class because I went to breakfast, that's why I'm not hungry for lunch*” and “*I'm lactose intolerant and cannot eat more than a little bit of pizza or ice cream.*” To deflect others' concerns about their binge eating or weight loss through restricting eating and over-exercising, women pretend, “*Everything's fine, fine, fine, moving along fine.*” In masking their problem to feel safe, they do not fully recognize or are unsure of their needs. A woman may use “*very skilled defense mechanisms to put back at them [others]*” if confronted but otherwise will “*push people away.*” Women put on the mask to hide the ED from themselves as well as others. They do this by exaggerating the number of calories in

food eaten (e.g., *"I'd be like banana = 150 calories"*) or exercising more than recorded *"to look like I wasn't lazy like I wasn't fat, and wasn't trying."* They prefer anonymity over joining a group. *"I don't want to talk; I just want to run."*

Women keep on the mask because they believe others will *"expect something"* from them if they talk about the ED. By the time the women think they can take off the mask and feel comfortable talking, they discern *"no one is asking"* and *"friends [are] no longer following up."* The desire to take off the mask occurs when a woman determines *"my whole world was out of control ... I needed someone to take me and put me somewhere where I needed to be."*

4.6.4. Learning to recover on own (No support, championing self)

Managing the eating disorder (ED) becomes an *"independent"* journey for women who acknowledge having *"no one to really count on."* Without social support, these women learn to self-champion. *"I'm making progress at not letting food control my life, but no one else is really helping me."* Women do not ask for help or disclose the ED to *"just anybody"* because they are unsure of the reactions from others who may not have *"the basic understanding of what you're going through."* One participant did not tell her mother because she thought her mother *"wouldn't think it's a big deal or else would think I'm overreacting."* Even when a woman is *"very open about it (the ED),"* she does not talk about it unless she feels that she will not be negatively judged. Roommates, older sisters, and long-time friends may only be approached. One participant hesitated to talk about her body image concerns with her female friends, who were *"pretty big feminists,"* because she assumed they would expect her to be comfortable with her body image. The loss of friendships related to having an ED and having no one to turn to means that for some women, *"There's been no helpful alternative suggested or like nobody's really helped me."*

Self-championing does not require others. *"Like I went out and did it myself. That's the type of person I am."* A history of successfully adapting to life transitions, such as moving and starting new schools, underpins a woman learning to recover independently. *"I know what I've got to do for myself, and ultimately, it's not how I compare myself to others. It's how I feel about myself."* Being stressed, tired, or bored fuels the realization, *"This needs to stop. I cannot be this overweight anymore."* Deep resolution to change and much perseverance to *"get out of that eating disorder mindset"* facilitates self-championing.

4.7. Survival support

Survival support (2nd column, Figure 1) focuses on eating-related symptoms more than relationships. It is generic, not tailored to individual needs. It includes limited informal support from friends and family and the involvement of health professionals. The women do not disclose to others and are unaware of their needs. However, they learn to limit unhealthy relationships with food and people.

4.7.1. Dependent on limited or informal support (unchampioned, survival support)

Size comparisons influence women to feel *"very isolated"* from others. *"It's hard to be around people who know they're good-looking and have great bodies."* One participant revealed an intense desire for others to understand by lamenting to a family member:

I wish I could put you in some fat suit. And turn you into my heaviest body weight just for a couple of hours, and make you try on my old clothing, and don't walk around in public, but spend 12 hours the way I was, where I was, you know, out of breath to go up a flight of stairs.

Women feel “*harassed*” when told by physicians to “*go to Weight Watchers*” or “*go to a dietician*” or by their father saying, “*Why don't you come with me to the gym at six o'clock in the morning?*” Some women ask others within their social network to help them make decisions and watch over their health (e.g., “*I cried one night on my knees begging my mom for help*”). *In contrast*, some women experience other people jumping in with support interventions even if not directly asked. To illustrate, one participant’s boyfriend tried to hold her back from purging in the bathroom; another’s boyfriend insisted on going out for dinner as she had not eaten all day. In these incidents, neither woman wanted direct physical support; however, they recognized their boyfriends’ good intentions to be helpful. “*I like to push people away, and that's hard to deal with. It always makes relationships untrusting.*” The support extended to them is perceived as inadequate because the women cannot say exactly what they want. One participant described this survival support as “*the ball was dropped for me many times.*”

4.7.2. Testing the waters (Championed by others, survival support)

University women “*test the waters*” by giving cryptic, constrained messages to others. The women expect others to pick up on their cues even though the ambivalent messages hinder problem recognition. A woman may see a dietician or other professional support if someone encourages it. Still, the woman does not disclose or get help for the eating issue if they perceive the support as unhelpful. “*It's difficult to admit that you have a problem. I talked to a counsellor but didn't find it helpful. I felt like she was being too dismissive.*” One participant did not make another appointment when a counsellor asked if the issue could be “*solved in three sessions.*” Women also disengage when their culture, relationship to their mother, and the way they were raised are insulted.

In testing the waters, women may seek out service providers for other issues or partial solutions while not engaging in therapeutic alliance. One participant described going to her guidance counsellor at high school to talk about the eating issue but “*ended up talking about university and school stuff instead.*” Having a prior connection with a service provider limits disclosure. “*If I didn't know them on a personal level beforehand, it would have been easier to go in and just go, I'm going to talk about it.*” When help is not forthcoming, as providers do not access the complete picture of the woman's experience, women tend to judge the providers negatively. For example, when one participant told her high school counsellor about overeating in response to past abuse, the counsellor, who “*had no background in eating disorders,*” merely told her to lose weight. The participant surmised, “*I didn't get help after that because I had a brain!*”

4.7.3. help-seeking without fully recognizing needs (Self-directing self-care, survival support)

Women may have only superficial realization of Eating Disorders (EDs) acquired from reading books or web pages and attending events and meetings open to the general public. “*To me, my weight equals my happiness. If I get lighter, I'm happier.*” They do not look for additional help until they suspect they actually have an ED and recognize a need for support. “*I'm not afraid to speak my mind, but when it comes to myself and my body image and stuff like that, I do not like talking about it.*” Women are embarrassed and ashamed to ask for help because they consider needing help as lacking self-control. “*I don't really like to see lack of discipline in others, so I don't like to see it in myself either, and I don't let other people know I*

lack this discipline myself." This shows the women do not fully recognize their need for help. Unsure of the complexity of their needs, they limit help-seeking efforts to a basic level. *"I still didn't like to specify that I had an eating problem; I just told her (counsellor) that I was finding it difficult to keep my weight off, so I didn't really talk to her about that [the ED]."* Suppose the available support is unacceptable (e.g., attending an Overeater Anonymous meeting but disagreeing with its philosophy or being told by the family doctor that he would not help her unless she told him why she does what she does). In that case, women passively follow the rules and accept others' evaluations rather than self-assertively defining their needs. This can include being scheduled for appointments but being sent away unseen. Getting help is harder if *"seeing a different counsellor each time," "waiting [ing] in line," "getting appointments cancelled,"* having a non-individualized therapeutic approach (e.g., a 12-step program), and falling into a gap in service coverage.

It was like holding your breath, waiting for your next chance to get help. After a while, I just got tired of holding my breath. I'm 18. They switch over the teams at 19. Under 19 is child and youth, but above 19 is the adult team. So, they didn't know where to put me because if they put me on the child and youth team, they'd have to switch me when I turned 19.

4.7.4. Boundary setting (Championing self, survival support)

Championing themselves at the highest level of survival support, women are determined to get better *"for real."* They break off or limit unhealthy relationships with food, activities, and people who are abusive or unhelpful. For instance, they *"avoid at all costs"* certain television shows that trigger binge eating or restriction. They further take care of themselves and establish healthy relationships by seeing a psychologist, dietician, and so forth while at the same time quitting unhealthy dancing and sports practices (i.e., not cutting weight [wrestling]) and not letting food control their lives. Aware that knowledge is not enough to change behaviours, they enact relevant, concrete boundaries such as *"not going to do a PhD unless I get better"* and replacing the sugar content in their daily intake with healthy foods, to the point of being able to *"eat banana bread, cake, everything!"* One participant drew a line in the sand with a potential boyfriend by telling him in front,

This [the ED] has been a problem for me before, like, I don't want to get into this relationship and then like have it get really serious, and then I get sick, and then you leave when I need you the most. I don't want that to happen.

4.8. Supporting self

Championing to support self, women connect indirectly to others with similar issues. Despite seeing common threads and feeling a sense of community with these others they may regard as potential role models, the women carefully differentiate between the other's positive and negative characteristics to figure out why when there is 'No Fit' with a role model. Acknowledging the problem as more complex than a physical journey or an individual issue, women strive to identify the root cause of the Eating Disorder (ED). By becoming self-sufficient with eating and participating in support interventions, women value and protect their health by living in the moment, asking for help, and contracting with others.

4.8.1. Connecting indirectly to others with like issues (unchampioned, supporting self)

Women connect indirectly to others through reading first-person accounts of living with an Eating Disorder (ED) and watching reality TV shows. They may attend available campus ED

peer education and support groups during the initial weeks but withdraw from the later meetings characterized by individual sharing. In connecting indirectly to others, the women's ideas are less cryptic than when testing the waters (4.7.2), and they look to see who responds.

You always feel like what you're going through differs from what anyone else could go through. Like 'you can't possibly understand' because my life and my situation are completely different than yours, so I feel like I can't relate to anybody. At the same time, it would be the greatest thing in the world to relate to somebody.

Women find it easier to hear advice that *"doesn't feel so much like preaching."* The women think same-aged persons will be better able to empathize with *"waking up feeling fat, overeating last night, and feeling guilty."* However, university women are astonished at how few people in their social network can tell them what is unhealthy to eat. Connecting with others who have similar issues may worsen the ED. *"My friend and I could motivate each other to get better. We could also trigger each other to get sick. I would have to be sick with her if she was getting sick again."*

Besides connecting with other people, the women journal to connect with themselves and make their experiences *"real."* They may connect with *"music that describes how I feel cause I'm not making it up on my own."* Similarly, they may use phone apps and inspirational messages. If championed by others to seek formal help, women who are not ready for full support merely theorize about similarities between support groups. One woman concluded, *"If you look in the DSM under substance abuse, a lot of women with an eating disorder could just put in food or pressure to be thin, and they could relate to it."* Women deem ED programs harder than drug and alcohol programs because *"you cannot abstain; you have to eat."*

4.8.2. Receptivity to role models (Championed by others, supporting self)

University women use their comfort level with their own bodies to distinguish role models who can support them. For instance, dancing women feel more comfortable with their bodies when the dance teacher is bigger. They feel uncomfortable when the teacher is critical of their body, regardless of size and shape. Similarly, they are not comfortable with and do not want to disclose the ED to a proctor who is experiencing an eating issue if the proctor has not already received help, does not know *"as much as I do,"* or complains about their body and food. Women question how someone who has not gone through an ED, *"like never gained 40 pounds in two years,"* knows what they are talking about. To women living with EDs, a role model's credibility lies in looking healthy and glowing in their physical being because they *"obviously know what [they're] doing."*

In addition to evaluating size and appearance, university women strive to figure out why when there is *"no fit"* with a potential role model. The woman asks herself, *"What can this person do for me? And what is this person doing that's not good for me?"* Through these questions, one participant determined her coach was not a good role model because the coach *"always made me feel like I need to eat more like her, but I knew that wasn't true."* Another participant realized that her anxiety therapist's use of exposure therapy with high-sugar foods ran counter to ED treatment of abstaining from foods with high sugar content. Going with her friends to the residence meal hall was helpful because her friends conversed with her and ate well, so she modeled their behaviours.

Feeling respected, allowing the woman to bring up the problem on her own, and having the ED taken seriously increases Receptivity to service providers. The provider's level of knowledge, understanding, and experience in working with ED patients are essential qualities

that help women feel supported and able to ask questions about the process of recovery and the difficulty of gaining weight. Women are more receptive to providers reassuring them that recovery will take time and may be uncomfortable and offering relevant learning activities. Women find treatment “*a little easier*” when providers do not judge or exert pressure. A woman may be unable to say “*what I was really thinking*” if singled out (for being the youngest group member there), challenged or pushed before feeling ready, dismissed (with “*Stop obsessing, don't worry about it. You're skinny, what are you bitching about?*”), and accused of lying (about not throwing up medicine). Women consider providers judgmental if what the women say does not match what the provider finds part of the problem.

She (the provider) had this view of what was happening or would kinda give me that look like, 'Uh, I don't think that's really what's going on here.' So, I'm not going to talk about it. And then it became like, why am I here if I can't really talk about what's on my mind?

4.8.3. Getting help (Self-directing self-care, supporting self)

Motivated by feeling “*sick and tired of being sick and tired,*” women purposely find an outlet for connection. As available, women get help through campus peer support groups and attending Eating Disorder (ED) treatment centres. Dialectical behaviour therapy, the spiritual component of connecting with others “*going through the same kind of thing,*” and structured mindful eating help support women. The workbooks used in her support group provided information on personal bills of rights that one participant found especially helpful.

I felt there were things I didn't feel like I had... like I have the right to ask for what I want. I don't feel comfortable asking for stuff. If I need help with something, I don't get help with it, and I do it on my own. I know I have the right to ask for stuff, but I don't feel comfortable doing it, I guess.

Exposure to others’ experiences helps women begin to figure out how they themselves developed the ED. One participant gained awareness while analyzing research interviews, “*It really hit, this had happened to me. That's when I got help.*” In listening to group members, women begin to understand the underpinnings of the ED while acknowledging the problem as more complex than a physical journey or individual issue. They further progress by realizing they are “*not at the group to support others but to get help for 'me.'*” Engaging somewhat self-sufficiently in getting help enables the woman to realize she is not “*crazy*” or “*weird but 'normal'*” and to make more appropriate choices such as “*eating more normally than I have in a long time.*” Women perceive the group as “*a safe zone*” where no one judges or is judged by others. “*There are hotlines you can call, but they aren't the same as someone you know and have been in a group with.*” Feeling this sense of community understanding is the major takeaway from participating in treatment or support groups. “*Just sitting and talking to people who have shared and feel the same way, it's supportive, I guess, and it feels good.*”

4.8.4. Protecting recovery progress (championing self, supporting self)

Women learn to treat recovery as a full-time job, which they strive to protect because “*relapse is right around the corner.*” Acknowledging the time and effort to make progress and vowing not to “*fall back into the cycle,*” the women strive to stay fully committed, open to information, and honest in sessions. They identify that they “*get cranky and irritable and [are] not fun to be with*” when they do not practise healthy self-care. “*For the first time in my life, I'm actually happy, and it's hard to turn my back on that.*” They protect their progress by developing greater self-awareness through allowing and feeling emotions, meditating, living in the moment, and being “*you with yourself.*” One participant asked herself, “*What's actually*

bothering you? What are you really hungry for, not food, but more friendships or more space?"

The women continue to progress by eating without distractions, getting a good night's sleep, assertively asking for what they need, enforcing personal boundaries, and contracting with others for support. The contract for another participant involved implementing a flagging system of green (doing well in all areas), orange (beginning to restrict and avoid interactions with others), and red (not meeting needs for nutrition, rest, and social interaction); she asked her advisor to prohibit her working on her thesis when she was at yellow and orange. The flag system proved helpful to her as *"I need all these supports to get better."* Protecting progress improved her confidence in a *"way of success more than any degree I could get."*

4.9. Supporting self and others

Women try to help others and themselves by raising awareness about eating disorders (EDs) and participating in research. They prioritize their needs within their current life demands. A woman may struggle to recognize her accomplishments yet be able to limit or direct others toward what she prefers to do rather than what she is told to do. Making their wisdom public, women speak out, organize anti-shame and anti-stigma campaigns, and demonstrate against fashion magazines. They celebrate themselves for regaining what was lost to the ED.

4.9.1. Perceived connection with others who are unable to support (unchampioned, supporting self and others) fully

Women living with EDs stay unchampioned when unable to garner support. Initially, to support themselves and others, they are not *"super comfortable"* with others and may attempt to please others. *"I didn't want them worrying about me. They have their stresses."* The women did not want to burden their families, already burdened with caring for aging grandparents, a parent with a terminal illness, and siblings with mental illnesses. For some women, *"workaholic"* family members and peers *"obsessed with school, marks, and popularity"* cannot support them. Even when women perceive a connection with others who are also living with EDs, *"we can't really support each other because we are going through the same problems, but we both feel like we don't feel the same way."* In these situations where women perceive a connection but cannot garner any new support, they are unchampioned.

Difficulty accessing support from others at times lies with a woman's perceptions about self and EDs, such as perceiving herself to be *"a terrible person because when I see obese people, I feel about them the way I perceive that other people feel about me."* One participant did not think anyone would help her because she perceived the ED as not a tangible problem like manic-depression or cutting *"that needs help."* At other times, people who negatively judge changes in the woman's appearance cannot support her. One participant found that her roommate, who *"was the pretty friend all the guys wanted,"* declined to be friends once. *"I lost weight, so now she's bigger."* Another participant's friend stopped talking to her after she became thin, saying, *"I don't know who you are anymore. You're a bitch now that you're thin. You think you're pretty, but I think you should go back to the way you were with everyone talking to you."*

4.9.2. Helping others while helping self (championed by others, supporting self and others)

Observing that *“No one is talking [about EDs]”* on campus, women attempt to help others and themselves by managing awareness booths to provide information for other students and participating in research interviews. Women championing others who have little social support while experiencing eating disorders (EDs) explain, *“It’s normal to have issues ... like writing a paper for seven hours and getting so bored that binge eating seems the only option; it’s ok to learn to adjust.”* Women champion others who lack support by recommending that others *“validate it feels wonderful to over-exercise or starve”* instead of judging with *‘Don’t you know what you’re doing to your body?!’* and *‘You look awful.’* Safety is a priority for women championing others: *“Don’t try to take away the ED when you don’t have anyone else; let the ED be your best friend for today. It’s better than killing yourself.”*

Women find it easier to relate to same-aged others they are close with; however, they find it harder to help others they consider more physically fit than themselves. Support may extend beyond words to additionally include preparing food, sitting down, and eating with someone who has not eaten for several days. One participant prevented herself from *“freak[ing] out”* over her friend wanting to have eggs and toast with her because *“eggs are so hard for me to eat, and they were runny. I don’t know why I can’t deal with eggs. Most of the time, I try to stay away from them.”* Nevertheless, she ate the eggs with her friend to avoid discouraging the friend. Acknowledging that while she could not do that (eat eggs) for herself, she could do it for someone else and would *“eventually be able to do it for myself.”*

4.9.3. Taking time for self and helping relationships (Self-directing self-care, supporting self and others)

Women living with EDs acknowledge that *“it takes a lot of work to feed yourself healthily.”* They learn to *“stay on top in the real world”* by prioritizing their self-care needs. Staying on top entails *“not going crazy and buying stuff that I know I’m just going to gobble down and feel guilty about,”* eating dinner each evening, making time for leisure, ensuring adequate sleep, and managing stress, including school work. They are willing to go away for treatment when needed and even *“fail a course to be healthy.”* Motivated by realizing they have done *“horrible things”* to their bodies, they now listen to their bodies. *“You can’t let yourself, your body, your physical health go by the wayside.”* At this point, women act because they want to, not because they are told to. For one participant, this meant not returning to work after treatment but staying in *“recovery mode”* and going to school.

In taking time for self and helping relationships, a woman may admit to still being *“really insecure about yourself,”* especially if having difficulty within a relationship with a boyfriend or girlfriend. The woman says, *“It’s nice to know that, even if you don’t feel like you’re perfect like you don’t feel like you have the perfect body, that maybe you do for them.”* They effectively use tools such as breathing exercises when struggling with a problem and also *“talk[s] about it [the problem]”* with others. The others who the women perceive as being best able to support them have histories of similar body sizes and weight gain or loss recovery experiences. These supportive others praise the women for their healthy efforts to overcome the ED.

4.9.4. Making wisdom public (championing self, supporting self and others)

At the highest level of championing self and others, women are able to give their “*inner self an outside voice*.” They take action, such as publicly speaking out about their experiences, conducting anti-stigma and anti-shame campaigns on social media, and demonstrating against fashion magazines. Through living with and effecting to overcome an eating disorder (ED), women see themselves as experts and want to share their knowledge with others. “*It’s having that wisdom made public*.” One participant observed that “*the more I talk about it, the more the ED voice is silenced*.” To her,

The ED is like a violent partner, with silence being the violence's ally. Healing is more than just getting your weight back and getting your meals back on track. It's about finding me and coming back to what I was before I was abused, celebrating myself and what I have become...I'm a success story!

6. Limitations

The sample size (N = 142) was not large enough to carry out multivariate logistic modeling to adjust for age, race/ethnicity, and other known correlates of having a high level of concern about diet, body weight, or problematic eating behaviours according to perceived available social supports and proactive coping behaviours. A non-clinical sample helped prevent oversampling of more impaired participants; however, there needed to be more detail about the ED classifications, specific treatments, duration of care provided, and range of community support available. Underrepresented populations with EDs (e.g., men and ethnic minorities) were not sought. Self-reported evaluations of eating attitudes, social support provisions, and coping may have introduced bias through individual response styles. Participants did not validate the researcher's interpretation of their narratives.

7. Conclusion

This study explored help-seeking behaviours among female university students experiencing eating disorder symptomatology. The analysis generated a rich understanding of (a) women’s access to social support and (b) women's individual efforts, as well as those of others, to champion women toward recovery. These results highlighted the complexity of women’s decision-making processes and support preferences not otherwise considered by service providers or informal social supports. Women without perceived social support and the proactive coping behaviours of health championing were significantly more likely to have a high level of concern about dieting, body size, and problematic eating. Differing motivational factors, such as initially protecting the ED from detection and not perceiving others as supportive, pointed out diverse needs for and responses to social support at various times. Recognizing the presence of the eating disorder changed the direction of the women’s efforts from denial and secrecy toward speaking out to obtain support. As women gained skills in self-care and advocacy, they could champion themselves and others toward recovery. Peer-led psych educational support groups provided acceptable, accessible resources.

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