ASSESSING PARENT-CHILD AGREEMENT ON AN EATING DISORDER
SYMPTOM QUESTIONNAIRE

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This study provides preliminary data from a parent-report measure for assessing eating disorder symptoms in preadolescents. The Parent Eating Behaviors and Body Image Test (PEBBIT) is based on the Eating Behaviors and Body Image Test (EBBIT; Candy & Fee, 1998), a self-report measure for pre-adolescent girls. Eighty three females in grades 4 through 6 were contacted from elementary schools, but only 10 participated. Girls’ individual responses on the EBBIT were compared to parental responses on the PEBBIT. Parents were able to accurately identify eating disorder behaviors in their children only 65.3% of the time when analyzing the individual responses found on the Binge Eating Behaviors subscale and only 58.6% of the time on the Body Image Disturbance Restrictive Eating subscale. Preliminary analyses suggest that a) clinicians and clinical researchers should supplement preadolescent girls’ self-report with parent report measures, and b) more detailed study of the PEBBIT’s psychometric properties is warranted.
DEDICATION

I would like to dedicate this research to my parents, Peter and Susan Klyce, and my brother Philip.
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The author would like to express sincere gratitude to Dr. Kevin J. Armstrong, my committee chairman, for his time and effort in helping me complete this research. Next I would like to thank the other members of my committee, Dr. Stephen Klein and Dr. Martin Geisen for their assistance in this research project. Without my entire committee this project would not have been completed and I greatly appreciate their tireless efforts and contributions. Although I cannot release their names in order to maintain student confidentiality; I would like to thank both the school and school board in the Southeast that allowed me to collect data from their students.
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CHAPTER I
INTRODUCTION

Overview of Eating Disorders

Eating Disorders are a significant problem today among preadolescents and adolescents, especially among females (Candy & Fee, 1998). During the preadolescent years, girls go through puberty (Sanders, Kapphahn, & Steiner, 1998). When their bodies change, they are more likely to accumulate body fat that can be a major factor in the onset of eating disorders. Girls tend to recognize that their bodies are physically changing. This increases their concern about weight gain, and they may become preoccupied with exercise and cutting back calories (Kelly & Ricciardelli, 1999; O'Dea & Abraham, 1999; Stein, 1995). Some girls eventually become so focused on becoming thin, they ignore any physical and psychological consequences that could occur from severe dieting or weight loss (Peters, Swassing, Butterfield, & McKay, 1984).

In the current paper, a summary of eating disordered behavior in preadolescent girls is presented. Self-report measures of eating disorder symptoms for preadolescent girls are discussed, and finally, the rationale for the development of parent-report measure of disordered eating patterns in preadolescent girls is presented. First, however, a basic review of the two main types of eating disorders is provided.
Types of Eating Disorders

The two major types of eating disorders identified by the *Diagnostic and Statistical Manuals of Mental Disorders Manual [DSM-IV-TR]* (American Psychiatric Association, 2000) are Anorexia Nervosa and Bulimia Nervosa. The central feature to eating disorders is the individual’s desire to be thin (Polivy & Herman, 2002), along with a need for control. A third type of eating disorder is Binge-Eating Disorder and it is defined as binging without purging. This review will focus on these disorders in females.

Anorexia Nervosa occurs in approximately .5% to 1% of females (*DSM-IV-TR*; APA, 2000). Women with anorexia nervosa have an exaggerated desire to be thin (Garfinkel, 2002) and continue to engage in food restriction behaviors, despite excessive weight loss, because limiting their food intake to lose weight may help them experience partial emotional gratification (Polivy & Herman, 2002). In addition to weight loss, signs of anorexia include obsessive-compulsive characteristics (i.e., perfectionism, especially with academics), conforming, socially inhibited, anxious, tend to hide emotions, and are not risk takers (Bryant-Waugh & Lask, 2002; Foreyt, Poston, Winebarger & McGavin, 1998). An individual experiencing anorexia may have a harder time concentrating due to the metabolic changes that occur (Peters et al., 1984). They also may be incapable of independence, have problems in relationships, and have fears of maturity (Garner, 2002). It is also common to see other impulsive behaviors such as substance abuse (Garfinkel, 2002).

Individuals suffering from anorexia are more difficult to treat because of their denial that a problem exists. It is more difficult to detect anorexia in younger adolescents
because of a lack of an assessment criterion. A clinician is less able to confirm amenorrhea (an absence of a menstrual cycle). Since girls are still growing, it makes it harder to determine what their weight should be so it is more beneficial to look for a significant decrease in the girl’s weight (Bryant-Waugh & Lask, 2002). There are two sub-types of anorexia: the Restricting Type where the individual prevents weight loss by excessive exercising, starvation or any other method to restrict calories, and the Binge-Eating/ Purging Type where the individual engages in the binge/purge cycle that is common with bulimia nervosa.

Bulimia Nervosa occurs in approximately 1% to 3% of females and usually starts around late adolescence (APA, 2000). This is an eating disorder in which a woman engages in binging episodes followed by purging. Purging is a behavior a woman uses to prevent weight gain from a binge. There are two sub-types of bulimia; purging and non-purging. The purging sub-type is characterized by the any means of purging after a binging episode (i.e., self-induced vomiting, laxative or diuretic abuse). The nonpurging subtype will use methods like fasting or excessive exercising after a binging episode. Bulimia may produce an emotional gratification that begins with the binging episode. Over time the person begins to experience guilt, which causes the bulimic to purge, purging gives them a new sense of gratification; they feel as if they are releasing built up tension (Peters et al., 1984; Polivy & Herman, 2002).

Foreyt et al. (1998) describe bulimics as having “poor impulse control, chronic depression, acting-out behaviors, low frustration tolerance, affective lability, difficult temperament and inhibition.” Individuals suffering from bulimia may also abuse alcohol and other substances, and may experience anxiety disorders (Garfinkel, 2002). Bulimia is
harder to diagnosis than anorexia because the person may look healthy and they may not have the excessively thin body type of a severe anorexic (Hill & Pomeroy, 2001). Unlike people suffering from anorexia, a person with bulimia is typically aware the disorder exists and that it is abnormal (Peters et al., 1984).

Both of these eating disorders have in common the fear of becoming overweight and persons with either disorder will engage in harmful methods to prevent the weight gain. Anorexia and bulimia are typically accompanied by other problems (e.g., behavior problems, mood disturbances, substance abuse) that are also of significance. Anorexia and bulimia both have multiple dangerous side effects that can be life threatening if not treated. Several researchers have been studying the occurrence of eating disorder symptoms in preadolescent girls. This research is described next.

Eating Disorders in Preadolescents

In one study, approximately 30% to 40% of girls in junior high school reported having concerns about their weight (Sanders, Kapphahn, & Steiner, 1998). However, it is difficult to know the true prevalence of eating disorders in preadolescents because of a lack of data (Stein & Reichert, 1990). According to the Diagnostic and Statistical Manual of Mental Disorders- IV- TR (APA, 2000), the average age of onset for anorexia in females is 17, but researchers have reported eating disorder behaviors in children as young as 6 years of age (Stein & Reichert). For example, Davies and Furnham (1986) found that 25-45% of 11 and 12 year old girls were already on a diet, girls as young as 9 years of age already had a history of dieting, some 8 year olds restricted their food intake, and many 7 year olds wanted to be thinner.
In their research, Stein and Reichert examined 235 girls and found that girls in grades 4-6 were more likely than boys to throw away food or completely skip meals because of their fear of gaining weight. They found that almost 4% \((n = 4)\) of girls in their 5th and 6th grade sample admitted to self-induced vomiting and almost 3% reported the use of diet pills. The girls in the O’Dea and Abraham (1999) study believed that physical appearance was related to romantic appeal and happiness, and the girls who were at the highest risk of an eating disorder were young, postmenarcheal high achievers with low self-esteem and high anxiety.

It has been suggested that attitudes toward eating are in place by the time a girl reaches pre-adolescence (Maloney, McGuire, Daniels, & Specker, 1989), and dieting among preadolescent girls appears to be a very popular trend. According to Hill (1993) dieting is popular because 1) there are numerous methods for losing weight, 2) when one is overweight, dieting is rewarding because one can correct the problem, and 3) negative stereotypes exist related to size of an individual’s body. Even if a preadolescent is dieting simply because it is popular to do so, dieting at this age can be dangerous, because it is a time when bodies should be growing and developing, and severe restriction of caloric intake can slow growth, delay puberty, lead to osteoporosis, and cause problems with cognitive functioning (Hill, 1993).

Much more research is needed in this area because disordered eating patterns are showing up at almost every age. Dysfunctional attitudes about size were formerly considered a problem among young adults, but now this problem is appearing in first and second graders. One approach to assessing these problems is the use of self-report
measures. Few self-report measures have been developed to assess eating disorder symptoms in preadolescents. These measures will be described in the next section.

Self-Report Measures for Eating Disorder Symptoms in Preadolescents

When clinicians perform assessments on preadolescents presenting an eating disorder behavior, they typically administer self-report measures along with other assessments (e.g., interviews). A problem with many of the self-report measures for preadolescents is that the majority of the instruments were developed for adults, and norms are not available for younger populations (Candy & Fee, 1998). Self-report measures developed for preadolescents need to have simple language so younger age groups can understand the questions, but the questions should not be so vague that the measure cannot detect an eating disorder (Kelly & Ricciardelli, 1999).

Measures developed for preadolescents include the Adapted Eating Attitudes Test (A-EAT: Vacc & Rhyne, 1987), Children’s Eating Attitude Test (ChEAT: Maloney, McGuire, & Daniels, 1988), the Eating Behaviors and Body Image Test (EBBIT: Candy & Fee, 1998), and the Kids’ Eating Disorder Survey (KEDS: Childress, Jarrell & Brewerton, 1993).

The Eating Attitudes Test (EAT; Garner & Garfinkel, 1979) is an adult and adolescent measure that was modified twice for younger populations. The Adapted Eating Attitudes Test (A-EAT; Vacc & Rhyne) was developed by changing the wording of the EAT to a third grade level. However, the A-EAT was evaluated with a group of graduate students instead of the preadolescents for which it was created (Vacc & Rhyne). The Children’s Eating Attitude Test (ChEAT; Maloney et al., 1988) is another children’s
version of the EAT and was tested on 318 children grades 3 through 6. It was found to have average test-retest reliability of .81, internal consistency of .76, and was thought to have face validity (Stein, 1995). A limitation with the ChEAT is the difficulty younger children might have with the wording. For instance, some preadolescents might not understand words like “diet” and “binge” (Candy & Fee, 1998).

The Kids’ Eating Disorder Survey (KEDS; Childress, Jarrell, et al.) is a 14 item self-report measure used to assess eating disorder pathology. The first major area assessed is weight dissatisfaction which includes items such as “wants to lose weight,” “felt/looked fat,” “afraid to eat because of weight gain,” “dieted,” and “exercised.” The second major area assessed is purging/restricting behaviors which includes the items “vomited to lose weight,” “fasted to lose weight,” “used diet pills,” “used diuretics,” and “used laxatives” (Childress, Jarrell et al., 1993). The KEDS was developed from the Eating Symptoms Inventory (ESI: Whitaker et al., 1989). The researchers believed the ESI was too long to administer to children so they shortened the length of the measure and modified it for cognitive differences between adolescents and children (Childress, Brewerton, Hodges, & Jarrell, 1993). In addition to these modifications, they also added two new questions, “do you want to lose weight now” and “have you ever exercised a lot to lose weight” (Childress, Brewerton, Hodges, & Jarrell). The KEDS had an internal consistency of .73 and test-retest reliability of .83 (Childress, Jarrell, et al.). A limitation of this measure is that it does not assess the frequency of disordered eating behaviors, except for binge eating, so it may overestimate the frequency of these behaviors (Childress, Jarrell, et al.).
The body image silhouettes from the KEDS are modified from the adult body image silhouettes developed by Stunkard, Sorensen and Schulsinger (1983) to assess body image perception (Childress, Jarrell, et al.). If a girl picks what she perceives as her “actual” size two or three times larger than what she truly is, and if she chooses a figure much smaller than she actually is (her desired size), then she is considered to have body dissatisfaction (Childress, Jarrell, et al.). The test-retest reliability for the KEDS was found to be .83, and it has an internal consistency of .73 (Childress, Jarrell, et al.).

An eating disorder behavior measure developed specifically for children and preadolescents is the Eating Behaviors and Body Image Test (EBBIT; Candy & Fee, 1998). This is a reliable measure which does not include words like “diet” and “binge” but instead uses behavioral definitions so children can better understand the questions. The EBBIT is a 42-item self-report scale for girls. It is used to assess body image and eating behaviors. It was developed based on diagnostic criteria for anorexia and bulimia from the Diagnostic and Statistical Manual of Mental Disorders Manual (4th ed. [DSM-IV], American Psychiatric Association, 1994). Normative data for the EBBIT (Candy & Fee) were obtained on a sample of 291 participants representing an 84% response rate.

In the development of the EBBIT, four categories were selected: restrictive eating, body-image dissatisfaction, binge eating, and compensatory behaviors. After the categories were specified, items were developed for each category based on previous research, open-ended interviews with preadolescent girls and their mothers, and finally a review by experts. Three professors in clinical psychology and 15 graduate students reviewed the items to ensure they were placed in the proper domain and to make sure the wording was appropriate for the preadolescent girls. The experts were also asked to
recommend any behaviors/items that were not included but felt to be important. It was also reviewed by experts in the field (Candy & Fee).

The Body Image Dissatisfaction and Restrictive Eating subscale possessed internal consistency reliability of .91, and the Binge Eating Behaviors Subscale possessed internal consistence reliability of .75 (Candy & Fee). The Body Image Dissatisfaction and Restrictive Eating subscale had a two-week test-retest reliability of .90, and the Binge Eating Behaviors Subscale had a .79 two-week test-retest reliability (Candy & Fee).

The Questionnaire of Eating and Weight Patterns (QEWP; Spitzer Devlin, M., Walsh, B. T., Hasin, D., Wing, R., Marcus, M., 1992 and Yanovski, S., Wadden, T., Wing, R., Marcus, M. D., Stunkard, A., et al. 1993) is a self-report measure that assesses binge eating behaviors in adults and was developed from the binge eating disorder criteria (Johnson, Grieve, Adams, & Sandy, 1999). There is also a form specifically for adolescents in grades 6-12 but not for preadolescents. The adolescent form contains 12 of the 13 questions from the adult version, but the wording on the QEWP-A was changed to language suitable for adolescents (Johnson et al.). In this study, 367 adolescents were divided into three categories based on the results of their responses: ND (no diagnosis), NCB (episodic overeating, eating distress, or binge eating but did not meet criteria for binge eating disorder), and BED (binge eating disorder). When parent and adolescent responses were compared, there was 81.6% agreement in the ND category, but only 25% agreement between parents and adolescents in the BED category, 15.5% agreement in the NCB category. Among the three categories, more adolescents met criteria for Binge Eating Disorder and No Diagnosis based on their responses, while more parents identified symptoms for Nonclinical Binging in their children (Johnson et al.).
It may be difficult to rely on preadolescents to give accurate responses on these measures of eating disorder symptoms. For instance, they may claim to eat enough each day, but their idea of “enough” may be far less than what is actually needed (Tranter, 1993). In addition, it may be easier for clinicians to diagnose an eating disorder when they have more information to rely on than just the child questionnaire responses. According to Garner and Parker (1993) a clinician should not rely solely on a self-report measure of the child or parent. As there are a number of child-report measures available for assessing eating disorder symptoms in preadolescent girls, a parent report measure would be a helpful component in the evaluation of eating disorder symptoms in preadolescents. Unfortunately no parent-report measure currently exists for this age group.

In the following section, the importance of including multiple informants in the diagnosis of childhood disorders is stressed. Examples of measures designed to assess other disorders of childhood for which parent and child measures exist are also presented.

Parent-Report and Child Self-Report Measures

Lachar and Gruber (1993) suggested that children may deny or minimize behaviors parents tend to identify as problematic (e.g., hyperactivity and noncompliance). Parent reports are beneficial when trying to identify overt symptoms exhibited by a child (Wierzbicki, 1987) and information that the child may not be able to recognize, e.g., sleeping and eating patterns; (Kazdin & Marciano, 1998). Parent reports are also useful because some young people have difficulty understanding the wording of the questionnaires (Maloney, McGuire, Daniels, & Specker, 1989). For instance, younger
children may have difficulty understanding the questions related to their eating and
dieting behavior.

Compared to parents, children are more likely to endorse behaviors that the parent
is unaware of (e.g., substance abuse) or behaviors and emotional states that are internal to
the child (i.e., depression, anxiety) (Lachar & Gruber, 1993). Therefore, child self-report
rating scales can be more effective than parent and teacher rating scales in certain
instances (Kazdin & Marciano, 1998). For example, some of the symptoms associated
with depression and anxiety are detectable only if reported by the person experiencing the
symptoms (e.g., sadness, feelings of worthlessness, suicidal ideation and anhedonia)
(Barkley, 1997; Kazdin & Marciano).

A number of instruments used in diagnosing problems in childhood have both
child and parent versions that correlate highly with each other. Examples include the
Children’s Depression Inventory (CDI; Kovacs, 1981), Personality Inventory for Youth
(PIC; Lachar & Gruber, 1993), and the Children’s Depression Scale (CDS: Tisher, Lang-
Takac, & Lang, 1992).

The Children’s Depression Inventory (CDI; Kovacs, 1981) is a 27-item self-report
measure of depression for children (Saylor, Finch, Spirito, & Bennett, 1984; Wierzbicki,
1987). The parent form was developed based on the child’s version by changing the
wording from “I” statements to “Your child” statements (i.e. “I am sad once in a while”
to “Your child is sad once in a while”). Wierzbicki (1987) conducted a study to examine
the relationship between the CDI and the parent version of the CDI. The study consisted
of two parts. First, mothers completed the parent CDI in groups while the children
completed the CDI individually. They both completed the measures again one month
later. Wierzbicki found a significant correlation between the parent and child version of the CDI on the second administration ($r = .59$), but only a modest correlation on the first administration ($r = .37$). The second part of this study included a different sample and parents completing the parent-CDI while children completed the CDI individually, and teachers completed the Children’s Depression Rating Scale (CDRS; Poznanski, E. O., Cook, S. C., & Carroll, B. J. (1979). Results showed that parent version of the CDI was significantly correlated with the CDI ($r = .66$). The correlations between parent and child ratings on the CDI factors were $r = .61$ for Affective Behavior, $r = .52$ on Image/Ideation, $r = .58$ for Interpersonal Relations and $r = .45$ on Guilt/Irritability (Wierzbicki).

The Personality Inventory for Youth (PIY; Lachar & Gruber, 1993) is a measure for children 9-18 years old (Lachar & Gruber, 1993; Lachar & Kline, 1994) and is the child self-report measure that compliments the parent-completed Personality Inventory for Children (PIC; Lachar, 1982). The PIC has 20 scales covering four broad areas including Undisciplined/Poor Self-Control, Social Incompetence, Internalization/Somatic Symptoms, and Cognitive Development (Lachar & Gruber; Lachar & Kline, 1994). The PIY and PIC were significantly correlated on some of the scales but not all. The mean correlation between parent and child forms in clinical samples was .37 while the mean correlation in the normal sample was .45 (Lachar & Gruber). The authors felt that the low correlations were due to children denying problems, over reporting problems, or inattention and/or not understanding the questions (Lachar & Gruber).

The Children’s Depression Scale (CDS, Tisher, Lang-Takac, & Lang, 1983) was developed for children ages 9 to 16 (Patton & Burnett, 1993). The parent form differs from the child version in that it is a pencil and paper assessment whereas the child
version has a card sort format (Moretti, Fine, Haley, & Marriage, 1985). Multiple studies have assessed the correlation between the parent and child versions of the CDS. When the two versions were compared in one study, the parents rated the child’s depression lower than the children rated their own depression (Tisher, Lang-Takac, & Lang). However, in another study, Kazdin and Marciano (1998) found that parents provided higher depression scores than the children. Lachar and Gruber (1993) summarized the results of studies which evaluated parent-child correspondence on the CDS, and found the older the child, the more likely the agreement between the parent report and the child report (Lachar & Gruber).

When it comes to eating problems, Childress, Brewerton, et al. (1993) suggested that children’s self-reports may not be accurate because of the tendency for children to minimize or deny the problem, because children may not recognize their eating behaviors as problematic. Individuals with eating disorders in general are less likely to admit that they have a problem or minimize the problem, and therefore their self-reports may not be accurate. For these reasons, a parent report seems especially important because parents may be able to recognize eating disorder symptoms in their children. It may be difficult to diagnose eating disorders in preadolescents, but signs to look for include slow eating, the display of eating rituals, poor nutritional status (Stein, 1995), and any combination of refusal to maintain a normal weight for height or overanalyzing caloric intake (Netemeyer & Williamson, 2001).

Parents also are interested in the eating patterns of their children. In the Steinberg et al. (2003) study, 23.2% of adolescents reported they had experienced an eating disorder episode, but parents reported a higher figure (34.6%) of children who had
experienced an eating disorder episode (Steinberg et al., 2003). In addition, parents and adolescents reported on binge eating behaviors and reported rates of 15.6% and 7.6% respectively (Steinberg et al.). In this study parents reported a higher prevalence of eating disorder symptoms which suggests that parents may be more likely to notice and report disordered eating than the children are willing, or able, to report. Thus, the importance of a parent report measure to assess eating disorder symptoms in preadolescents is again highlighted.

The original purpose of this study was to establish a reliable and valid parent questionnaire to measure the eating behaviors of preadolescents (i.e., the Parent Eating Behaviors and Body Image Test; PEBBIT). However, an insufficient response rate prevented analyses of the psychometric properties of the PEBBIT. Instead, this study explores the difference in parent and children’s ratings for behaviors related to eating disorders symptoms. A qualitative analysis on the agreements and disagreements between parent and child ratings is provided. Similarities and discrepancies are assessed based on three strategies: a) comparing the 2 known factors of the EBBIT, b) comparing items assessing covert versus overt behaviors, and c) comparing items with the largest discrepancies.
CHAPTER II

METHOD

Participants and Setting

Eighty-three 4\textsuperscript{th}, 5\textsuperscript{th}, and 6\textsuperscript{th} grade girls from a public school system in the southeastern United States were recruited. Of this number, 37 parents returned the packets. Of the 37, 17 parents declined participation and 7 returned blank forms. A total of 13 parents agreed to allow their child to participate in the study, but only 10 were able to complete the study due to scheduling parameters. Parent consent (Appendix A) was obtained for the parents and girls to participate along with permission from teachers (Appendix F), principals (Appendix E) and superintendents (Appendix D). Child assent (Appendix G) was also obtained.

Measures

Parents completed the Demographic Information Form and the Parent Eating Behaviors and Body Image Test (PEBBIT). The girls completed the Eating Behavior and Body Image Test (EBBIT). The participants’ heights and weights were also obtained. Details follow.
Demographic Information Form

The Demographic Information Form (Appendix B) was filled out by the girls’ parents. These forms were sent home from school for parents to provide information about the ethnicity and race of the girls and their parent/primary caregiver. This form also contains questions about the parent’s (or primary caregiver’s) highest level of school completed and income level.

Eating Behavior and Body Image Test (EBBIT)

The EBBIT (Appendix I) is a 42-item self-report scale for girls. It is used to assess body image and eating behaviors. Previous factor analytic studies revealed two factors producing the “Body Image Dissatisfaction and Restrictive Eating (BIDRE)” subscale composed of 22 items and the “Binge Eating Behaviors Subscale (BEB) composed of 15 items.” In a study with a sample of 291 girls between the ages of 8-13, the BIDRE subscale possessed internal consistency reliability of .91 (as measured by Cronbach’s coefficient alpha), and the BEB Subscale possessed an internal consistency reliability of .75 (Candy & Fee, 1998). With a subsample of 70 girls, the BIDRE subscale had a two-week test-retest reliability of .90, and the BEB Subscale had a .79 two-week test-retest reliability (Candy & Fee). In this study, children participants completed the EBBIT. Children answered questions on a 4-point Likert Scale. The scale reflects how much a child engages in the specific behavior (0= “Never”, 1= “Rarely” [Once a month], 2= “Often” [Once a week], 3= “Most of the time” [Everyday]).

The EBBIT was developed based on diagnostic criteria for anorexia and bulimia in the Diagnostic and Statistical Manual of Mental Disorders Manual (4th ed. [DSM-IV],
APA, 1994). In the development of the EBBIT, four categories were selected: restrictive eating, body-image dissatisfaction, binge eating, and compensatory behaviors. After the categories were specified, items were developed for each category based on previous research, open-ended interviews with clients (preadolescent girls) and their mothers, and finally reviewed by experts. Three professors in clinical psychology and 15 graduate students reviewed the items to ensure they were placed in the proper domain and to make sure the wording was appropriate for the preadolescent girls. The experts were also asked to recommend any behavior/item that was not included (Candy & Fee).

**Parent Eating Behavior and Body Image Test (PEBBIT)**

The PEBBIT (Appendix C) is a field trial version of the EBBIT (Candy & Fee, 1998) with items reworded so that parents understood they were to rate their own child. The PEBBIT contains 65 items – all 42 items from the EBBIT plus 23 repeated but slightly rephrased items meant to aid in assessing internal consistency. The four domains include (1) restrictive eating behaviors, (2) body-image dissatisfaction, (3) binge eating, and (4) compensatory behavior for eating. Although compensatory behaviors were not supported by factor analysis of the field trial version of the EBBIT, the items were retained for the modified version of the EBBIT and will be included in the PEBBIT. Parents answered questions on a 4-point Likert Scale. The scale reflects how much a parent believes his/her child is engaging in the specific behavior (0= “Never”, 1= “Rarely” [Once a month], 2= “Often” [Once a week], 3= “Most of the time” [Everyday]).
Body Mass Index (BMI)

The BMI is typically calculated using height and weight. The formula used in girls ages 2 to 20 is $\text{BMI} = \frac{\text{weight in kg}}{\text{height in m squared}}$ (Keyes et al., 1972). Due to the large heterogeneity of maturation rates in girls of these ages, the measure used in this study was the body mass index-for-age percentiles designed by the Center for Disease Control. The girls were measured on a beam balanced scale facing away from the scale so they would not know their measurements. They were measured individually so no one else would be aware of their measurements, and they were not told of their measurements.

Procedure

Teachers were provided with the assessment packets to send home with the girls to their parents. The assessment packet consisted of consent forms along with the Demographic Information Form, a copy of the PEBBIT, and an envelope with “return to teacher” stamped on it. If the parents did not wish to participate, they were asked to send the consent forms back to school with the girls indicating they do not want to participate. The parents were asked to return the forms to school with their daughter in a sealed envelope to maintain confidentiality of the data.

The parent forms were sent home on a Monday. The primary researcher returned to the schools on Wednesday of the same week to collect the returned forms, and parents who did not return the packet were sent another set of forms. The primary researcher returned to the schools on Monday of the following week to collect the returned forms. Parents who have not returned the forms were sent another set of forms that day. The
primary researcher returned to the schools the following Wednesday to collect the returned forms. There were no more attempts to send the forms home, and there were no contact with the parents who did not return the forms. Eighty-three parents had forms sent home, 37 parent packets were returned: 17 declined participation, 3 packets were returned blank, 13 parents accepted, but only 10 were successfully scheduled and completed data collection.

The researcher administered the forms at the school at a convenient time specified by the teacher. Girls participating in the study were first asked for their assent. Then, they were administered the EBBIT (Candy & Fee, 1998). The girls completed the forms in groups of approximately 5 girls at a time. They were asked to read 2 to 3 questions from the EBBIT so the researcher will be sure the girls are able to understand the questions. The girls were told that if they have any problems reading or understanding questions they should ask the researcher. The girl’s height and weight were recorded last.

Following the administration of the EBBIT (Candy & Fee, 1998) and the height and weight measurements, the girls were debriefed (Appendix N). The debriefing included a thank you for their involvement and information on healthy eating and exercise.

The researchers wanted to notify the parents of any girls who reported they were engaging in any significant disordered eating behaviors frequently. If the parents or girl endorse any of the compensatory behaviors, the parents were notified and provided with an appropriate referral to a local clinic specializing in the assessment and treatment of possible eating disorders. In the current study only one parent was called in regard to her child’s responses. This child indicated she used laxatives frequently. The parent was
called multiple times and messages were left, but the parent never returned the call so a referral was not able to be given.
CHAPTER III
RESULTS

Demographics

The mean years of age for participants completing the study was 9.6 (range = 9-10). This study included 10 pairs of parents and children endorsing the following racial identities: 7 Caucasian, 2 African American, and 1 Hispanic. Calculating the BMI for a prepubescent age range is not accurate valid procedure. In looking at the Body Mass index-for-age percentiles graph (CDC, 2000) 1 girl fell in the 0-5th percentiles, 1 fell in the 5th -10th percentiles, 3 fell in the 25th - 49th percentiles, 1 in the 50th - 74th percentiles, 1 participant at the 75 percentile, 1 in the 75th - 85th percentiles, and 2 in the 95th - 100th percentile range. All of the girls who participated were in the 4th grade at a public school in the Southeastern part of the United States.

Four girls had parents who both completed their high school degree, 2 had parents who both completed college, and 1 participant had parents who both completed post graduate degrees. Three participants had parents who completed different levels of schooling, 2 participants had mothers who completed college and fathers who completed graduate school and 1 participant had a mother who completed high school and a father who completed graduate school.
Five participants lived in a household with an income of $25,000-$49,999, 1 participant lives in a household with an income of $50,000-$74,999, 1 participant lives in a household with an income of $75,000-$100,000, 1 participant lives in a household with an income of over $100,000, and 1 of the 10 participants receives free or reduced cost lunches at school.

None of the participants had started their menstrual cycle at the time of data collection. One participant lived in a household where their parents served a restricted diet). Her family ate meat twice a week and seasonally for religious purposes. Three of the 10 participants had medical reasons for limiting their diet. One participant had reflux, 1 was allergic to fish and some fruits, and the other had to limit her dairy intake.

EBBIT

Individual responses for the items on the EBBIT are provided in Appendix P. Summary scores for the EBBIT’s two primary factors are presented in Table 1.
### Table 1

*Subscale Scores for all Child Participants*

<table>
<thead>
<tr>
<th>Race</th>
<th>BEB Factor Items</th>
<th>BIDRE Factor Items</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>M</td>
<td>SD</td>
<td>Range</td>
<td>M</td>
</tr>
<tr>
<td>Caucasian</td>
<td>4.86</td>
<td>2.6</td>
<td>0-7</td>
<td>10.43</td>
</tr>
<tr>
<td>(n = 7)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>African</td>
<td>3</td>
<td>N/A</td>
<td>2-4</td>
<td>10</td>
</tr>
<tr>
<td>American</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(n = 2)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hispanic</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>(n = 1)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>3.4</td>
<td>2.2</td>
<td>0-7</td>
<td>11.8</td>
</tr>
<tr>
<td>(N = 10)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*Potentially Clinically Significant Responses on EBBIT.*

Overall, 7 participants reported answers in a potentially clinical significant range across 14 items on the EBBIT. These are items the girls indicated a frequency of “Once a week” or “Everyday.” The subject numbers and EBBIT items yielding significant responses are presented in Table 2.
Table 2

**EBBIT Items with Potentially Clinically Significant Responses**

<table>
<thead>
<tr>
<th>Subject Number(s)</th>
<th>EBBIT Question</th>
</tr>
</thead>
<tbody>
<tr>
<td>1,2,3,5</td>
<td>I do not eat junk food or “fatty” food because I want to lose weight</td>
</tr>
<tr>
<td>2,4</td>
<td>I wish I was thinner</td>
</tr>
<tr>
<td>2,4</td>
<td>I look at the fat on my body and wish that it was not there</td>
</tr>
<tr>
<td>4</td>
<td>I think I weigh more than most girls my age and height</td>
</tr>
<tr>
<td>4</td>
<td>I worry about gaining weight</td>
</tr>
<tr>
<td>4</td>
<td>I take diet pills to lose weight</td>
</tr>
<tr>
<td>1</td>
<td>I take laxatives to lose weight</td>
</tr>
<tr>
<td>7</td>
<td>I feel really bad after I eat a lot of junk food, so I think about how to get rid of what I just ate</td>
</tr>
<tr>
<td>4</td>
<td>I worry if I eat, I might gain weight</td>
</tr>
<tr>
<td>4</td>
<td>My current weight bothers me</td>
</tr>
<tr>
<td>4</td>
<td>I exercise to burn off the food I eat</td>
</tr>
<tr>
<td>6</td>
<td>I drink diet soda, instead of eating meals or snacks</td>
</tr>
<tr>
<td>2</td>
<td>I do not eat dessert (cake, ice cream, cookies) because I want to lose weight</td>
</tr>
</tbody>
</table>

**Protocols Reviewed for Logically Inconsistent Responses**

Children’s responses were reviewed for logically inconsistent responses. Only one participant, subject 1, reported answers that did not match. She reported denying a want to be thinner, reported her weight did not bother her, reported she did not worry about weight gain, reported she did not think she is fat, and reported denying that she took pills to lose weight. However, she did report that she diets, avoids fatty foods (but does not
avoid desserts), does not take diet pills but does use laxatives, and denied self-induced vomiting and diuretic use. Her reported behaviors and thoughts about herself and weight are not consistent.

Two girls had BMI’s that fell in low percentile ranges, one in the 5\textsuperscript{th} - 10\textsuperscript{th} percentile range and one below 5\textsuperscript{th} percentile range on the Body Mass Index-for-Age chart. The participant who fell in the 5-10\% range indicated “I feel really bad after I eat a lot of junk food, so I think about how to get rid of what I just ate” once a week; often in frequency. This participant’s mom did not indicate any clinically significant disordered eating behaviors in her child, but did state “My child feels bad after eating a lot of food” often, once a week in frequency. The participant who had a BMI in the 5\textsuperscript{th} - 10\textsuperscript{th} percentile range did not report any clinically significant disordered eating behaviors. Her mother did indicate “my daughter will gather food into her room and eat it all at once” and “friends, family, etc. have told my daughter that she needs to eat more” often, once a week in frequency.
PEBBIT

Individual responses for the items on the PEBBIT are provided in Appendix Q.

Summary scores for the PEBBIT’s two primary factors are presented in Table 3.

Table 3

**PEBBIT Subscale Total Scores**

<table>
<thead>
<tr>
<th>Race</th>
<th>BEB Factor Items</th>
<th>BIDRE Factor Items</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>M</td>
<td>SD</td>
</tr>
<tr>
<td>Caucasian</td>
<td>6.86</td>
<td>2</td>
</tr>
<tr>
<td>(n = 7)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>African</td>
<td>5</td>
<td>N/A</td>
</tr>
<tr>
<td>American (n = 2)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hispanic</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>(n = 1)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>6.4</td>
<td>2.3</td>
</tr>
<tr>
<td>(N = 10)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Overall results from the PEBBIT are reported in Table 2. Overall, 6 parent participants reported answers with potential clinical significance across 11 items on the PEBBIT. These are items the parents indicated a frequency of “Once a week” or “Everyday.” The subject numbers and PEBBIT items yielding significant responses are presented in Table 4.
Table 4

PEBBIT Responses with Potentially Clinically Significant Responses

<table>
<thead>
<tr>
<th>Subject Number(s)</th>
<th>PEBBIT Question</th>
</tr>
</thead>
<tbody>
<tr>
<td>9,8</td>
<td>Friends, family, etc. have told my daughter that she needs to eat more</td>
</tr>
<tr>
<td>6</td>
<td>My child’s current weight bothers her</td>
</tr>
<tr>
<td>9</td>
<td>My child eats a lot of food at once</td>
</tr>
<tr>
<td>6</td>
<td>My child wishes she were thinner</td>
</tr>
<tr>
<td>9</td>
<td>My child will gather food into her room and eat it all at once</td>
</tr>
<tr>
<td>2</td>
<td>My child thinks she weighs more than other girls her age and height</td>
</tr>
<tr>
<td>6</td>
<td>My child worries about gaining weight</td>
</tr>
<tr>
<td>7</td>
<td>My child exercises to burn off food she eats</td>
</tr>
<tr>
<td>6</td>
<td>My child worries about the size of her hips, bottom, and/or thighs</td>
</tr>
<tr>
<td>8</td>
<td>My daughter will stop eating before her stomach feels full</td>
</tr>
<tr>
<td>4</td>
<td>My daughter worries about her body changing or developing too fast</td>
</tr>
</tbody>
</table>

Observed Agreements and Disagreements Between the EBBIT and PEBBIT

Between the EBBIT and PEBBIT, there are 41 items that correspond to each other. The item stating “I feel really bad after I eat a lot junk food and think about how to get rid of what I just ate” on the EBBIT does not have a PEBBIT correlating item. There are 22 items on the PEBBIT that do not have directly corresponding items on the EBBIT.
The matching 41 items were examined for whether parent and child both provided zero or non-zero responses. Thus, it was considered an agreement if parent and child each gave a zero response, and it was also an agreement if the parent and child indicated non-zero responses (i.e., even if the parent or child response was higher than the other – agreements were based on whether both said zero or both said something other than zero).

Overall, there were 19 significant responses by 7 children, but only 12 significant responses by parents of 6 children. Four children reported significant responses multiple times and none of their parents reported any significant disordered eating behaviors in their children. Three parents reported significant disordered eating behaviors, but none of their children reported any significant behaviors. Parents were reporting bingeing behaviors and behaviors based on emotions that the children were not reporting. The children were reporting more restricting and compensatory behaviors the parents either were not aware of or were not reporting.

**Comparing Subscale Scores**

There are 2 factors- Body Image Dissatisfaction/Restrictive Eating (BIDRE) and Binge Eating Behaviors (BEB). The BIDRE factor has 23 items and the BEB factor has 15 items.

Every BIDRE item had at least one child indicate a “yes” response, while the BEB factor had 3 items where every child answered no (i.e., “I eat till my stomach feels uncomfortable,” “I collect food in my room and sometimes I eat it all at once,” and I would eat 10 candy bars at once if my parents would let me”).
Matching responses mean the parent and child both indicated the child is engaging in the disordered eating behavior (any degree of frequency) or both agreed the child is not engaging in the disordered eating behavior. As for the BIDRE items, 58.6% of parent’s responses had matching responses with their children. On the BEB items, 65.3% of parent’s responses and children had similar answers.

Key Items

Most children responded they are not happy with their body (i.e. believe they are fat, want to be thinner, wish they had less body fat), but denied engaging in any compensatory behaviors. They may avoid fatty foods, but denied dieting. They endorsed thoughts of “getting rid of the food they ate” but did not report (except one) that they did anything other than exercise to get rid of the food they ate.

Other Items

One key question regarding a compensatory behavior of significance that did not load on either the BIDRE or BEB factor asked about self induced vomiting after eating. Every participant reported they did not engage in this behavior.

Parents overestimated the disordered eating behaviors in their children were engaging in 15% and 23.3% of the time on the BIDRE scale and BEB scale, respectively.

Parents overestimated the disordered eating behaviors in their children were engaging in 14.6% of the time overall. Parent’s underestimated their child’s disordered eating behaviors 30.9% of the time on the BIDRE scale and 14.6% of parent’s responses indicate an underestimation of binge eating behaviors.
Discrepancies

The largest discrepancies between child and parent ratings (i.e., ratings that were 3 values apart) were found 5 times for 4 children on 5 items. On all 5 of these items the child indicated a 3 in frequency (“Most of the time (everyday)”) and the parent indicated their child did not engage in this behavior at all. The items producing the largest observed discrepancies (in order from most common to least common) include:

“I/My child tries to lose weight by dieting.”
“I/My child avoids junk food or “fatty” food because she wants to lose weight.”
“I/My child look at food labels to see calories and fat content.”
“I look at the fat on my body and wish it was not there/ My child wishes she had no fat on her.”
“I/My child exercise to burn off the food I eat.”

Post Hoc Examination of Overt and Covert Behaviors

In an effort to examine potential commonalities among items with discrepant ratings, a post hoc qualitative analysis was performed to compare parental accuracy on children’s ratings of items tapping overt (more observable behaviors) versus items tapping covert (more private behaviors).

Overt Behaviors

Overt behaviors are external behaviors that are easily identified by others, i.e. sleep patterns, eating patterns, disruptive behavior. Research has shown that parents typically have an easier time identifying overt behaviors than covert behaviors. Some
overt behaviors are still hard to identify because of the secretive nature and because they may be based on internal emotions.

Overt behaviors are those that can be seen/measured visually by others (Kazdin, 2001). In this study parents were able to identify overt behaviors in their children 66.7% of the time. Some overt behaviors are driven by internal states/motivation that is not as easily witnessed by others and in these instances parents were able to identify the behaviors in their children 75.4% of the time. In looking at the overt behaviors that were not accurately rated in frequency parents tend to over/under estimate their child’s behavior 17.5% and 20.4% of the time, respectively.

Less Overt Behaviors

In looking at the less overt behaviors (i.e., those that have the possibility of private behaviors) that were not accurately rated in frequency, parents tend to over/under estimate their child’s behavior 10% and 17.2% of the time, respectively.

Covert Behaviors and Affective States

In looking at the results from covert behaviors, parents were able to accurately identify if their child was engaging in these behaviors 71.2% of the time. Many eating disordered behaviors are driven by internal emotional (affective) states. These behaviors may be overt or covert, but they all have affective states that may act as the driving force behind the behavior. Parents were able to identify behaviors initiated by these affective states 70% of the time.

In looking at the covert behaviors that were not accurately rated in frequency, parents tend to over/under estimate their child’s behavior 14.7% and 19.4% of the time,
respectively. In looking at the covert behaviors (with an affective state) that were not accurately rated in frequency, parents tend to over/under estimate their child’s behavior 16.6% of the time for each.
CHAPTER IV
DISCUSSION

The primary purpose of this study was to examine the agreements between child and parent ratings of the children’s eating disorder symptoms and related behaviors. This study, along with others, suggests the potential importance of considering sources of agreement and disagreements between how parents and children may report symptoms necessary for assessing eating disorder behaviors in preadolescents. The literature has suggested that preadolescents, along with older children, are likely to minimize or hide eating disorder behaviors. A parent questionnaire provides another important perspective on the child’s eating behaviors.

The mean EBBIT factor scores obtained for the 10 participants in this study were lower than the scores reported by Candy and Fee (1998). However, there were many non-zero responses (i.e., potentially clinically significant responses) provided by both the children and the parents, and responses to these items were reviewed. The most commonly reported symptoms reported by the children dealt with restricting behaviors, compensatory behaviors (i.e., laxatives, diuretics), and fear of gaining weight. The most commonly reported symptoms reported by the children dealt with worry and fear associated with weight gain and binging behaviors.
Overall, it appeared that the children were capable of comprehending the questions and of providing reliable and valid responses. There were relatively few examples of children providing logically inconsistent responses. It seems likely that if the children’s version of the scale was used with younger children, the proportion of logically inconsistent responses could rise.

Responses on the PEBBIT also showed some significant responses on items related to worry and fear associated with weight gain and binging behaviors. Compared to their children’s responses, it was found that parents underestimated their child’s disordered eating behaviors by 30.9% on the BIDRE scale and 14.6% of parent’s responses indicate an underestimation of binge eating behaviors. Parents overestimated the disordered eating behaviors in their children by 15% and 23.3% on the BIDRE scale and BEB scale, respectively. Thus, it appears that parents may be more likely to provide important evidence for some symptomatic behaviors.

Given concern that covert behaviors would be more difficult for parents to assess accurately, a post hoc analysis comparing agreements on overt and covert symptoms was also undertaken. A post hoc analysis comparing agreements on all overt and covert symptoms/questionnaire items was also undertaken. In looking at overt behavior, 17.5% and 20.4% of item responses were over/under estimated by parents of their child’s behavior. Parents were able to accurately identify if their child was engaging in covert behaviors in 71.2% item responses. Eating disordered behaviors that are driven by internal emotional (affective) states may be overt or covert and parents were able to identify behaviors initiated by these affective states in 70% of their responses. Results suggest that parents and children were most likely to disagree on items assessing covert
items (versus overt). This would be expected as parents should have less access to accurate information about the child’s internal states. Given the presence of these disagreements, clinicians should routinely interview children in addition to parents in assessing eating disorder behaviors in preadolescent children.

The existence of disagreements certainly suggests that it could prove useful to clinicians to routinely include both child and parent report of eating disorder symptoms in assessments. Examination of differences between the child and parent reports suggests some preliminary areas of concern in trusting either child or parent report alone in assessing eating disorder behavior in preadolescents.

Strengths of Study

There is limited research comparing parent and preadolescent children’s views of the child’s eating behaviors. This study has helped identify initial areas of concern in assessing agreements between child and parent ratings. Clinicians and clinical researchers interested in using self-report in preadolescent populations are encouraged to monitor the data provided by child informants for responses that indicate random responding, lying, or otherwise inaccurate content. Similarly, clinicians and clinical researchers utilizing parent report should consider the added difficulty parents have in accurately assessing covert behaviors.

Limitations of Study

The most obvious limitation of the study was that there was a very low participation rate (3%). With only 10 pairs of children/parent responses available for analysis, all observations and conclusions must be regarded as tentative at best. Further,
the sample may have had fewer eating disorder symptoms that would typically be seen in larger samples based on Candy and Fee’s data set. It is likely that a larger sample would result in identifying a clearer picture of items on which parents and children are likely to provide different ratings. It is somewhat puzzling to contrast Candy and Fee’s parent responses rate of 84% versus the 3% response rate obtained in this study. Importantly, Candy and Fee’s study required only that parents permit their child to complete a questionnaire while this study required parents to also provide data. Perhaps even more importantly, these may be additional reasons for parents not willing to participate. It could be that parents had something they wanted to hide as results of the EBBIT for the 10 participant in this study showed considerably lower scores on the EBBIT factors than in the Candy and Fee sample. This underscores the importance of future studies obtaining representative samples.

To obtain a higher participation rate, future researchers could word the parent cover letter to emphasize the importance of this research and then do more to reassure the parent that this should not in any way give their child any ideas about (i.e., prompt) ED behaviors.

Due to the low teacher return rate, any future researcher could ask the superintendent or principal to send a letter informing teachers of the study and their approval so the teachers may feel more inclined to participate. Further, it may be helpful to pair the data collection with an educational component so that parents/children believed they were “getting something” from participating.
In addition to the low participation rate, another limitation was that all participant dyads were from the same geographic location. Future researchers may want to include participants from other areas and private schools.

Recommendations for Future Research

The psychometric properties of the PEBBIT need to be investigated through a larger scale study with 300 pairs of children and parent respondents. Reliability and validity could be better established through a series of planned analyses. These analyses could include a factor analytic method in order to evaluate the PEBBIT’s factor structure. Cronbach’s alpha would be computed to determine the internal consistency reliability. Relationships would be calculated among BMI, BIS (dissatisfaction, perceived and desired), age, race, school type, and PEBBIT factor scores to reveal multicollinearity for the regression analysis. A sequential multiple regression using BMI, BIS scores, age, race, and PEBBIT factor scores would be used to assess preliminary validity. Intercorrelations between PEBBIT and EBBIT scores would be calculated to look at parent-child agreement.

The ideal method to obtaining data for this study would be to recruit a clinical population of child participants at the inpatient or residential treatment level about a month into treatment. At this point in treatment, specifics about their eating disorder have already been identified through multiple assessments, psychological and medical, along with measuring food and liquid intake and output. The researchers would be able to identify the accuracy in the child responses. The PEBBIT would be given to the parents of these children and researchers would be able to assess how accurate the parent’s
responses are and how well they are able to identify eating disorder related behaviors in their child. In absence of objective data, the only way you can assess accuracy in the parent responses is to examine the discrepancies in the parent and child responses.

Clinical researchers are encouraged to focus on further assessing the benefits of assessing both child and parent repost of eating disorder symptoms in preadolescents. Although past research has indicated children tend to minimize or deny certain behaviors it is still important in the assessment to obtain their self report because it is difficult for parents to accurately identify all behaviors and affective states of their children.
REFERENCES


APPENDIX A

PARENT/PRIMARY CAREGIVER INFORMED CONSENT

(PARTICIPANT AND RESEARCHER’S COPY)
Dear Parent/Legal Guardian,

We are working on a project to better understand eating problems and how they affect children. We are asking parents of children to help us with this project.

If you provide your consent, you will be asked to complete the attached demographic form and parent questionnaire regarding eating behaviors. This should take approximately 15 minutes.

Your daughter would then be asked to participate in a session that will last approximately 30 minutes. During the session, she will complete similar questionnaires and have her height and weight measured in-private and she will not be told her height and weight. The questionnaires look at eating behaviors and self-image.

Two weeks after the completion of this phase of the study 60 parents will be randomly selected to participate a second time and you would be asked to complete the eating behavior questionnaire a second time.

If you are interested in helping us, please return the signed forms in the attached envelope to your daughter’s teacher. Please seal the envelope and sign your name across the seal for confidentiality purposes.

Participation is completely voluntary, and you may withdraw at any time without penalty. You do not have to answer any questions that you do not want to. Your child may also choose not to participate, answer any specific questions, and/or withdraw at any time. All information will be kept confidential by putting identification numbers on the forms. No name will appear on any of the questionnaires. Consent forms will be stored in a separate location.

If any girl becomes upset, the session will be stopped and you will be called. In the event that any girls are expressing serious concerns about their weight or serious problematic eating behaviors, we will call the parents to let them know and encourage them to contact their child’s pediatrician. You will also be provided a referral to the Adolescent Medicine Clinic at Children’s Hospital (205) 934-4531 where they will conduct an assessment and treatment of possible eating disorders.

Your participation will be greatly appreciated. If you have any questions, feel free to call Dr. Kevin Armstrong at (662) 325-7657 or Lindsay Klyce at (205) 915-4758. For additional information regarding your rights as a research participant, please feel free to contact the MSU Regulatory Compliance Office at 662-325-5220.

Sincerely,

Lindsay Klyce
Graduate Student
Mississippi State University

Kevin Armstrong, Ph.D.
Licensed Clinical Psychologist (in MS)
Associate Professor
Mississippi State University
I, ____________________________, having read this consent form:

(Name and relationship to Child)

_______ PROVIDE MY CONSENT

_______ DO NOT PROVIDE MY CONSENT

to participate in the project described above and

_______ GIVE MY CONSENT

_______ DO NOT GIVE MY CONSENT

for my daughter to participate if she is interested.

(Parent’s Signature and Date) (Parent’s Name- PLEASE PRINT)

Daughter’s Name (PLEASE PRINT): _______________________

Parent’s Phone Number: _______________________

**Please return the completed packet to your daughter’s teacher**
Dear Parent/Legal Guardian,

We are working on a project to better understand eating problems and how they affect children. We are asking parents of children to help us with this project.

If you provide your consent, you will be asked to complete the attached demographic form and parent questionnaire regarding eating behaviors. This should take approximately 15 minutes.

Your daughter would then be asked to participate in a session that will last approximately 30 minutes. During the session, she will complete similar questionnaires and have her height and weight measured in-private and she will not be told her height and weight. The questionnaires look at eating behaviors and self-image.

Two weeks after the completion of this phase of the study 60 parents will be randomly selected to participate a second time and you would be asked to complete the eating behavior questionnaire a second time.

If you are interested in helping us, please return the signed forms in the attached envelope to your daughter’s teacher. Please seal the envelope and sign your name across the seal for confidentiality purposes.

Participation is completely voluntary, and you may withdraw at any time without penalty. You do not have to answer any questions that you do not want to. Your child may also choose not to participate, answer any specific questions, and/or withdraw at any time. All information will be kept confidential by putting identification numbers on the forms. No name will appear on any of the questionnaires. Consent forms will be stored in a separate location.

If any girl becomes upset, the session will be stopped and you will be called. In the event that any girls are expressing serious concerns about their weight or serious problematic eating behaviors, we will call the parents to let them know and encourage them to contact their child’s pediatrician. You will also be provided a referral to the Adolescent Medicine Clinic at Children’s Hospital (205) 934-4531 where they will conduct an assessment and treatment of possible eating disorders.

Your participation will be greatly appreciated. If you have any questions, feel free to call Dr. Kevin Armstrong at (662) 325-7657 or Lindsay Klyce at (205) 915-4758. For additional information regarding your rights as a research participant, please feel free to contact the MSU Regulatory Compliance Office at 662-325-5220.

Sincerely,

Lindsay Klyce
Graduate Student
Mississippi State University

Kevin Armstrong, Ph.D.
Licensed Clinical Psychologist (in MS)
Associate Professor
Mississippi State University
I, ____________________________, having read this consent form:
    (Name and relationship to Child)

_______ PROVIDE MY CONSENT

_______ DO NOT PROVIDE MY CONSENT

to participate in the project described above and

_______ GIVE MY CONSENT

_______ DO NOT GIVE MY CONSENT

for my daughter to participate if she is interested.

_________________________    _____________________________
(Parent’s Signature and Date)    (Parent’s Name- PLEASE PRINT)

Daughter’s Name (PLEASE PRINT): ________________________________
Parent’s Phone Number: ________________________________

**Please return the completed packet to your daughter’s teacher

“RETURN THIS COPY TO YOUR CHILD’S TEACHER IN THE ENVELOPE PROVIDED”
APPENDIX B

DEMOGRAPHIC INFORMATION FORM
Demographic Information Form

Please answer all questions honestly. Your cooperation is greatly appreciated and will help us a great deal.

1. Child’s age

2. Child’s race/ethnicity (check one)
   - African American/Black
   - Asian American
   - Caucasian American/White
   - Native American
   - Hispanic American/ Latina/ Latino
   - Other, specify

3. Race/ethnicity of mother/primary female caregiver
   - African American/Black
   - Asian American
   - Caucasian American/White
   - Native American
   - Hispanic American/ Latina/ Latino
   - Other, specify

4. What was the highest grade completed by the
   - Mother?
   - Father?

5. Was a high school diploma earned?
   - Mother? Yes/No GED? Yes/No
   - Father? Yes/No GED? Yes/No

6. Did mother attend college? Yes/No Number of years?

7. Did father attend college? Yes/No Number of years?

8. Annual family income before taxes (optional)
   - Under $1,000
   - $1,000 - $24,999
   - $25,000 - $49,999
   - $50,000 - $74,999
   - $75,000 - $100,000
   - Over $100,000

9. Does your child receive free or reduced cost lunches at school? Yes No

10. Has your daughter started her menstrual cycle? Yes/No If yes, has she had more than one
     period? Yes/No

11. Does your child have any medical problems that cause her to eat certain foods?
    (Please circle) Yes No
    If yes, what is it?

12. Does your family have a special diet (example, vegetarian)?
    (Please circle) Yes No
    If yes, what is it?

50
APPENDIX C

PARENT EATING BEHAVIOR AND BODY IMAGE TEST (PEBBIT)
Parent Questionnaire

Directions:

The mother, or primary care-giver, should try to answer every question by circling the appropriate number. Do not confer with others. Thank you!
<table>
<thead>
<tr>
<th>Example</th>
<th>Most of the time</th>
<th>Often</th>
<th>Rarely</th>
<th>Never</th>
</tr>
</thead>
<tbody>
<tr>
<td>My child eats a lot when watching t.v.</td>
<td>3………………2…………1………………0</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Most of the time</td>
<td>Often</td>
<td>Rarely</td>
<td>Never</td>
<td></td>
</tr>
<tr>
<td>(everyday) (once a week) (once a month)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3………………2…………1………………0</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1) My child diets (lose weight by eating less than normal) as her friends do.</td>
<td>3……….2……….1……….0</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2) My child’s current weight bothers her</td>
<td>3……….2……….1……….0</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3) My child eats a lot of food at once</td>
<td>3……….2……….1……….0</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4) My child will eat when not hungry</td>
<td>3……….2……….1……….0</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5) My child wishes she were thinner</td>
<td>3……….2……….1……….0</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6) My child avoids junk food or “fatty” food because she wants to lose weight.</td>
<td>3……….2……….1……….0</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7) My child tries to lose weight by dieting</td>
<td>3……….2……….1……….0</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>8) My child eats when she is mad</td>
<td>3……….2……….1……….0</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>9) My child will gather food into her room and eat it all at once</td>
<td>3……….2……….1……….0</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>10) My child thinks she is fat</td>
<td>3……….2……….1……….0</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>11) My child makes herself throw up after eating.</td>
<td>3……….2……….1……….0</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>12) My child thinks she weighs more than other girls her age and height.</td>
<td>3……….2……….1……….0</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>13) My child eats what she wants, when she wants to</td>
<td>3……….2……….1……….0</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>14) My child sometimes eats too much and then has an upset stomach</td>
<td>3……….2……….1……….0</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>15) My child worries about gaining weight</td>
<td>3……….2……….1……….0</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>16) My child eats all her Halloween candy in one sitting</td>
<td>3……….2……….1……….0</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Most of the time (everyday)</td>
<td>Often (once a week)</td>
<td>Rarely (once a month)</td>
<td>Never</td>
</tr>
<tr>
<td>---</td>
<td>---------------------------</td>
<td>-------------------</td>
<td>---------------------</td>
<td>-------</td>
</tr>
<tr>
<td>17) My child takes diet pills</td>
<td>3........2........1.......0</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>18) My child feels bad after eating a lot of food</td>
<td>3........2........1.......0</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>19) My child skips meals to lose weight</td>
<td>3........2........1.......0</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>20) My child feels hungry when she is not eating</td>
<td>3........2........1.......0</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>21) My child likes an empty stomach</td>
<td>3........2........1.......0</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>22) My child will hide and eat junk food alone</td>
<td>3........2........1.......0</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>23) My child uses laxatives to lose weight</td>
<td>3........2........1.......0</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>24) My child feels fat</td>
<td>3........2........1.......0</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>25) My child will eat a lot even when not hungry</td>
<td>3........2........1.......0</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>26) My child worries about gaining weight from the foods that she eats</td>
<td>3........2........1.......0</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>27) My child looks at food labels to check fat and calories content</td>
<td>3........2........1.......0</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>28) My child skips a meal after eating a lot of food at once</td>
<td>3........2........1.......0</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>29) My child would eat 10 candy bars at once if I let her</td>
<td>3........2........1.......0</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>30) My child sometimes sneaks food</td>
<td>3........2........1.......0</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>31) My child avoids foods with a lot of fat</td>
<td>3........2........1.......0</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>32) My child wishes she had no fat on her</td>
<td>3........2........1.......0</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>33) My child eats when sad</td>
<td>3........2........1.......0</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>34) My child eats when bored</td>
<td>3........2........1.......0</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>35) My child takes diuretics to lose weight</td>
<td>3........2........1.......0</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>3</td>
<td>2</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>---</td>
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<td>---------</td>
<td>---------</td>
<td>---------</td>
</tr>
<tr>
<td>36) My child exercises to burn off food she eats…</td>
<td>3</td>
<td>2</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>37) My child diets like I do………………………</td>
<td>3</td>
<td>2</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>38) There are some foods my child would eat way too much of if she were allowed.</td>
<td>3</td>
<td>2</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>39) My child thinks about food when not eating…</td>
<td>3</td>
<td>2</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>40) My child drinks diet soda, instead of snacking.</td>
<td>3</td>
<td>2</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>41) My child does not eat dessert in order to lose weight.</td>
<td>3</td>
<td>2</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>42) My child weighs more than others her same age and height.</td>
<td>3</td>
<td>2</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>43) My child eats a lot when watching TV.</td>
<td>3</td>
<td>2</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>44) My child tries to eat very slowly.</td>
<td>3</td>
<td>2</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>45) My child can stop eating her favorite foods even when there is more of it to eat.</td>
<td>3</td>
<td>2</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>46) My child tends to cut her food into tiny pieces.</td>
<td>3</td>
<td>2</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>47) My child does not get enough exercise.</td>
<td>3</td>
<td>2</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>48) My child thinks that she would have more friends if she were thinner.</td>
<td>3</td>
<td>2</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>49) My child worries about the size of her hips, bottom, and/or thighs.</td>
<td>3</td>
<td>2</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>50) Friends, family, etc. have told my daughter that she needs to eat more.</td>
<td>3</td>
<td>2</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>51) My daughter is happy with the way she looks.</td>
<td>3</td>
<td>2</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>52) My child feels fine after eating dessert or a big meal.</td>
<td>3</td>
<td>2</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>Question</td>
<td>Rating</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>-------------------------------------------------------------------------</td>
<td>--------</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>53) Other people have told my daughter she exercises too much.</td>
<td>3</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>54) My child feels bad after eating sweets and junk food, so she thinks of how to get rid of it and lose weight.</td>
<td>3</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>55) My daughter will stop eating before her stomach feels full.</td>
<td>3</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>56) My daughter worries that if she eats, she might gain weight.</td>
<td>3</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>57) My daughter tries not to eat meat.</td>
<td>3</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>58) My daughter has gone 24 hours (1 day) without eating solid foods.</td>
<td>3</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>59) My daughter thinks that others look at her and think of her as being fat.</td>
<td>3</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>60) My daughter only really enjoys eating sweets and junk food.</td>
<td>3</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>61) My daughter diets like others in the family do.</td>
<td>3</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>62) My daughter hates to exercise.</td>
<td>3</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>63) My daughter likes the way she looks in most of her clothes.</td>
<td>3</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>64) My daughter worries about her body changing or developing too fast.</td>
<td>3</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
APPENDIX D

SUPERINTENDENT PERMISSION FORM
Dear Superintendent,

We are beginning working on establishing a reliable and valid parental questionnaire regarding children’s eating behaviors. We are seeking permission from you to recruit teachers from your district to assist us by allowing us to send home a parent packet with girls in the 4th, 5th, and 6th grades. After providing their consent, parents will be asked to complete a demographic form and a parent questionnaire regarding the eating behaviors of their daughters. In addition, parents would be asked to provide their consent for their daughters to complete questionnaires rating their body size and eating behaviors and for us to weigh and measure them. We are interested in sending packets home with all of the girls in the 4th, 5th and 6th grade.

Two weeks after completing primary data collection, in a second phase, 60 randomly selected parents will be asked to complete one of the forms a second time.

We expect it would take approximately 30 minutes for the girls to fill out their forms. We will be extremely careful to accommodate teachers’ schedules. Participation in the project for teachers, parents, and children will be solely on a volunteer basis. It will be made clear to them that they do not have to complete any particular questions that they would be uncomfortable completing, and they will have the right to withdraw from the project at any time. The identities of the participants will be protected by using ID numbers on the questionnaire protocols and when labeling data. Consent forms and assent forms are the only forms on which names will appear, and these will be stored in a locked filing cabinet separate from the data. If any girl should become upset during the study, the session will be stopped. The parents of any girls showing serious signs of an eating disturbance will be called and given an appropriate referral to a local clinic specializing in the assessment and treatment of possible eating disorders.

If you agree to help us, we will need your signature on the attached permission form printed or photocopied onto your school district’s letterhead.

Enclosed is an envelope for your reply. You may contact us at (662) 325-7657 for any further questions or information. For additional information regarding your rights as a research subject, please feel free to contact the MSU Regulatory Compliance Office at 662-325-5220. Thank you for your time and for the consideration of helping with this.

Sincerely,

Lindsay Klyce
Graduate Student
Mississippi State University

Kevin Armstrong, Ph.D.
Licensed Clinical Psychologist (in MS)
Associate Professor
Mississippi State University
PERMISSION FORM

I, ____________________________, Superintendent of the __________________________ School District, or my designee shown below, (Name) provide permission for Lindsay Klyce and Dr. Kevin Armstrong to work on the above-described project within our school system. I understand I may withdraw at any time. I certify that I have such authority to grant such permission on behalf of the school district.

Printed Name

Title (if authorized designee)

Signature

Date
APPENDIX E

PRINCIPAL PERMISSION FORM
Dear Principal,

We are beginning working on establishing a reliable and valid parent questionnaire regarding children’s eating behaviors. We are seeking permission from you to recruit teachers from your school to assist us by allowing us to send home a parent consent form with girls in the 4th, 5th, and 6th grades. The parents will be asked to complete a demographic form and a questionnaire regarding eating behaviors of their daughter’s. In addition, parents would be asked to provide their consent for their daughters to complete questionnaires rating their body size and eating behaviors and for us to weigh and measure them. The number of girls participating from your school will depend on the number available and the number who receive permission from their parent/primary caregiver.

Two weeks after completing primary data collection, in a second phase, 60 randomly selected parents will be asked to complete one form a second time.

Approximately 30 minutes of the child’s time will be required for the session. We will be extremely careful to accommodate teachers’ schedules.

Participation in the project for teachers, parents, and children will be solely on a volunteer basis. It will be made clear to them that they do not have to answer any questions they do not want to answer, and they will have the right to withdraw from the project at any time. The identities of the participants will be protected by using ID numbers on the questionnaire protocols and when labeling data. Consent forms and assent forms are the only forms on which names will appear, and these will be stored in a locked filing cabinet separate from the data. If any girl should become upset during the study, the session will be stopped. The parents of any girls showing serious signs of an eating disturbance will be called and given an appropriate referral to a local clinic specializing in the assessment and treatment of possible eating disorders.

Enclosed is an envelope for your reply. You may contact us at (662) 325-7657 for any further questions or information. For additional information regarding your rights as a research subject, please feel free to contact the MSU Regulatory Compliance Office at 662-325-5220. Thank you for your time and for the consideration of helping with this.

Sincerely,

Lindsay Klyce
Graduate Student
Mississippi State University

Kevin Armstrong, Ph.D.
Licensed Clinical Psychologist (in MS)
Associate Professor
Mississippi State University
Check one:

_______ Agree to participate

_______ DO NOT agree to participate

I, ____________________________, Principal of ________________________ School,
(Name)
or my designee shown below, provide permission for Lindsay Klyce and Dr. Kevin
Armstrong to work on the above-described project within our school system. I understand
I may withdraw at any time. I certify that I have such authority to grant such permission
on behalf of the school district.

____________________________  ______________________________
Printed Name      Title (if authorized designee)

____________________________  ______________________________
Signature      Date
APPENDIX F

TEACHER PERMISSION FORM
Dear Teachers,

In order to come to a clear understanding of the impact of eating problems in children, we are conducting a project at Mississippi State University. We are seeking the assistance of teachers, grade 4, 5, and 6 who are willing to help us with this project. Permission to conduct this research has already been obtained from the superintendent of schools and the principal of your school.

Participating teachers would assist by sending home a packet consisting of a consent form, demographic information form, and a parent questionnaire regarding eating behaviors with all of their female students. Then, girls would complete questionnaires outside the classroom. In a second phase, some of the parents would be sent home a second questionnaire.

The administration time would be arranged so that it is convenient to your schedule, and the questionnaires will be administered away from the classroom. The session with students should take about 30 minutes.

If any girl becomes upset, the session will be stopped and you will be called. In the event that any girls are expressing serious concerns about their weight or serious problematic eating behaviors, we will call the parents to let them know and encourage them to contact their child’s pediatrician. You will also be provided a referral to the Adolescent Medicine Clinic at Children’s Hospital (205) 934-4531 where they will conduct an assessment and treatment of possible eating disorders.

Please understand that your participation is completely voluntary, and you may withdraw at any time. You may elect not to participate and/ or choose to terminate at any time. However, your help in completing this project would be greatly appreciated. If you have any questions or concerns, feel free to call Lindsay Klyce at (205) 915-4758 or Dr. Kevin Armstrong at (662) 325-7657. For additional information regarding your rights as a research subject, please feel free to contact the MSU Regulatory Compliance Office at 662-325-5220.

Sincerely,

Lindsay Klyce     Kevin Armstrong, Ph.D.
Graduate Student    Licensed Clinical Psychologist (in MS)
Mississippi State University  Associate Professor
Mississippi State University
I, ______________________, having read this permission form, agree/ do not agree to allow recruitment of students/ parents for the project described above, conducted by Dr. Kevin Armstrong and Lindsay Klyce as principal investigators. I understand that I may withdraw at any time.

_________________________  ____________________________
(Teacher’s Signature)        (Date)
APPENDIX G

CHILD ASSENT FORM
Child Assent

We are interested in looking at different eating behaviors in people your age. Your parents have already granted permission for you to do this and have filled out some surveys. We are asking you to fill out some surveys and answer some questions, this will last about 30 minutes. There are no right or wrong answers. We would like you to answer the questions as best as you can.

You do not have to fill out the surveys or answer any questions that you do not want to. If you have any questions, you can ask them at any time. Your participation is completely voluntary and you may stop at any time without penalty.

Please do not put your name on any of the forms. You will be given an identification number so your information will be kept confidential. The only way anyone will find out your responses is if we are worried about you and need to contact your parents. If you have any questions about what we are doing, please feel free to ask. We appreciate your help.

Also, your height and weight will be taken individually so the information remains confidential. This will be done in a private location and you will not be told your height and weight.

If you are willing to participate, please read the following statement and write your name and the date below.

Thank you for your time and help.

Sincerely,

Lindsay Klyce
Graduate Student
Mississippi State University

Kevin Armstrong, Ph.D.
Licensed Clinical Psychologist (in MS)
Associate Professor
Mississippi State University

I agree to participate in this project. I know I am able to quit at any time. I am also aware that I am not required to answer the questions I do not want to.

(Signature) (Date)
APPENDIX H

DATA RETENTION PROTOCOL
1. Upon receipt of the parent consent form, on a roster, id numbers will be assigned to the parent’s name, child’s name, school name, and the teacher’s name. These codes will not be written on the consent form. Instead, identifiers (ID numbers will not be associated with SSN or a staff ID number. They are randomly assigned) along with id#, teacher and id#, and school and id# will be kept on a separate roster to facilitate data collection and allow for contact of parents should data indicate their child may need medical attention.

2. Once the ID number is assigned parent consent forms (again, with no ID number) will be mailed to Dr. Armstrong using registered mail to be placed in a locked filing cabinet.

3. The parent data will be immediately labeled with the id numbers to be entered on the computer at a later time.

4. The cover sheet on the child data packet will be labeled with id#, school #, and teacher #. No identifiers will appear anywhere on the data packets administered to the girls.

5. When the data are collected with the girls, the graduate student will bring the roster along so the correct children can be matched with their coded packets.

6. The roster will also be used to send the PEBBIT to enough randomly selected parents a second time.

7. Immediately prior to administering questionnaires the appropriate ID number will be placed on the packet. The PEBBIT and EBBIT will be scored within one week of receipt. During this time, the experimenter will keep all data in a locked safe. The parents of any girls whose data indicates a referral is necessary will be contacted. The roster will be turned over to Dr. Armstrong via registered mail and it will be stored securely in his office until such time that all contacts are made with parents of subjects needing clinical referrals. Once all contacts have been made, the roster will be destroyed by shredding.

8. As soon as the data is entered, it will be turned over to Dr. Armstrong by registered mail who will be responsible for its retention. Consent forms will be retained for three years and all other data will be retained for five years post-publication.

Lindsay Klyce/ Date  Dr. Kevin Armstrong/ Date
APPENDIX I

EATING BEHAVIOR AND BODY IMAGE TEST (EBBIT)
INSTRUCTIONS

Please write down how old you are where it says “age.” On the next line circle whether you are White, Black, Asian, Indian, or other. If you circle other, put your race on the line provided. Write in the grade you are in. Has everyone finished?

Here all the girls will read two randomly selected items. For any girl who has difficulty reading the items, the items will be read to her, and the examiner will circle the response.

Now I would like you to read the questions and circle the number that describes you. Rate what you do or think and not what you think is a right answer because there are no right answers.

Please raise your hand whenever you don’t understand something or if you cannot read a word or do not understand what it means. I will then come by and help you. Any questions? You may begin.
1. Do you have any medical problems that cause you to eat certain foods? (Please circle) No Yes

If yes, what is it? ________________________________

2. Does your family have a special diet (example, vegetarian)? (Please circle)

No, we eat meat and vegetables

Yes, what kind? ________________________________
**Example**

I eat a lot when watching T.V.  ........................................ 3       2       1       0

1) I diet (lose weight by eating less than normal) like my friends do.  ........................................ 3       2       1       0

2) My current weight bothers me.  ........................................ 3       2       1       0

3) I eat a lot of food at once.  ........................................ 3       2       1       0

4) I try not to eat even when I am hungry.  ........................................ 3       2       1       0

5) I wish I was thinner.  ........................................ 3       2       1       0

6) I do not eat junk food or “fatty” food because I want to lose weight.  ........................................ 3       2       1       0

7) I try to lose weight by dieting.  ........................................ 3       2       1       0

8) I eat when I feel mad.  ........................................ 3       2       1       0

9) I collect food in my room and sometimes I eat it all at once.  ........................................ 3       2       1       0

10) I think I am fat.  ........................................ 3       2       1       0

11) I make myself throw up after eating.  ........................................ 3       2       1       0

12) I think I weigh more than most girls my age and height.  ........................................ 3       2       1       0

13) I eat what want to eat, anytime I want to.  ........................................ 3       2       1       0

14) I eat until my stomach feels uncomfortable.  ........................................ 3       2       1       0

15) I worry about gaining weight.  ........................................ 3       2       1       0

16) I eat all of my Halloween candy at once.  ........................................ 3       2       1       0

17) I take diet pills to lose weight.  ........................................ 3       2       1       0
<table>
<thead>
<tr>
<th></th>
<th>Most of the time (everyday)</th>
<th>Often (once a week)</th>
<th>Rarely (once a month)</th>
<th>Never</th>
</tr>
</thead>
<tbody>
<tr>
<td>18) I feel really bad after I eat a lot of food</td>
<td>3………2……….1……….0</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>19) I skip meals to lose weight</td>
<td>3……….2……….1……….0</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>20) I feel hungry when I am not eating</td>
<td>3……….2……….1……….0</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>21) I like my empty stomach to feel empty</td>
<td>3……….2……….1……….0</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>22) I eat junk food alone in my room, so no one sees what I am eating</td>
<td>3……….2……….1……….0</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>23) I take laxatives to lose weight</td>
<td>3……….2……….1……….0</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>24) I feel fat</td>
<td>3……….2……….1……….0</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>25) I feel really bad after I eat a lot of junk food, so I think how I can get rid of what I just ate</td>
<td>3……….2……….1……….0</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>26) I eat a lot of food sometime when I am not even hungry</td>
<td>3……….2……….1……….0</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>27) I worry that if I eat, I might gain weight</td>
<td>3……….2……….1……….0</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>28) I look at food labels to see fat and calorie content</td>
<td>3……….2……….1……….0</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>29) After I eat a lot of food at one time, I try to Skip the next meal or the next two meals</td>
<td>3……….2……….1……….0</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>30) I would eat 10 candy bars at once if my parents would let me</td>
<td>3……….2……….1……….0</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>31) I sometimes sneak food</td>
<td>3……….2……….1……….0</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>32) I try not to eat foods with a lot of fat</td>
<td>3……….2……….1……….0</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>33) I look at the fat on my body and wish it was not there</td>
<td>3……….2……….1……….0</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

74
<p>| | | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>34) I eat when I feel sad.</td>
<td>3</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>35) I eat when I feel bored.</td>
<td>3</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>36) I take diuretics to lose weight.</td>
<td>3</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>37) I exercise to burn off the food I eat.</td>
<td>3</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>38) I diet like my mother or sister does.</td>
<td>3</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>39) There are some foods I would eat way too much of if I had the chance.</td>
<td>3</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>40) I think about food a lot when I’m not eating.</td>
<td>3</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>41) I drink diet soda, instead of eating meals and snacks.</td>
<td>3</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>42) I do not eat dessert (cake, ice cream, cookies) because I want to lose weight.</td>
<td>3</td>
<td>2</td>
<td>1</td>
</tr>
</tbody>
</table>

I feel that I was able to answer these questions honestly? Yes or No
APPENDIX J

SCRIPT FOR HEIGHT AND WEIGHT MEASUREMENT
INSTRUCTIONS

Height and weight will be taken individually, with shoes off, and facing away from the scale so that you will not know the measurements.

(Measuring Weight)
“Please take your shoes off and step up on the middle of the scale facing away from the scale.”

(Measuring Height)
“Please remain on the scale and make sure you stand up straight while I measure your height.”
APPENDIX K

PARENTAL NOTIFICATION OF EATING DISORDERS
Directions for Telephoning Parents

(Directions to be read for participants who exhibit dangerous eating habits)

(Parents of girls who exhibit potentially dangerous eating habits will be notified by telephone. Telephone numbers will be provided by parents when completing the consent form.)

Hello. My name is Lindsay Klyce, and I am a graduate student at Mississippi State University.

Your daughter recently participated in a project we conducted in which we were interested in developing a parent questionnaire regarding eating behaviors in preadolescents.

Your daughter endorsed some questionnaire items that we thought you should know about.

(Specific items of concern that were endorsed will then be read to the parent.)

Dr. Kevin Armstrong, my supervisor and a licensed psychologist in Mississippi, feels the best source of help for these kinds of problems is the Adolescent Medicine Clinic at Children’s Hospital which has an outpatient program for the assessment and treatment of eating disorders, 205-934-4531. If you would like to talk with Dr. Armstrong about your concerns or questions, please feel free to call him at (662) 325-7657.

(Directions to be read for participants who do not exhibit dangerous eating habits, but who did become upset while completing the forms)

Hello. My name is Lindsay Klyce, and I am a graduate student at Mississippi State University.

Your daughter recently participated in a project we conducted in which we were interested in establishing a parental questionnaire regarding eating behaviors in preadolescents.

Your daughter did not endorse dangerous eating behaviors, but did become upset while she was completing the forms and we thought you should know about it.

If you would like to talk with my supervisor, Dr. Armstrong, about any concerns or questions, please feel free to call her at (662) 325-7657.
APPENDIX L

CHILD’S PACKET COVER SHEET
Child’s ID #________________

School’s ID#_______________

Teacher’s ID#_______________
APPENDIX M

INFORMATION READ TO STUDENTS
Information that will be read to students:

Everyone please sit at a different table in the room. We want to learn about how girls your age see themselves and what they think about dieting. Your names were picked randomly. We are going to ask you some questions about how you feel about food and the way that you look. If anyone does not want to do this they don’t have to. You don’t have to answer any questions if you don’t want to. You can change your mind and stop at any time. It’s okay if you want to stop, okay?

We want you to answer the questions how they best describe you. There are no right or wrong answers, so don’t worry about getting any questions right or wrong. The right answer is how you feel about yourself. No one will know what your answers are, except for myself. The only way we would tell someone about your answers is if someone was in danger to themselves. Then we would call that girl’s parents.

Thank you for all of your help.

Read this permission slip carefully and sign your name at the bottom if you want to participate. Be sure to read the slip before signing. If you don’t understand something raise your hand and I’ll explain it to you. Don’t be scared to ask questions, some times forms are hard to understand.

(Child Assent Forms Collected) Is everyone sure they want to keep going?

Tests will be administered to the girls one at a time. Girls will be instructed to raise their hands if they need help understanding any questions. All forms will be looked at for missing information when turned in.
Information that will be read to the students during procedures:

(On the EBBIT)
Please write down how old you are where it says “age.” On the next line circle whether you are White, Black, Asian, Indian, or other. If you circle put, put your race on the line provided. Write in the grade you are in. Has everyone finished?

Here all the girls will read two randomly selected items. For any girl who has difficulty reading the items, the items will be read to her, and the examiner will circle the response.

Now I would like you to read the questions and circle the number that describes you. Rate what you do or think and not what you think is a right answer because there are no right answers.

Please raise your hand whenever you don’t understand something or if you cannot read a word or do not understand what it means. I will then come by and help you. Any questions? You may begin.

(On the Body Image Silhouettes)
First, I would like you to look at the pictures of the girls. Please circle the one that looks most like you. (Wait until everyone has done so). Now please underline the one that you would most like to look like. (If any child is having trouble she will be helped individually).
APPENDIX N

SCRIPT FOR DEBRIEFING THE PREADOLESCENT GIRLS
Debriefing

I would like to thank you again for your help. All of you have been a really big help to me, and I thank you for your time. Again, I want you to know than nothing you have written or said will be shared with anyone else except possibly your parent. Your name will be taken off everything that you have helped me with today. I want you to know that you were chosen by giving me your consent to participate, and I think all of you look great just the way you are.

If you are worried about the way you look, you should talk with your parents or the school guidance counselor.

If doing this today made you worried, concerned, or upset, you could also talk with your parents or guidance counselor. However, I want you to know that everyone is different, and being active and getting regular exercise along with eating healthy food is a good way to feel and look your best. I hope you had fun helping me.
Table 5

EBBIT Item Responses

| Subject | 1  | 2  | 3  | 4  | 5  | 6  | 7  | 8  | 9  | 10 | 11 | 12 | 13 | 14 | 15 | 16 | 17 | 18 | 19 | 20 | 21 | 22 | 23 | 24 | 25 | 26 | 27 | 28 | 29 | 30 | 31 | 32 | 33 | 34 | 35 | 36 | 37 | 38 | 39 | 40 | 41 |
|---------|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|
| 1       | 1  | 0  | 0  | 0  | 2  | 3  | 0  | 0  | 0  | 0  | 0  | 0  | 0  | 0  | 0  | 0  | 0  | 0  | 0  | 0  | 0  | 0  | 0  | 0  | 0  | 0  | 0  | 0  | 0  | 0  | 0  | 0  | 0  | 0  | 0  | 0  | 0  | 0  | 0  | 0  | 0  | 0  | 0  | 0  | 0  | 0  | 0  |
| 2       | 0  | 1  | 1  | 0  | 2  | 2  | 0  | 0  | 0  | 1  | 0  | 1  | 1  | 0  | 1  | 0  | 0  | 0  | 1  | 0  | 2  | 1  | 0  | 0  | 1  | 1  | 1  | 1  | 1  | 0  | 1  | 0  | 0  | 2  | 3  | 0  | 0  | 0  | 1  | 0  | 1  | 1  | 0  | 0  | 0  | 0  | 0  | 0  | 0  | 0  | 0  | 0  | 0  | 0  | 0  | 0  | 0  | 0  | 0  |
| 3       | 0  | 0  | 1  | 0  | 0  | 3  | 0  | 0  | 0  | 0  | 0  | 0  | 0  | 0  | 0  | 0  | 0  | 0  | 0  | 1  | 0  | 1  | 0  | 0  | 0  | 0  | 0  | 0  | 0  | 0  | 0  | 0  | 0  | 0  | 0  | 0  | 0  | 0  | 0  | 0  | 1  | 1  | 0  | 0  | 0  | 0  | 0  | 0  | 0  | 0  | 0  | 0  | 0  | 0  | 0  | 0  | 0  | 0  | 0  |
| 4       | 0  | 2  | 1  | 1  | 1  | 2  | 1  | 0  | 0  | 0  | 1  | 0  | 2  | 1  | 0  | 2  | 0  | 2  | 0  | 1  | 0  | 2  | 0  | 0  | 1  | 1  | 1  | 2  | 1  | 1  | 0  | 0  | 2  | 0  | 2  | 0  | 0  | 1  | 0  | 1  | 0  | 3  | 0  | 0  | 0  | 0  | 0  |
| 5       | 1  | 0  | 0  | 1  | 1  | 2  | 0  | 0  | 0  | 0  | 0  | 0  | 0  | 1  | 0  | 0  | 0  | 1  | 0  | 1  | 0  | 0  | 1  | 1  | 0  | 0  | 1  | 1  | 0  | 1  | 0  | 0  | 1  | 3  | 1  | 0  | 1  | 0  | 0  | 1  | 0  | 0  | 0  | 0  | 0  | 0  | 0  |
| 6       | 1  | 1  | 0  | 1  | 1  | 1  | 0  | 0  | 1  | 0  | 1  | 0  | 1  | 0  | 1  | 0  | 0  | 0  | 0  | 0  | 1  | 0  | 0  | 0  | 1  | 0  | 0  | 1  | 1  | 0  | 0  | 0  | 2  | 1  | 0  | 1  | 0  | 1  | 0  | 0  | 0  | 2  | 0  | 0  | 0  | 0  | 0  |
| 7       | 1  | 0  | 2  | 0  | 1  | 0  | 1  | 1  | 0  | 0  | 0  | 0  | 1  | 1  | 0  | 1  | 1  | 0  | 1  | 0  | 1  | 0  | 1  | 0  | 0  | 1  | 0  | 0  | 0  | 0  | 0  | 0  | 1  | 0  | 1  | 0  | 1  | 0  | 1  | 0  | 0  | 0  | 0  | 0  | 0  | 0  | 0  |
| 8       | 0  | 0  | 0  | 0  | 0  | 0  | 0  | 1  | 0  | 0  | 0  | 0  | 0  | 2  | 0  | 0  | 0  | 0  | 2  | 0  | 1  | 0  | 0  | 0  | 0  | 2  | 0  | 0  | 0  | 0  | 0  | 0  | 1  | 0  | 0  | 0  | 0  | 0  | 0  | 0  | 0  | 0  | 0  | 1  | 0  | 1  | 0  |
| 9       | 1  | 0  | 0  | 0  | 0  | 0  | 1  | 0  | 0  | 0  | 0  | 0  | 0  | 1  | 1  | 0  | 1  | 0  | 1  | 1  | 0  | 0  | 0  | 0  | 0  | 0  | 1  | 1  | 1  | 0  | 0  | 1  | 0  | 1  | 0  | 0  | 1  | 1  | 0  | 0  | 0  | 0  | 0  | 0  | 0  | 0  | 0  |
| 10      | 1  | 0  | 0  | 0  | 0  | 0  | 0  | 0  | 0  | 0  | 0  | 0  | 0  | 0  | 0  | 0  | 0  | 0  | 0  | 0  | 0  | 0  | 0  | 0  | 0  | 0  | 0  | 0  | 0  | 0  | 0  | 0  | 0  | 1  | 0  | 0  | 0  | 1  | 0  | 0  | 0  | 1  | 0  | 0  | 0  | 0  | 0  |

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APPENDIX P

PEBBIT RESPONSES
## Table 6

**PEBBIT Item Responses**

| Item # | 1   | 2   | 3   | 4   | 5   | 6   | 7   | 8   | 9   | 10  | 11  | 12  | 13  | 14  | 15  | 16  | 17  | 18  | 19  | 20  | 21  | 22  | 23  | 24  | 25  | 26  | 27  | 28  | 29  | 30  | 31  | 32  | 33  | 34  | 35  | 36  | 37  | 38  | 39  | 40  | 41  |
|--------|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|
| 1      | 0   | 0   | 0   | 0   | 0   | 0   | 2   | 0   | 0   | 0   | 0   | 0   | 0   | 0   | 0   | 0   | 0   | 0   | 0   | 0   | 0   | 0   | 0   | 0   | 0   | 0   | 0   | 0   | 0   | 1   | 0   | 0   | 0   | 0   | 0   | 0   | 1   | 0   | 0   | 0   | 0   | 0   |
| 2      | 0   | 1   | 1   | 1   | 1   | 0   | 0   | 1   | 0   | 1   | 0   | 0   | 0   | 0   | 1   | 0   | 0   | 0   | 1   | 1   | 1   | 0   | 1   | 0   | 0   | 1   | 0   | 1   | 0   | 0   | 2   | 0   | 0   | 0   | 2   | 1   | 0   | 0   | 0   | 0   | 0   | 0   |
| 3      | 0   | 0   | 1   | 1   | 0   | 0   | 0   | 0   | 0   | 0   | 0   | 0   | 0   | 0   | 0   | 0   | 0   | 0   | 0   | 0   | 0   | 0   | 1   | 0   | 0   | 0   | 0   | 0   | 0   | 0   | 0   | 0   | 0   | 0   | 0   | 0   | 0   | 0   | 0   | 0   | 0   | 0   |
| 4      | 0   | X   | 1   | 1   | 0   | 0   | 0   | 0   | 1   | 1   | 0   | 0   | 0   | 0   | 0   | 0   | 0   | 1   | 0   | 0   | 0   | 0   | 0   | 0   | 0   | 0   | 0   | 0   | 1   | 0   | 0   | 0   | 0   | 0   | 0   | 0   | 0   | 0   | 0   | 0   | 0   | 0   |
| 5      | 0   | 1   | 1   | 0   | 1   | 0   | 0   | 1   | 0   | 1   | 1   | 0   | 0   | 0   | 0   | 0   | 0   | 1   | 0   | 1   | 0   | 0   | 0   | 0   | 0   | 0   | 0   | 0   | 1   | 1   | 1   | 1   | 0   | 0   | 0   | 0   | 0   | 0   | 0   | 0   | 0   | 0   |
| 6      | 0   | 2   | 0   | 0   | 0   | 1   | 0   | 0   | 2   | 2   | 2   | 0   | 0   | 0   | 0   | 1   | 0   | 0   | 0   | 1   | 0   | 1   | 1   | 0   | 0   | 1   | 1   | 0   | 0   | 1   | 0   | 0   | 0   | 0   | 0   | 0   | 0   | 0   | 0   | 0   | 0   | 0   |
| 7      | 0   | 1   | 1   | 1   | 1   | 0   | 0   | 0   | 0   | 0   | 0   | 3   | 1   | 1   | 0   | 0   | 0   | 0   | 1   | 0   | 0   | 0   | 1   | 0   | 0   | 0   | 1   | 0   | 0   | 0   | 0   | 1   | 0   | 3   | 0   | 2   | 1   | 1   | 0   | 0   | 0   | 0   |
| 8      | 0   | 1   | 1   | 0   | 0   | 0   | 0   | 0   | 0   | 0   | 0   | 3   | 1   | 0   | 0   | 0   | 2   | 0   | 0   | 1   | 0   | 0   | 0   | 1   | 0   | 0   | 0   | 0   | 0   | 0   | 0   | 0   | 0   | 0   | 0   | 2   | 1   | 1   | 0   | 0   | 0   | 0   |
| 9      | 0   | 0   | 2   | 1   | 0   | 0   | 0   | 0   | 0   | 0   | 0   | 1   | 0   | 0   | 1   | 0   | 0   | 2   | 0   | 0   | 0   | 0   | 0   | 0   | 0   | 0   | 1   | 0   | 0   | 0   | 0   | 0   | 0   | 1   | 0   | 2   | 0   | 0   | 0   | 0   | 0   | 0   |
| 10     | 0   | 0   | 1   | 2   | 0   | 0   | 0   | 0   | 0   | 0   | 0   | 1   | 0   | 0   | 1   | 0   | 0   | 0   | 1   | 0   | 0   | 0   | 1   | 1   | 1   | 1   | 0   | 0   | 0   | 0   | 0   | 0   | 2   | 1   | 0   | 0   | 0   | 0   | 0   | 0   | 0   | 0   |

*Note:* The table contains responses from different subjects to the PEBBIT items.
APPENDIX Q

HUMAN SUBJECTS INSTITUTIONAL REVIEW

BOARD APPROVAL LETTER
March 2, 2007

Lindsay Kyoe
SB17 Savannah Place
Birmingham, AL 35215

RE: Regarding study number 05-178: Developing a Parental Questionnaire for Eating Disorders in Pre-adolescents

Dear Ms. Kyoe,

Your request for approval of the new study listed above was reviewed at the 8/19/2005 meeting of the Mississippi State University Institutional Review Board.

This is to confirm that your application was approved. The protocol is approved through 6/1/2007.

You are granted permission to conduct your study as described in your application effective immediately. This study is subject to continuing review at least 6/1/2007, unless closed before that date.

Please note that any changes to the study as approved must be promptly reported and approved. Some changes may be approved by expedited review, others require full board review. Contact Christine Williams (cwilliams@research.msstate.edu or by phone at 662-325-0700) if you have any questions or require further information.

Sincerely,

[Please with electronic submissions]

Christine Williams
IRB Administrator

cc: Kevin Armstrong