THE UNIVERSITY OF MANITOBA

Blending a Feminist Perspective with a Cognitive Behavioural Approach to the Treatment of Eating Disorders.

by Kym S. Cuthill

A Practicum Report
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DEDICATION

This practicum report is dedicated to my family - my mother, Gabriele Cuthill; my father, the late James Richard (Dick) Cuthill; and my brother, Tom Cuthill. I could not have struggled through the experience of graduate studies without their support.

Mom - you provided me with much encouragement, love and yes, well needed financial help! Tom - you provided me with an "academic" role model, your love and acceptance, and ongoing support and encouragement. Thanks to both of you, from the heart.

Dad - I know you would be proud!

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INTRODUCTION

Rationale

The purpose of this practicum was to provide individual focused treatment to women who were experiencing eating disorders. The student undertook the task of blending current theory about eating disorders as provided by the literature in the field(s) with the opportunity to explore the existing treatment being offered through the Health Sciences Centre Eating Disorders Clinic. The author brought a feminist, philosophical practice base to this experience. Exploring the fit between a feminist orientation and the use of a cognitive-behavioural treatment strategy made for rich learning.

The practicum offered the challenge of exploring a contemporary, complex phenomenon. It is the author's hope that this report will do justice to the complexity of issues. This report will outline the present state of knowledge. As such, it will be impossible not to highlight confusion and a multitude of diverse opinions on the etiology, understanding and treatment of eating disorders. It has been through exploration, openness and, most of all, through communicating with other women (both clients and other practitioners) that the author has developed understanding in this area.

The author's motivation to explore this area is both

professional and personal. It was felt that there is a significant need for developing research and treatment resources in this area. Social Work, as a profession, is generally sadly lacking knowledge in regard to eating disorders, and therefore our ability to deal with people who have an eating disorder is limited. Anorexia Nervosa or Bulimia Nervosa, as part of a client's profile, currently is often undetected. Neglecting to recognize signs of eating disorders among clients may result in many detrimental effects. Certainly, clients who battle eating disorders put themselves in positions of compromised health. Many long-term physiological effects are associated with Anorexia Nervosa and Bulimia Nervosa (hereinafter referred to as AN&BN). Cardiovascular, gastrointestinal, dental, skeletal, endocrine and reproductive systems may be damaged as a result of bulimic behaviours or self-starvation. Self-destructive practices such as excessive exercising, or various obsessional behaviours can be debilitating over the long run. A psychological toll on the individual is inevitable.

There is evidence that eating disorders are increasing among the general population. A recent statistic for the propensity of eating disorders is as follows: "In a Canadian study, 22.3% of female students and 5.7% of male students ages 12 to 20 scored in the anorexic range according to the Eating Attitudes Test (EAT)." (Leichner, 1985) This is thought to be a conservative estimate and does not comment on the 20-year and above

population. The incidence of Bulimia Nervosa within selected populations, "in both college and high school women has been estimated to be approximately 4% (Pyle et al, 1983), and it has been reported as common in community-based samples (Cooper and Fairburn, 1983; Fairburn and Cooper, 1982)." (Garner et al., 1984, p. 513) In 1985, Pierre Leichner cautioned that epidemic-like increases were being seen in relation to eating disorders. (Leichner, 1985) Many authors have recently commented that AN&BN are no longer conditions related to the upper class female adolescent (which was thought to be the demographic profile in the early 1970's) and that there has been a steady increase in the prevalence of eating disorders. (Leichner, 1985; Hotelling, 1987; Garner, Olmsted and Polivy, 1983; Bruch, 1982)

The nature of these disorders (particular Bulimia Nervosa) includes a secretive component known only to the affected person, and therefore the estimates of a clinical population are difficult to make. Lastly, it should be noted that some individuals with eating disorders will die as a result of starvation, other self-abusive practices or through suicide. It is the author's contention that we are facing a serious and increasing problem which the Social Work profession is compelled to address. It will further be argued that the socio-cultural context of our western society perpetuates women's struggle with body image, self-esteem and identity and therefore is presently putting women at large

risk for developing eating disorders. Until we see significant changes occurring at a societal level, we will most likely see an increase in numbers.

Social workers have an important role to play in this area - either as members of a treatment team, as private practitioners, or as educators. Social workers' expertise in recognizing systemic dynamics (on a familial and cultural level) puts the profession in a key position for early detection and primary intervention. We can offer valuable treatment, particularly where treatment is scarce or non-existent. Social workers are in a position of bringing alternate, or multidisciplinary approaches to the treatment of eating disorders. According to Nancy Mintz:

> Social workers can also provide an important preventative service by educating such potential target groups as high school and college classes about Bulimia Nervosa (and Anorexia Nervosa). Social workers employed in hospitals can provide this service to departments of pediatrics or medicine. Educating teachers and health care providers about the syndrome and about society's attitudes towards it would help promote early detection. Thus, the social worker has a major role to play on the treatment team dealing with the prevention and treatment of Bulimia Nervosa (and Anorexia Nervosa) and with educational efforts concerning the disorder/s. (Mintz, 1985, p.118)

Other authors, such as Hedblom, Hubbard and Anderson (1987) have outlined in detail the role of the social worker as a member of a multidisciplinary hospital-based team which is involved in the treatment of eating disorder patients for family members. Hedblom et al identify, outline, and clarify four stages of treatment which involve a specialized function from Social

Work. They begin with describing: 1) the treatment of starvation, and follow with: 2) psychotherapy, 3) return of controls to patients, and 4) planning and implementing follow-up. Details of the three sets of professional functions (nursing, medicine, and social work) are outlined in Appendix A.

Manitoba currently lacks treatment resources for the increasing numbers of people who are struggling with eating disorders. Often treatment is available only to those who reach a life threatening stage and thus can be hospitalized. Admission into hospital may occur on a voluntary or non-voluntary basis.

Winnipeg's Health Sciences Centre is generally considered a forerunner in the treatment of eating disorders, having the only established Eating Disorders Clinic in Manitoba. The Clinic is currently reporting a waiting list of six to twelve months for outpatient treatment. The inpatient unit is small and specialized for individuals who have developed entrenched, maladaptive lifestyles and who require hospitalization to be stabilized physiologically. The inpatient unit is also used for patients who live outside of Winnipeg. In addition, those clients who are unable to make changes as an outpatient are often recommended inpatient treatment. The Clinic reports ongoing funding difficulties and frustrations with their inability to provide adequate post-hospital follow-up and outpatient treatment in general.

The other forms of service available are ad hoc and function

independently of each other. A body of women, their family members and professionals came together to form the Winnipeg Chapter of the Anorexia Nervosa and Bulimia Foundation. In part, they were attempting to bridge the gap between services (such as the Health Sciences Centre and the Women's Health Clinic) and to bring concerned families and professionals together. Many family members have voiced their frustration with the lack of resources available and with the difficulty connecting with existing resources. Furthermore, individuals and family members alike have reported being ill-advised by professionals. It is the author's observation that people seeking treatment for these conditions often have to deteriorate to the point of physical or emotional crisis before they can access hospital service.

A handful of private counsellors, with various backgrounds (psychiatric, psychological, social work, and others) have begun to address this need. They are providing counselling which is fee based. Costs may range anywhere from $35.00/hour up to $100.00/hour or more. Some practitioners offer a sliding scale. There are many individuals and families who are not in a financial position to afford this treatment. People who have eating disorders are obviously going without counselling, are confused about where to turn, and those who are fortunate enough to access service will often deteriorate in the long waiting list periods before counselling begins.

The mental health system is presently struggling to identify, understand, and treat individuals who have eating disorders. Through the author's work with the Anorexia Nervosa and Bulimia Foundation, an appreciation was developed for the need to educate professionals and lay people alike as to the seriousness of the problem. The demographic profile of persons with AN&BN behaviour is now expanding to include those who are from a broader socioeconomic background, younger and older persons as well as to include both sexes.

Although the author's focus was with individual counselling, it is recognized that work at a broader societal level is necessary to address various macro social issues impacting on women. Current attitudes toward women emphasize and direct attention to their bodies and size. The pursuit of beauty is encouraged and equated with slenderness. We need to ease the contemporary madness towards the unhealthy emphasis on thinness. However, simultaneous efforts at counselling the individual woman are necessary, for it is these many individuals who have succumbed to the destructive messages present in our society.

Aims and Educational Benefits

The author's aims in providing a blended treatment strategy in this practicum were as follows:

1. To provide individual treatment to women experiencing eating

disorders. Individual counselling was employed, with provisions for participation in adjunctive services (such as family therapy, couple counselling or participation in a support group).

2. The author conceptualized AN&BN on a continuum, therefore treatment was offered to women who were at different points on the continuum. Women ranged from being "self identified" as having an eating disorder to those who more closely matched a psychiatric definition of the problem. (Chapter III of this report will outline and define the specific criteria employed for the selection of clients and assessment procedures.)
3. To experiment with blending cognitive-behavioural therapy with a feminist approach. To use cognitive-behavioural therapy in an effort to experience its strengths and weaknesses in the treatment of AN&BN.
4. To learn to provide (as part of a package) a behavioural focus, to assist women with making changes in eating and dieting related obsessions.
5. To evaluate the clinical effectiveness of using this blended treatment strategy.

The educational benefits of participating in this exercise were as follows:

1. Refining counselling skills in the assessment and treatment of

individuals.

2. Providing the task of blending two orientations (theoretically and practically). Learning about the fit between a feminist approach in counselling and employing cognitive-behavioural therapy/interventions.
3. Increasing knowledge about eating disorders. Specifically, learning further about understanding (theoretical frame-works) as well as assessment (models and approaches) and lastly, the varied techniques and interventions currently being practiced by other disciplines.
4. Developing a planned and systematic intervention with an effort to define an approach for a professionally accountable intervention in the treatment of eating disorders.
5. Sharing knowledge and practice as a member of a health care team to learn about and practice an integrated approach to the problem. To learn more about the treatment of the physiological effects associated with eating disorders.
6. Reporting and sharing findings in an effort to add to Social Work's knowledge of the treatment available for eating disorders.

Description of Setting

The site of the practicum experience was the Eating Disorders Clinic at the Health Sciences Centre in Winnipeg,

Manitoba. The author was the second graduate Social Work student to enter this setting in a four year period. A nine-month placement from November, 1988 to August, 1989 was negotiated with Daryl Johnston, Clinic Coordinator and nurse therapist. (See Appendix B for a detailed copy of the practicum agreement.)

The Eating Disorders Clinic offers both inpatient and out-patient treatment. The inpatient unit houses eight beds which are devoted to eating disorders patients. The ward can accommodate patients as young as 14 years, although it is felt the ward is more suitable to older teenagers and adults. The ward is separate from and borders an adult psychiatric ward.

All staff have received specialized training in the treatment of eating disorders. A concerted effort was given to using a multidisciplinary team approach to treatment. Professionals involved (in a direct consultative fashion) included occupational therapy, physiotherapy, psychology, social work, dieticians, medicine, and nursing. Although it is beyond the scope of this report to describe the inpatient treatment program in comprehensive detail, there are certain features which are useful to highlight. It was a useful exercise as part of the student's orientation to the Clinic to observe and learn about the inpatient program. This provided an understanding as to how the eating disorders program functioned in its entirety.

The inpatient program focuses largely on the nutritional and

physiological rehabilitation of the eating disorders patient. As such, there are behavioural strategies employed in order to assist individuals in stabilizing their weight and health. Along with the attention given to a patient's physical status, the patient is given the opportunity to receive individual and group therapy. The duration of treatment for an individual depends largely on their success in reestablishing healthy eating patterns and a stabilized weight. Patients are offered follow up services through the outpatient psychiatry department after their hospital discharge. In order to provide continuity in care, the professional who is to provide follow up is involved with inpatient treatment.

All patients with eating disorders are originally assessed through the Eating Disorders Outpatient Clinic. If inpatient treatment is recommended, then it is the professional who was involved with this assessment phase that is required to prepare the individual for their hospital stay. At the time of assessment, the patient may be presented with either a recommendation for outpatient counselling, inpatient treatment or perhaps referral to a more appropriate community resource.

The outpatient Eating Disorders Clinic was the main site of the student's practicum involvement. The outpatient clinic consists of a coordinator, two part-time psychiatrists, a nurse clinician and students (such as psychiatry residents, nursing students and the author). The outpatient department functions as a screening facility for inpatient treatment, but mainly

provides outpatient treatment. Weekly assessments are scheduled for individuals who may possibly require inpatient treatment (higher priority referrals) as well as individuals who have been put on a waiting list, in probable need of outpatient counselling.

The clinic also provides a valuable service to a variety of professionals who refer patients for assessment. At the time of the student's placement, consultations and treatment recommendations were given to other psychiatrists, medical doctors, private counsellors, school counsellors, and in one case, prison officials. Many other professionals consulted the clinic either for treatment recommendations or for direct referral to the clinic. The clinic is seen to provide a valuable educative component to the community.

The outpatient staff were also intricately involved with the inpatient team as indicated earlier. Patients were often seen in an effort to avoid hospitalization. Patients were assessed on intake and placed, where appropriate, on the outpatient waiting list. At the time of the student's practicum experience, the waiting list of potential patients spanned one year in the future. This was an obvious source of frustration for patients and clinic staff. This also carried several implications for the clinic as a whole. Judging and priorizing patients' needs was a constant necessity. The resource climate (i.e. the absence of other resources in the province) made preventative efforts virtually impossible.

Working Definitions

It is important to outline the definitions of eating disorders that will be used throughout this report in order to provide clarity. The writer chose the DSM IIIR definitions of Anorexia Nervosa and Bulimia Nervosa because they were easy to understand and they were a natural outcome of assessment in a psychiatric setting. They are as follows:

> **Anorexia Nervosa**
> The essential features of this disorder are: refusal to maintain body weight over a minimal normal body weight over a minimal normal weight for age and height; intense fear of gaining weight or becoming fat, even though underweight; a distorted body image; and amenorrhea (in females). (The term anorexia is a misnomer since loss of appetite is rare.)
>
> The disturbance in body image is manifested by the way in which the person's body weight, size, or shape is experienced. People with this disorder say they "feel fat", or that parts of their body are "fat", when they are obviously underweight or even emaciated. They are preoccupied with their body size and usually dissatisfied with some feature of their physical appearance.
>
> The weight loss is usually accomplished by a reduction in total food intake, often with extensive exercising. Frequently there is also self-induced vomiting or use of laxatives or diuretics. (In such cases Bulimia Nervosa may also be present.)
>
> The person usually comes to professional attention when weight loss (or failure to gain expected weight) is marked. An example is weighing less than 85% of expected weight (85% is provided as an arbitrary but useful guide). By the time the person is profoundly underweight, there are other signs, such as hypothermia, bradycardia, hypotension, edema, lanugo (neonatal-like hair), and a variety of metabolic changes. In most cases amenorrhea follows weight loss, but it is not unusual for amenorrhea to appear before noticeable weight loss has occurred.

Diagnostic Criteria for Anorexia Nervosa

A. Refusal to maintain body weight over a minimal normal weight for age and height, e.g. weight loss leading to maintenance of body weight 15% below that expected; or failure to make expected weight gain during period of growth, leading to body weight 15% below that expected.
B. Intense fear of gaining weight or becoming fat, even though underweight.
C. Disturbance in the way in which one's body weight, size, or shape is experienced, e.g. the person claims to "feel fat" even when emaciated, believes that one area of the body is "too fat" even when obviously underweight.
D. In females, absence of at least three consecutive menstrual cycles when otherwise expected to occur (primary or secondary amenorrhea). (A woman is considered to have amenorrhea if her periods occur only following hormone, e.g. estrogen, administration.)

Bulimia Nervosa

The essential features of this disorder are: recurrent episodic binge eating (rapid consumption of a large amount of food in a discrete period of time); a feeling of lack of control over eating behavior during the eating binges; self-induced vomiting, use of laxatives or diuretics, strict dieting or fasting, or vigorous exercise in order to prevent weight gain; and persistent overconcern with body shape and weight. In order to qualify for the diagnosis, the person must have had, on average, a minimum of two binge eating episodes a week for at least three months.

Eating binges may be planned. The food consumed during a binge often has a high caloric count, a sweet taste, and a texture that facilitates rapid eating. The food is usually eaten as inconspicuously as possible, or secretly. The food is usually gobbled down quite rapidly, with little chewing. Once eating has begun, additional food may be sought to continue the binge. A binge is usually terminated by abdominal discomfort, sleep, social interruption, or induced vomiting. Vomiting decreases the physical pain or abdominal distention, allowing either continued eating or termination of the binge, and often reduces post-binge anguish. In some cases vomiting may itself be desired, so that the person will binge in order to vomit, or will vomit after eating a small amount of food. Although eating binges may be pleasurable, disparaging self-

criticism and a depressed mood often follow.

People with Bulimia Nervosa invariably exhibit great concern about their weight and make repeated attempts to control it by dieting, vomiting, or the use of cathartics or diuretics. Frequent weight fluctuations due to alternating binges and fasts are common. Often these people feel that their life is dominated by conflicts about eating.

Diagnostic Criteria for Bulimia Nervosa

A. Recurrent episodes of binge eating (rapid consumption of a large amount of food in a discrete period of time).
B. A feeling of lack of control over eating behavior during the eating binges.
C. The person regularly engages in either self-induced vomiting, use of laxatives or diuretics, strict dieting or fasting, or vigorous exercise in order to prevent weight gain.
D. A minimum average of two binge eating episodes a week for at least three months.
E. Persistent overconcern with body shape and weight. (DSM IIIR, 1987, pp. 65-69)

Although the DSM IIIR classifications are widely used, there are obvious limitations with the DSM IIIR definitions. Clinicians differ in their use of the labels Anorexia Nervosa and Bulimia Nervosa. Confusion remains regarding the criteria for eating disorders. How the criterion is being applied for practitioners is largely a function of what terminology they adopt.

Nancy Mintz discusses this dilemma and offers a descriptive approach to Bulimia Nervosa as her resolution to the present day confusion with terminology (Mintz, 1985). She identifies factors that have added to our confusion:

> . . . first there have been varying points of view about nosology - whether Bulimia should be considered a separate eating disorder from Anorexia Nervosa - and much is still unknown about the etiology of Bulimia. Second, the disorder has been referred to by a

> bewildering variety of terms, including "bulimia nervosa", "bulimarexia", "dysorexia", "dietary chaos syndrome", and "the binge/purge syndrome". It is not unusual to hear participants at eating disorder conferences voice confusion about the differences among the binge/purge syndrome, bulimarexia, bulimia, and Anorexia Nervosa. (Mintz, 1985, p. 113)

This dilemma has led to the use of a further category in the DSM IIIR - "Eating Disorders Not Otherwise Classified". It was the author's experience that this label was widely used to deal with the difficulties in describing a patient as either "anorexic" or "bulimic". The difficulties with diagnosis will further be elaborated on in section three of this report.

LITERATURE REVIEW

In researching the literature available in the area of eating disorders, it became apparent that although this is a relatively new field of inquiry, there is already a vast amount of material available on the subject.

It appears as though there are seven separate conceptualizations. I have coined the seven perspectives as follows: A traditional (medical-historical) perspective, a medical-psychoanalytic perspective (contributions from Dr. Hilde Bruch), a psychotherapeutic approach to understanding and treatment (Dr. Steven Levenkron), recent medical contributions, a family-systems orientation, a feminist perspective and recent multi-dimensional approaches. I will begin by introducing each perspective and commenting generally on their frame of reference. I will then elaborate on each of the seven sections by highlighting what is thought to be the source of the condition and what, therefore, is the preferred therapeutic modality. Comments on the anticipated outcome of treatment will then follow. Criticisms by competing viewpoints will be offered in order to conclude each section.

There were what may be referred to as "traditionalists" - those who understood the struggles of women with Anorexia or Bulimia as a neurosis, a phobia or perhaps an obsessive compulsive personality trait. They saw the source of the

condition in the personality of the individual. The interpretations appear steeped in the psychoanalytic tradition. Often this literature discussed the importance of examining "transference issues" in psychotherapy as well as aiming to assist the individual develop their "ego strength". The predictions for success in this therapy were reported as dismally low.

Next, there were members of the medical community which offered explanations of women with eating disorders in the context of their health. They saw the source of the condition in the physiological state of the body. The interrelationship between starvation (for example) and the psychological state of the individual was stressed. Often a behaviourist orientation was offered as the therapy of choice - emphasis being on the physical restoration of health for the individual.

The feminist stance, on the other hand, would frequently utilize an historical framework. Hence, the source of the condition was seen as the sociocultural environment, which the individual is part of. Political and sociocultural explanations are offered as theoretical rationale for the present explosion of eating disorders. Feminists have examined the conceptualizations of other perspectives and have been very critical of treatment modalities which are described as misunderstanding or basically mistreating women. Eating disorders were predominantly viewed on a continuum (i.e. occasional dieter, chronic dieter, bulimic or anorexic). Furthermore, the symptoms of AN&BN were almost

always reframed as understandable expressions of rebellion - effort on behalf of females to control their own bodies.

Family systems therapists offered a focus on the context of the family. The family system was thought to be the source of the condition. Indeed, the family was thought to provide the genesis of pathology for the individual. Interactional difficulties as well as role confusion, enmeshment and the effect of dysfunctional family life in general, are seen as the precursors for AN&BN.

Lastly, recent literature speaks of a preference towards multidimensional assessment and multimodal treatment approaches. The challenge of assessment becomes to integrate more than one understanding of the etiology of eating disorders. Treatment, deliberately, is openly custom fit to the individual and can incorporate a blend of individual, marital, family or group psychotherapy (for example).

Research in this area appears to be at an infancy stage, or more precisely at a theory generation stage. There are a multitude of perspectives seen in the literature. Knowledge is evolving as each area develops further. It appears that little is known about the success of treatment. Clinicians continually experiment with varying approaches. The literature will now be examined by reviewing what is known about each perspective.

Traditional Perspective (A History of Understanding)

The literature makes references to the condition of Anorexia Nervosa (also referred to as AN in this paper) having been known (to medicine) for centuries. Strober makes reference to the physician Bucoldianus describing cases of Anorexia in 1542 (Strober, 1986). Bruch refers back as far as 1888 with the description of Anorexia by Gull (Bruch, 1978). Gull is credited with coining the term "Anorexia Nervosa" (literally translated to mean, "nervous lack of appetite"). Both Gull and another physician, Lasegue, began recognizing the condition more frequently in females than in males. They also documented the onset of Anorexia as characteristically occurring around adolescence.

Modern western society began re-identifying and attempting to treat Anorexia around the 1940's and 1950's. Following the advent of psychology as a distinct discipline this would mean that the mainstream psychoanalytic tradition of the day would be reflected in the understanding and treatment of Anorexia. "In keeping with the basic tenets of psychoanalytic understanding, various writers espoused the view that Anorexia Nervosa was symbolic of fixated unconscious conflicts relating to oral-sadistic fears, oral impregnation, and other regressive wishes and primitive fantasies" (Strober, 1986, p. 236).

Freud's drive theory and his development of the id, ego and

superego concepts became the backdrop of explaining the self-imposed starvation and other various rituals associated with Anorexia Nervosa. Freudian psychoanalysts postulated that the individual was fixated at the "oral" stage of personality development and would require years of psychotherapy to progress. Transference issues were examined during therapy, as well as mother-child interactions during the patient's childhood. Although the psychoanalysts were curious, their interest and willingness to treat this new phenomenon was often met with dismally poor results.

The Medical-Psychoanalytic Model: Dr. Hilde Bruch

Then along came a woman who was soon to become a pioneer in this field - Dr. Hilde Bruch. Her frustrations with the ineffectiveness of traditional analysis led her to change the emphasis and approaches to this problem. Her early work (1960's) advanced the understanding of Anorexia remarkably. She described the demographic profile of Anorexia and attributed psycho-sociological factors to its existence (Bruch, 1978). Through her countless hours of experience, she learned that the client needed therapy that would focus on helping them build a stronger sense of self. She theorized that Anorexia developed in individuals who otherwise were dealing with a paralyzing sense of ineffectiveness. She understood that the inability of these women

to be insight-oriented was due to their lack of recognition of their own needs and feelings.

Dr. Bruch also suggested the importance of the patient exerting their own independence. She warned against duplicating previous relationships where the experience of the client was one where they were encouraged to be dependent on the therapist. The "expert" should avoid using their position to tell the client how to feel, or what decisions to make in their lives, for example. Bruch recommended strongly that the anorexic patient become an active participant in the treatment process:

> . . . treatment with traditional psychoanalysis was rather ineffective in true Anorexia Nervosa. This observation was made on my own patients and on numerous others who had been in analysis with someone else and for whom consultation was requested because their progress was unsatisfactory. Similar difficulties were reported by others. To them the traditional psychoanalytic setting represents a factual reexperience of the transactional patterns that have pervaded their whole lives, namely, that somebody else knew what they felt but they themselves did not know or feel it. (Bruch, 1982)

Bruch described the adolescent anorexic as a child who was totally unprepared to move psychologically beyond her immediate family. The families of such children she described as middle to upper class and as appearing "normal" to the outside world. However, to Bruch the clinician, these same families appeared to demonstrate many psychological disturbances. They were often preoccupied with appearances and held extremely high expectations for their children. They had come to expect obedience from

their daughters and often had set unrealistic goals for them to achieve.

It appeared that Bruch was also able to bring her medical background to psychology and the understanding of eating disorders in a way that had not yet been achieved. She outlined the psychological effects of starvation and highlighted the interplay between the mind and body. Her treatment strategy incorporated the goal of reestablishing normal nutrition while engaging an individual in examining her life through therapy. The therapeutic task changed from examining the oral stage of development (the traditional approach) to examining the individual's difficulty and confusion with "hunger awareness".

If or when a patient's childhood was scrutinized Bruch would look at the same parent/child interaction, particularly around feeding. She found in scrutinizing these relationships, that she sometimes could uncover the beginnings of eating difficulties for the individual. This would be the case where a child's emotional needs were being inappropriately met with food. Hence, from a young age, a child learned confusion regarding hunger, satiation and the meeting of emotional needs. Bruch recommended family therapy only where present day conflicts were attributed to a person's ill health. She was generally skeptical about short-term miraculous recovery, whether preferred by family therapists or behaviourists.

All in all, Bruch made a tremendous impact on the under-

standing and treatment of eating disorders. Her work spanned an unprecedented half a century. She was writing the foreward to the Handbook of Eating Disorders - Physiology, Psychology and Treatment of Obesity, Anorexia and Bulimia when she died in December of 1984. Albert Stunkard reflects on her contributions in the following quote:

> Angry, questioning, probing, she scorned both the endocrinologists and the psychoanalysts (who weren't speaking to one another). She was adamant: If we knew so much about eating disorders, why couldn't we treat them? She was particularly incensed over the established views on Anorexia Nervosa. At that time, the established view was that Anorexia Nervosa was caused by unconscious fears of oral impregnation, a theory that was proving better suited to explain therapeutic failure than to contribute to successful treatment. Bruch dismissed it as "gobbledygook" and wasn't afraid to say so. Perhaps it was this lack of reverence for the established views that enabled her to see for the first time what has now become so obvious: the critical role of what she was to call "the relentless pursuit of thinness". (Brownell and Foreyt, 1986)

Bruch has written extensively and her valuable experience and impact in this field can not be underestimated.

Psychotherapy

In the 1970's, Steven Levenkron (a psychologist) impacted on this field in several ways. He appeared to be the first to identify previously vague, or a limited set of psychological symptoms. He also created a social awareness of Anorexia by writing The Best Little Girl in the World (Levenkron, 1978).

This soon became a handy pocketbook for professionals and laypersons alike. He reported 12 psychological symptoms associated with AN. According to Levenkron, they are as follows:

> 1) phobias concerning bodily appearance, 2) obsessional thinking, 3) obsessive-compulsive rituals, 4) feelings of inferiority, 5) splitting or perceiving decisions and consequences in terms of polarities, 6) passive aggressive behaviour, 7) disinterest in sexuality; (a) general immaturity (b) fear of intimacy (physical/ emotional), 8) delusional thinking, 9) paranoid fears, 10) depression, 11) anxiety, and 12) denial. (Levenkron, 1982)

Levenkron also made revisions to the terms of reference for the clinical diagnosis of Anorexia, which stressed the physical complications of self starvation. He offered a profile of the "typical anorexic", which was a combination of features seen in his treated patients over the years. This profile mirrored the thinking of the day (i.e. Anorexia as an affliction of adolescent girls raised in upper middle class homes, etc.). He estimated that Anorexia was affecting 3% of the female population, that there was a 7:1 female/male ratio, and that there was a 10 to 15 percent mortality rate associated with Anorexia. (Levenkron, 1982)

In his book, Treating and Overcoming Anorexia Nervosa, Levenkron proffered a "nurturant-authoritative" stance in psychotherapy with the anorexic individual. Once again we see variations and deviations from traditional Freudian psychoanalysis being recommended. The "NA" stance is described as a

directive, yet non-threatening approach. The therapy gently urges the patient to confront their difficulties. Denial is examined and the patient is encouraged to share their emptiness, disappointment and feelings of low self-esteem. Although Levenkron is a major proponent of individual, long-term psychotherapy, he also recognized the need for (and importance of) family therapy, or at the very least the need for offering supportive group therapy for parents of anorexics (see Appendix C and D).

Medical Contributions

The medical community can be credited with advancing our understanding of the physiological effects of eating disorders as well as for the categorization and differentiation between various forms of eating disorders. Medical contributions to the field coincided with therapists' attempts to publish their clinical findings.

It is beyond the scope of this discussion to present the intricate findings of the medical field. It will be more purposeful to examine the specific findings which have influenced our clinical understanding and which have implications for the treatment of eating disorders.

To begin with, it is important to distinguish between primary AN and Anorexia which may accompany other mental illness.

According to the Diagnostic and Statistical Manual of Mental Disorders (3rd edition revised):

> In **Depressive Disorders**, and **certain physical disorders**, weight loss can occur, but there is no disturbance of body image or intense fear of obesity. In **Schizophrenia**, there may be bizarre eating patterns; however, the full syndrome of Anorexia Nervosa is rarely present; when it is, both diagnoses should be given. In **Bulimia Nervosa** (without associated Anorexia Nervosa) there may be a fear of fatness, and weight loss may be substantial, but the weight does not fall below a minimal normal weight. In some instances Anorexia Nervosa occurs in a person with Bulimia Nervosa, in which case both diagnoses are given. (DSM IIIR, 1987, p. 66)

It is interesting to highlight the introduction of the terms Bulimia and Bulimarexia. According to Marlene and William White,

> Bulimarexia was introduced in 1976 to identify an aberrant behaviour pattern observed in a large number of female students seeking treatment at Cornell University. At that time the second edition of the Diagnostic and Statistical Manual of Mental Disorders considered Bulimia a rare disorder that involved binge eating with no reference to purging. (Brownell and Foreyt, 1986)

We can well imagine that this new terminology would have caused considerable confusion and perhaps led to misdiagnosis at this time. However, with the recognition of binging and purging as additional phenomena, this allowed for the differentiation between AN&BN, and what is now sometimes referred to as Bulimarexia.

The psychiatric labelling of eating disorders has become more refined. Nevertheless, there still is overlap between the symptoms present in the categories that describe the various

disorders. This has caused confusion and therefore, terms have often been used interchangeably.

In addition, there is controversy over whether eating disorders are considered "mental illness" at all. O'Grady and El-Sobky researched the attitudes of health care providers towards eating disorders (sample restricted to psychiatrists) as well as health care users (clients). They found that their lay population categorically did not view obesity (for one) as a mental illness and that they viewed Anorexia as a treatable, yet psychiatric problem. There appeared to be little or no stereotype associated with Anorexia, however, unlike a multitude of other mental health problems. There was a near consensus that Anorexia is a psychiatric, treatable problem. There was agreement between the lay and professional group in this regard. (O'Grady, T. and El-Sobky, 1987)

There appears to be disagreement between the feminist orientation and the psychiatric orientation (in particular) around whether eating disorders should be further categorized as "disease". Several medically oriented authors refer to Anorexia as as "syndrome". (Goodsitt, in Handbook of Anorexia Nervosa and Bulimia, 1985) The syndrome definition appears to be very similar to the category of disease. A "syndrome" stresses a cluster of symptoms and still signifies an underlying disease.

Significant segments of the medical community have applied a disease model orientation towards the understanding and treatment

of eating disorders. This bias has meant that the physical complications have sometimes been overemphasized.

Psychiatry has attempted to balance treatment to focus on the mind as well as the body. Psychological treatment has been offered; therapy stresses insight development or behaviour modification. This is often combined with the use of psychotropic medication.

The disease model has predominated the framework for understanding eating disorders in the medical field. Physiological methods (such as tube feeding and some behavioural methods) have been employed in order to effect a cure. Speculations about biological determinants of AN&BN are found in the literature. For example, in 1983 Dr. Philip Gold (of the National Institute of Mental Health in the U.S.A.) reported finding that many Anorexia patients secreted an abnormal level of a hormone called vasopressin. This sparked arguments regarding this biological cause. There were also theories regarding a biological/hormonal predisposition towards developing Anorexia offered.

Dr. Pierre Leichner (current President of the Anorexia Nervosa and Bulimia Foundation in Montreal, Canada) advises that a careful, complete medical work up be done on all patients displaying anorexic-like symptoms. He forewarned that in a small number of cases, "Brain tumors, particularly in the area of the hypothalmus, pituitary and the floor of the fourth ventricle, seem to mimic Anorexia and Bulimia". (Leichner, 1985)

Other abnormalities, such as diabetes and ulcerative colitis, have also been recently associated with Anorexia. Lesions of the central nervous system have also been mentioned. (Brownell, K. and Foreyt, J., Handbook of Eating Disorders, 1986)

Ruling out these remote, yet real possible causes or associated medical conditions is part of providing a thorough medical assessment. It should be noted that although this is not a Social Work function per se, it is valuable for Social Workers to know that in some cases, a biological determinant may underlie an eating disorder. It would be inappropriate and anti-therapeutic to suggest to a teenager (or adult woman) who was eventually diagnosed with a brain tumor (for example), that she was anorexic. I have seen a case where a 16 year old girl was being considered anorexic after she experienced a 40 pound weight loss. In this situation, the girl was diagnosed with Hodgkins disease. The importance of medical screening can, therefore, be critical.

As far as the medical management of eating disorders is concerned, there has been a recent development that warrants attention. Clinicians and researchers alike are looking at the use of anti-depressant medications for the treatment of Bulimia. It is popular to prescribe anti-depressants as an adjunct to counselling. While the effectiveness of using anti-depressant medication is presently being researched, there appears ample evidence of proponents of this approach in the literature. (Anderson, 1986; Fairburn, Cooper, and Cooper, 1986; and

Wilson, 1986) The guidelines for screening patients for pharmacotherapy and particularly for the use of anti-depressants remain vague. Family doctors and psychiatrists (in private practice) widely prescribe pharmacological remedies.

Terence Wilson, after completing a comprehensive review of published results in the area of pharmacological therapies concluded that their effects appeared modest. He also raised concerns about long-term implications for the patient. (Wilson, 1986)

More research appears to be necessary in this area. As more multidisciplinary approaches are taken towards treatment (i.e. drugs not given in isolation, but rather combined with counselling), it will become even harder to ascertain which variable is associated with which results in treatment.

Behavioural modification programs traditionally have been utilized within the medical model of treating eating disorders. They are appropriately discussed here, as behavioural modification strategies appear to focus mainly on the restoration of physical health for the individual. Applying the principles of behavioural modification to the treatment of AN&BN has traditionally meant focusing on changing the "anorexic" behaviours. Early accounts of behaviour modification were applications of Skinnerian learning theory. (Scrigner, 1971) Inpatient programs often have used (and some today continue to use) tube-feeding to force feed patients. Hospital programs for

patients have been developed around elaborate reinforcement schedules. Patients earn privileges (such as being allowed access to visitors, television, magazines, etc.) depending on their ability to ingest food and avoid purging, as well as their ability to gain a goal weight. Hence, behavioural success is viewed as the restoration of pre-morbid weight, or the reaching of stability in physical health (e.g. electrolyte imbalances corrected, restoration of menses, cardiac irregularities no longer apparent).

Outpatient behavioural modification treatment within the traditional medical model included the use of self monitoring, praise, and the use of food journals and calorie counting. Once again, the primary treatment goals emphasized successful weight gain and restoration of physical health. The underlying psychological components or the precipitating psychological or social stressors are largely left unexplored. The preceeding forms of behaviour modification focused on alleviating distressful symptoms. The approach has met with criticism for its superficiality and successful behavioural treatments have been criticized for providing only short-term results. (Bruch, 1974; 1975)

Today's treatment approaches often combine behavioural strategies with other orientations. The use of specific behavioural techniques within counselling is commonplace. Cognitive-behavioural therapy has also emerged as a highly regarded and effective treatment for AN&BN. (Garner and Bemis, 1982)

Family Systems Orientation

The next framework for exploration is the family systems orientation. Interactional difficulties between the members of a family and the effects of dysfunctional family life in general are viewed as the precipitants of the development of an eating disorder.

The following quote captures the movement towards applying family therapy in the arena of eating disorders:

> Our work with Anorexia Nervosa began as a search for more effective models of treating psychosomatic illnesses in children. In the course of ten years of research, we have broadened the scope of both diagnosis and therapy by taking the current conflicts of the anorectic and her family into account. Our paradigm, a systems model, explores the past influence of family members on the development of symptoms. But it also explores the influence of family members on the maintenance of those symptoms in the present. The model delineates and therefore opens to therapeutic change, aspects of the family members' behaviour that currently constrain the anorectic child as well as the other family members and maintains the Anorexia syndrome. (Minuchin, Rosman, and Baker, 1978)

The systems perspective in this family practice orientation directs the focus away from the individual and the examination of the individual's intrapsychic manifestations. What has emerged instead is the coining of such phrases as "anorectic family", or "anorexogenic" to describe families that produce children with Anorexia. (Minuchin, Rosman, and Baker, 1978) Simply put, the individual is understood in context of their family.

It follows from this perspective that the targeted locus for

change becomes the family system in its entirety. Family therapists utilize a systemic approach to attempt to assess many dimensions of family life. For example, they look at communication patterns, boundaries and the sub-systems (i.e. spousal, parental, and sibling) within the family. They will also explore the family structure, rules, and expectations.

The experience of working with anorectic families has demonstrated that there were difficulties particular to such families. Enmeshment between mothers and daughters is often apparent as well as fathers having been described as distant or disengaged. There is often a distinct lack of affective involvement within these families. Dealing with anger or conflict is often a key problem area. A predisposition for focusing on bodily functions within the family is also mentioned, so much so that Minuchin makes direct reference to these families as "psychosomatic" in nature. Perhaps the focus on the body (or sometimes physical pain) is a symptom substitute for the psychological issue at hand. Bemis suggests that, "A relatively high incidence of psychoneurotic disturbances in the families of anorectics has been reported in a number of studies". (Bemis, 1978)

For the individual (again, typically female) the enmeshed family life has taught her the ability to sublimate her own needs for the sake of others. Complicating this, these families are seen to be controlling and providing an overall intrusive environment. There is often little tolerance for individuality. Under these

conditions young women (consciously or unconsciously) develop control of their own lives through desperately rebelling and refusing to eat. The task of the family in therapy is to change the system sufficiently so that family life will no longer collude in the maintenance of the "anorexia" syndrome.

Goals of treatment include realigning boundaries, giving permission for the child to individuate from the family as well as changing communication patterns. Family therapists will direct parents to change rigidness as well as overprotectiveness towards their children, when these dynamics are present. There is considerable emphasis put on lowering unrealistic expectations of the anorexic individual or on any family member. Often the child also has been overly involved in parental issues and needs to be realigned within a sibling subsystem. Marital therapy is frequently recommended for parents of the anorexic individual. Strengthening the parent subsystem aids in breaking parent/child coalitions. In general, once major issues within the family have been addressed, this should lead to a diminishing need for the child to act out family problems.

On the other hand, the issues present in families whose daughters present with Bulimia can be quite different. The clinical picture (emerging from recent literature) describes "bulimic" families as open, chaotic, disengaged, and having many difficulties with impulse control. Poor marital relations between parents underscores both profiles. Susan Wooley and Ann

Kearney-Cooke describe the differences:

> In contrast to the consistent picture of pseudoharmony, family loyalty and cohesion characterizing the families of anorexic patients, the families of bulimic women seem far more variable. Some resemble the anorexigenic family. But some have already undergone divorce and for others it appears imminent. There seems to be less cohesion and more conflict, a finding supported by early research data. (Wooley and Kearney-Cooke, 1986, p. 140)

Kramer, in his recent overview of information available on the family treatment of eating disorders has compiled a comprehensive list of criticisms of the family systems/therapy approach. He contends that the research in the family arena is riddled with inconsistencies in method and that the results are sometimes misleading. He makes three important points. While ". . . clinicians and researchers have been trying to distinguish different subtypes of anorexic patients . . . (that) there is little systematic research in comparing these subtypes with one another." (Kramer, 1988, p. 166) This has resulted in some confusion regarding the family profile of women who have AN&BN. What is needed perhaps is an intelligent dialogue on the nuances of both the similarities and differences.

Kramer's second point is that, ". . . although there have been the anorexic, there is a paucity of literature on bulimic family systems." (Kramer, 1988, p. 169) Hence we see an imbalance in the study of families facing different types of eating disorders. This is to say nothing about the virtual non-existence

of literature which deals with the families of adult women. There is an imbalance in focusing primarily on families of origin. Family treatment needs to begin to include the implementation of marital and family counselling with adult women dealing with eating disorders. Lastly, he criticizes the mere lack of "empirically-controlled studies on family systems and eating disorders". (Kramer, 1988, p. 170)

Other recent criticisms of the family systems approach are provided by Walter Vandereycken. He presented the ideas at the 1986 Second International Conference on Eating Disorders held in New York. He noted that, "following the example of Minuchin and Selvini Palazzoli, many clinicians seem to prefer family therapy as the treatment of choice in anorexic patients. This movement, however, is based upon personal beliefs rather than on solid research. Family therapy should be viewed as a component to be integrated within a multidimensional approach that is guided by a constructive and positive attitude towards the family." (Vandereycken, 1987, p. 455)

Vandereycken is particularly concerned about the axiom that every anorexic woman's family is disturbed. He suggests an open response to families, attaching no blame, and demonstrating a willingness to recognize family strengths as well as pathology. Like others, Vandereycken is concerned about using family therapy as the treatment of choice to the exclusion of any focus on the individual (medically or otherwise). All in all, he is

supportive of a "constructive family approach to eating disorders" and argues in favour of a multidimensional approach where family therapy is but one of the helpful components of a treatment response. (Vandereycken, 1987)

Contributions from a Feminist Perspective

AN&BN has been perceived by previously discussed orientations as family created and maintained problems, or as indications of individual pathology. In either case, the feminist perspective provides a context for an understanding of eating disorders.

Feminist analysis has added a sociocultural emphasis to the examination of eating disorders. This perspective places women in the context of their culture. Historically, women's struggles with their bodies are also placed within the sociocultural context. The feminist perspective therefore adds a historical socioculturally based context to what has been a culturally devoid, medically dominated, pathology based model.

This section will review contributions from the feminist perspective. We will see that women have historically mutilated their bodies in order to achieve the cultural ideal of the preferred feminine body shape. An exploration of our contemporary society and why the "thin ideal" has emerged will be discussed from a sociological and feminist point of view.

The feminist perspective will offer challenges to the thin ideal and challenges to the mental health field's understanding and treatment of the problem. New connections between eating disorders and other women's issues (such as sexual abuse), will also be presented to reflect a broad picture of women's contemporary struggles.

Lastly, we will see that eating disorders can be viewed as a culturally explainable (and acceptable) form of "madness". Women's struggles with identity, power and self-worth are all associated with the development of eating disorders. Our society perpetrates the development of eating disorders and profits directly (in a capitalist, monetary sense) from female obsessions with their body and appearance.

To begin with, a look at the images of women in Western society is warranted. According to the feminist orientation, body shape has reflected the roles of women at various times in our history. Throughout history, women have conformed to societal notions of beauty, so much so that women in almost every culture have been known to mutilate their bodies with their attempts to meet these external expectations.

As we look in a time in North America where thinness and technology are being worshipped, we see such modern practices as liposuction, cosmetic surgery, the use of electric stimulation of muscle tissue for toning (and so on), all being used to form women's bodies. These, in combination with the personal

activities and practices of individuals dealing with eating disorders can all be dangerous practices. The problem is becoming pervasive in our culture.

> In one recent survey by Susan Wooley, reported in the May 1986 issue of Ms., 75 percent of 33,000 women described themselves as "too fat" although of these 45 percent were underweight according to height-weight charts! Other research has indicated that among female college students, 79 percent experience bulimic episodes and 20 percent develop bulimia. (Brown and Forgay, 1987, p. 11)

The pursuit of slenderness comes at a time where many women have been making desperate attempts at asserting their independence and power in a society that devalues and oppresses them. In her book, The Obsession, Kim Chernin presents the issues of weight control and body size as cultural problems with female power. At a time when women are fighting to be heard, and taken seriously, it is no coincidence that society reveres women who are so thin that they are defeminized and in essence, infantalized.

Women are made to feel that their value is tied to their attractiveness and therefore, to their bodies. A tremendous amount of energy is demanded to attain and maintain a "perfect" body. Energy that otherwise could be directed at a variety of constructive avenues can be wasted in this pursuit of slenderness. The "thin ideal" we presently see in western culture puts women in the untenable position of striving for thinness as a way and means of becoming successful. Thinness is equated with

happiness and being in control. Those who are able to succeed with their quest are often devastated to learn that transforming their body has not changed the problems in their lives, or how they feel about themselves. The underlying problems are common to many women - low self-esteem, difficulties with self-assertion, feeling powerless, and depression for example. This is, of course, reflected at a societal level.

Sociological interpretations of the increase seen in eating disorders attempt to explain the new emphasis on thinness for females;

> The contemporary idealization of thinness is the product of a historical evolution over the past century, an epoch that Bennett and Curin (47) have dubbed aptly, "The Century of Svelte". The authors, in their excellent book on dieting, have traced this historical development, beginning with the "femme fatale" of the 19th century, to the "flapper" of the 1920's, and finally to the extreme of the "Twiggy" body that emerged in the late 1960's and has become the standard of the late 20th century. They argue that the evolution of the image of the thin female had a great deal to do with the emergence of the politically and sexually liberated woman. Thinness at once implied mobility, both physical and social, and also a disengagement of female sexuality from the functions of childbearing and child-rearing, the latter being typically associated with maternal plumpness, while thinness originally took on symbolic value for women as a sign of freedom from traditional constraints and oppressions, it was soon exploited by a profit-oriented fashion industry, which played upon a set of motivations in women that conflicted sharply with emerging ideals of female assertiveness and independence - namely, the traditional desire to be beautiful and sexually attractive. Thus, the meanings of thinness were highly suited to express the psychological conflicts regarding identity." (Gordon, 1988, p. 157)

The feminist orientation refers to the preponderance of eating disorders today as reflecting women's underlying difficulties with self-esteem and identity in a male dominated culture. Men have a legacy of legally, economically and physically dominating women. Women's last vestige of power has traditionally come through their ability to procreate and through the use of their bodies, in general. It follows form this that women have always acted out their emotional and psychological difficulties on (and with) their bodies. Orbach compares the 19th Century "hysterical" women to her modern day counterpart - the anorectic. Both have used their bodies as weapons. Today, women strive to feel good about their bodies and their looks in a culture that promotes essentially unattainable ideals. Still, female body image remains inextricably bound to male conceptions of beauty and sexual attractiveness!

To a large extent then, women remain dominated in our present culture. Changing roles for women have created particular confusion for modern women. The advent of birth control has created new choices. The ability to plan children, or to remain childless, has freed women from the primary role of mother. This, combined with the tolerance, acceptance (some argue necessity) of women in today's job market, has created new roles and identities for women. Many women have responded to the demands of the work force by emulating their male counter-parts. Still others struggle with maintaining a sense of their

femininity while adopting traditionally held, positively perceived, male attributes (aggressiveness, for example). The dilemma for women becomes one of trying to balance the often contradictory roles of wife, mother, and employee. Expectations for the role of women in today's society have also changed. We see the emergence of new "superwomen" who balance the majority of household/childcare responsibilities with busy, working lives outside the home as well.

Palazzoli reflects on this dilemma:

> . . . the particular intrapsychic conflicts experienced by the anorexic, which on an individual level originate in her early experience in her family, both reflect and magnify recent cultural pressures on women associated with a drastic shift in role expectations. Thus, modern women are expected to have careers and to adopt traditionally "masculine" values that permeate the universities, the professions, and the business world. At the same time they are under increasing pressure to maintain traditional female role orientation, that is to say, to be attractive and fashionable, as well as continuing to carry out the tasks of childbearing and motherhood. These highly stressful pressures are experienced by the majority of women in the culture, but come to a head in the woman who develops Anorexia Nervosa. (Gordon, 1988, p. 155)

The recognition of these insights into the plight of women today has led feminists to question and denounce certain perspectives. They have spoken out against treatment which is perceived as patronizing, or allows women to develop dependency on experts, or where treatment is generally humiliating or harmful towards women. To begin with, the practice of psychiatrically labelling women has come under attack. The

purpose of such labelling is questioned. There is recognition that there is a stigma associated with labelling. Chernin says of her work:

> . . . in all these books I wish to place women's struggle with food and eating within the largest possible context of meaning. We cannot heal ourselves until we understand the hidden struggle for self-development that eating disorders bring to expression in a covert way. We cannot indeed begin to think about self-healing, until we stop using the words "eating disorder" to hide from ourselves the formidable struggle for a self in which every woman suffering in her relationship to food is secretly engaged. (Chernin, 1985, p. XVI)

We see a reframing done by the feminist orientation. There is recognition of the strength in women as well as a hesitancy (if not refusal) to label women with eating disorders as deviant. Susie Orbach suggests, "accepting the symptom" in her work with women who present with anorexic and bulimic symptoms. (Orbach, 1985) The implications for treatment then become acceptance of the behaviours associated with the problem and the necessity of, or permission to, focus on the underlying issues. There is an understanding that on a continuum of women's lives, those who are anorexic and/or bulimic are only more visibly expressing the dilemmas present for all women. It becomes a matter of the degree of a symptom, rather than the symptom as reflecting individual abnormality.

It follows from this that the treatment of symptomatic behaviour by the use of drugs, electroshock and strict behavioural therapy is irrelevant and open to criticism. To treat

the symptom is criticized as trivializing the problem. At times, individual treatment is described as demeaning to the women - particularly where tube-feeding or drug therapy is employed.

Today, even core assumptions about the unhealthiness of fat are being challenged (Brown and Forgay, 1987; Wooley and Wooley, 1986; Sternhall, 1985; and Kano, 1985). Overall, feminists and others are striving to have women accepted for all of their natural capacities, as well as shapes and sizes. The challenge is to divert the focus away from the body; to acknowledge that women are more than their packages. Women's success and value should not emphasize their bodies. It was feminists who also began the exploration of the link between women's unhealthy body images and sexual abuse (which we are finally recognizing as part of women's experience). While the scientific verification of a link has yet to be established, clinicians and academics alike are postulating the connections.

Anecdotal evidence of the link between eating disorders and sexual abuse surfaces, for example, in information coming from an Eating Disorders Clinic in Cincinnati where Susan and Wayne Wooley report; ". . . almost half the women they see in their eating disorders clinic are incest survivors" (Brown and Forgay, 1987, p. 14). Goldfarb recently reported three cases where sexual abuse preceded the development of eating disorders in women (Goldfarb, 1987). In the same fashion, Schechter, Schwartz, and Greenfeld described two further cases (Schechter,

Schwartz and Greenfeld, 1987). In a very recent study it was also found that,

> . . . interrelationships between problems associated with eating and sexual experience were examined in a nonclinic population. The Eating Attitudes Test and a Sexual Events Questionnaire were used with a sample of 130 female undergraduates; the data confirmed the hypothesis that there is a significant association between unwanted sexual experience and eating problems. It is suggested that sexual abuse may act as one of a number of setting conditions for the development of eating problems and that intrafamilial and extrafamilial experiences may differently affect the type of symptomatology exhibited. (Calam and Slade, 1989, p. 139)

To conclude this section, I wish to reflect back on sociocultural context and offer Richard Gordon's thinking on eating disorders as a "culturally sanctioned" form of madness for women. In his article entitled, "A Sociocultural Interpretation of the Current Epidemic of Eating Disorders", he describes AN&BN as "ethnic disorders". He goes on to describe this concept as, "a focal expression for the core psychological tensions, conflicts and contradictions of a culture" (Gordon, 1988, p. 152).

Gordon identifies five tenets (derived from Devereaux's essays on abnormality) to argue this proposition. He argues that eating disorders are widespread, that there appear to be "subclinical" forms of eating disorders apparent in our western culture (i.e. an eating disorder can be conceptualized on a continuum) and that the symptoms of eating disorders (in clinical populations) represent extremes of otherwise normative behaviours within our culture. This argument defines eating disorders as a natural

extension of societal norms. Additionally, he argues that eating disorders are a culturally sanctioned form of madness. He points to the media, the diet industry and female role models as negative cultural influences.

Gordon cites a popular example, the story of Jane Fonda. Fonda has been perceived as a pioneer of women, both in terms of the fitness industry and as a role model of a competent, assertive woman. She has publicly disclosed a 21 year history of Bulimia. Unfortunately, to some the technique of purging may be transmitted or interpreted as a secretive, successful weight control mechanism.

Lastly, Gordon describes a typical, ambivalent response towards eating disorders which is pervasive in our society. The ironic position of both sanctioning (or rewarding) the problems while punishing those who go too far is endemic. The ambivalent response seen by society is not surprising when one considers that multi-million dollar industries (such as the diet, fitness and cosmetic industries, for example) are being supported by women!

In concluding, it is important to note that Gordon does not identify his theory as feminist in nature, he champions the philosophy of the "personal equals political" which in the author's opinion demonstrates an inherently feminist stance.

We have seen then, that the feminist perspective emphasizes the broader, societal and political context in which women live. The additional historical context is provided in order to enhance

our understanding from where women have evolved. Lastly, the feminist orientation has challenged the traditional understanding of the nature of this problem, as well as the very treatment of women with eating disorders.

Recent Multidimensional Approaches

David Garner, Paul Garfinkel, and Kelly Bemis are credited with integrating a variety of approaches towards treatment. Their approach warrants examination for a number of reasons. First, it is one in a small minority in the literature that attempts to synthesize knowledge and experience gained from differing orientations. Second, many authors are recognizing the importance and richness of combining perspectives for a better understanding of the complex nature of eating disorders. Lastly, it appears that such combinations may represent a new and developing approach to both the understanding and treatment of this problem.

Garner, Garfinkel, and Bemis have recommended combining cognitive methods of individual psychotherapy with behavioural methods. They also suggest the use of family therapy as adjunctive, or part of ongoing therapy. Contemporary treatment approaches have included combinations of individual (using mainly cognitive and/or behavioural strategies), family and drug therapy in the treatment of Anorexia, for example. Whatever the

treatment approach, the variables that may need to be addressed by therapists are: psychological distress (obsessional thinking, all-or-nothing thinking for example), emotional difficulties (low self esteem, depression), family or interactive difficulties, as well as the behavioural and physical manifestations of the particular disorder.

Garner, Garfinkel, and Bemis have suggested viewing AN as a multidetermined disorder. They attribute six predisposing factors to the development of an eating disorder in an individual. they are:

> 1. a disturbed family, 2. maturation fears, 3. perceptual and body image disturbances, 4. ego, identity problems, 5. personality development problems, and 6. cultural pressures for thinness. (Garfinkel, P. and Garner, D., 1982)

Understanding that many influences impact on an individual's predisposition towards developing an eating disorder has made it possible for multidimensional approaches to be developed in an attempt to address the various factors. As we develop more sophisticated knowledge of the effectiveness of the treatment of eating disorders, there may be stronger arguments for particular modes of intervention. The use of several strategies is becoming highly recommended. "From a clinical standpoint, we have found a treatment approach which incorporates principles from differing therapies most useful when applied to particular problem areas." (Garner, Garfinkel, and Bemis, 1982, p. 5) This has several implications for the understanding and treatment of eating

disorders.

Of particular importance is the incorporation of understanding the physical effects of starvation into the treatment process. In counselling, the importance of using "bibliotherapy" or the use of "psychoeducational principles" has been highlighted in recent years. The client is informed of the effects of starvation on their body, brain, and as well on their mind (or thinking). This serves the purpose of demystifying some of the often frightening occurrences associated with Anorexia, such as the heightened sensitivity towards cold and heat, or obsessive thinking. For some, explaining the destructive effects of using excessive laxatives and caffeine, or of frequent vomiting (to name a few practices), is enough for the client to examine their dieting and health practices critically.

Hence, we see a new understanding of the blend between the physical and psychological impact of eating disorders. It is necessary for a therapist to understand this interplay, so as to educate clients about the process (and impact) of the development of AN&BN, as well as the process of reestablishing mental as well as physical health.

Bringing in an understanding of women's issues and the sociocultural factors impacting on women today can also be part of the multidimensional re-education/therapy application. Helping women to recognize the connections between their situation and other women's lives is important in several regards. A woman

who is struggling with Anorexia or Bulimia, must learn to deal with the massive fashion, cosmetic, and fitness industries that prey on all women's insecurities today.

Strengthening women who are at great vulnerability to such destructive messages is a part of therapy. Creating awareness of these messages is the first step. Then challenging the client to look at how they are affected by these messages (subtlely or otherwise) brings this issue to the foreground. Once again, a multidimensional approach allows the opportunity of providing such a necessary component.

A multidimensional approach towards treatment opens the possibility of providing flexible, appropriate service. Multi-dimensional therapy would encourage the utilization of various modalities which are designed to meet the specific needs of each individual. Components of individual, couple, family, and group counselling can be combined. In essence, when done well, the client may receive custom fit therapy. Such approaches naturally demand a broad base of knowledge and skill on the part of the therapist. Additionally, the therapist must be willing to share their client with others, to consult other services when appropriate, and (importantly) to select with the client the most appropriate forms of therapy.

In conclusion, the multidimensional approach provides a two-fold challenge to existing models of practice. To begin with, it challenges the practitioner to combine cognitive and behavioural

interventions. Also, because of the broad conceptualization of the problem, the multidimensional approach focuses the practitioner to view the individual in context of their family and society. To this end, a variety of treatment approaches are recommended in order to deal with the various arenas that are involved (and support the existence of) the problem.

Without doubt, this field has grown tremendously in the past 15 years. It appears that many challenges lie ahead. Researchers and clinicians from the varying perspectives (medical or psychiatric orientations, feminist orientation, family therapy orientation, or proponents of the multidimensional orientation) are now dialoguing and learning from one another. This is promising as a valuable interchange of ideas is occurring in this way. The profession of Social Work is challenged to develop our own valuable role in adding to the knowledge available in this field.

CLINICAL INTERVENTION

Treatment Goals

The goals of this practicum in providing individual counselling to women with eating disorders were as follows:

1. To educate clients regarding the physiological, emotional and cognitive effects of starving as well as the negative effects of binging and purging (i.e. to outline health hazards).
2. To create awareness that eating disorders and weight preoccupation are predominantly issues inherent in the socialization of women.
3. To provide a challenge to cultural values of idealized shape for women. To assist the individual in addressing the personal difficulties they may be experiencing in their attempts to maintain (or attain) a "perfect" shape. To explore the "fear of fat" as one aspect of individual interpretation of cultural expectations.
4. To enhance a positive body image for the individual.
5. To explore the meaning of, and change the role of food in one's life, where eating may be perceived as difficult or painful. To decrease the use of food as an emotional outlet.
6. To increase self-esteem. For the individual to attain skill in identifying negative thinking patterns and the ability to know how to change destructive (or negative) thinking.

7. To assist individuals in developing skills in self assertion.
8. To assist the individual to control extreme and obsessive patterns of behaviour involving food intake, exercising, or binging. Susie Orbach has described success in treatment in the following way: "I use the term recovery here to mean the capacity to live a life free from the hourly terrors that accompany food deprivation, its associated ritualistic behaviours and thought patterns." (Orbach, 1986, p. 121)

Rationale and Approach (An Overview)

Treatment goals were expected to be most effectively approached through a feminist based approach to counselling. As Anorexia and Bulimia are well documented as mainly female afflictions, the rationale for a feminist approach should require little explanation. However, a rationale for using a feminist approach has been succinctly stated by Orbach:

> The fact that AN is almost exclusively a distress symptom associated with girls and women and that there has been a dramatic use in the incidence of AN over the last 15 years (Crisp, Palmer & Lacy, 1976) suggest that both an analysis of the disorder and the possible treatment avenues must take into account the psychological construction of femininity and the vicissitudes of the passages from girlhood to womanhood in contemporary society. (Orbach, 1985, p. 83)

To begin with, a feminist framework was applied to the conceptualization of the problem. This meant that the therapist was willing to accept the "symptom" associated with AN&BN. The

particular behavioural manifestations were confirmed for each client as understandable and reflective of several core issues. Low self esteem, difficulties with reconciling societal expectations of identity or role, and the right to express personal needs and feelings were all underlying concerns. For these women, hidden conflicts were translated behaviourally into the socially acceptable practices of dieting, exercise, and the general emphasis on looks and the perfect body image.

Developing a therapeutic strategy that would not collude with the symptomatic difficulties was necessary. Focusing solely on weight gain (or loss) would be seen as highlighting the behavioural manifestations and missing the important underlying issues. The application of behavioural techniques in therapy, while one option for consideration, were utilized moderately. Intervention involved providing the women with information about ways to change destructive health practices. The "success" of therapy however, was not measured solely in terms of changes in eating behaviour. The rationale for limiting use of behavioural strategy is supported by research which has suggested that strict behavioural programs have not been successful at treating eating disorders effectively.

> One of the longest follow-up studies of a behavioural program (Bhanji and Thompson, 1974) is also the most pessimistic; after examining the status of patients an average of 32 months after discharge, the authors concluded that operant conditioning techniques are often inadequate for long-term maintenance of normal eating habits and weight, and they are probably best used

simply as a means of rapid weight restoration at times of nutritional crisis. (Bemis, 1978)

A Description of the Process

Women that were selected for outpatient counselling were not in immediate physical danger. They were voluntary clients. Often, their primary concern was to get assistance with out of control dieting and eating practices. The writer began with low key input regarding behavioural change (such as normalizing eating patterns) and slowly decreased this emphasis. This addressed the need for information in regards to changing eating patterns and nutritional counselling. This was therefore a logical starting point. It was also felt that starting on the topic of eating and attitudes towards food in general, was safer (less threatening) for most patients. Trust building and the therapeutic alliance could be built through this technique.

For some women, breaking through secrecy (of any shame associated with eating or self-destructive practices) was necessary. This was particularly the case with women who had bulimic tendencies. Being honest about their eating patterns (with all the accompanying feelings of embarrassment) and being able to experience being understood and accepted, was a very important part of the therapeutic process.

Opening a dialogue about food and eating was important to

build a new foundation for understanding nutrition and health in general. Examining attitudes towards food uncovered many faulty beliefs. Almost all women had their own set of "good food / bad food" lists. Many emotional responses were also associated with particular foods. For example, some women binge ate when they were angry or sad; others practiced fasting when they were experiencing feelings of low self esteem.

The content for nutritional counselling came from a review of the literature and consultation with clinic personnel. The following were guidelines used to counsel patients in regards to establishing healthy eating patterns:

1. "Dieting" is a precursor to Anorexia and Bulimia. Therefore, caloric restriction is not encouraged. It is favourable to establish a pattern of eating regular meals with a variety of foods.
2. Vegetarianism, or any other practice which excludes whole food groups, is discouraged during counselling. It was felt that in order to practice healthy eating, women must be able to choose from a wide range of foods.
3. The Canada Food Guide - which supplies approximately 1,000 to 4,000 calories per day and incorporates four food groups: (a) milk and milk products, (b) meat and alternates, (c) bread and cereals, and (d) fruits and vegetables is offered as a general guide for dietary planning.
4. The patterns of intake were documented through food

journals which were scrutinized for the following:

a) Was there evidence of food restrictions?

b) Were there patterns emerging [i.e. certain eating behaviours] and the patient's emotional state?

c) Was the patient eating a wide variety of foods or are there restrictions or overemphasis on certain foods?

d) Were there periods of binge eating present? When, why, and with what foods?

e) Was the patient drinking excesses in fluids (often - in order to squelch hunger or to facilitate vomiting)?

f) Was there evidence of "anorectic" eating behaviours present at meals (overemphasis on eating vegetables)?

g) Was the patient making healthy food choices, or is there a lot of "junk food" being eaten?

h) Did the patient eat differently when alone versus when eating socially?

5. The pattern of eating three sensible meals was encouraged. This pattern was felt to be extremely important initially, as it helped the patient build structure into their eating and helped the patient begin to make changes in their eating.

6. Binge eating was discouraged by suggesting some, or all of the following:

a) The patient was to avoid purchasing bulk quantities of food. Grocery shopping should be planned, and meal planning was encouraged. Groceries should be pur-

chased in pre-packaged and individual sized portions. Shopping at convenience stores, or last minute grocery shopping, was to be avoided.

b) After a patient became aware of their own circumstances which made them vulnerable to binging, they were encouraged to use "interruptive techniques". The interruptive techniques were custom fit to the individual and may include planning ahead to share meals with others, going for a walk (or other distraction) after a planned meal, or planning a relaxation exercise after eating.

c) It was important to establish "normal" eating right after an episode of binging. The usual pattern of dieting (or fasting) post binge had to be combatted in order to stop the cycle. Patients needed to be aware that "slips" in binge eating would occur, and they would have to be prepared in how they should respond appropriately. It is an unrealistic expectation that binge eating will never occur in a patient's life again.

7. Psychoeducational literature was used to validate the therapist's contentions regarding the ill effects of dieting, starvation, and binging and purging. Also, the concept of set point theory (or homeostatis regarding weight and body fat composition) was introduced. Further discussion regarding healthy female body shape and the importance

and necessity of body fat was covered. Patients were given the Canada Food Guide and articles to read which provided education and supplemented therapy:

a) Leichner, P. (1985) "Detecting Anorexia Nervosa and Bulimia" in DIAGNOSIS, January, 1985, p. 31 - 47.

b) Garner, D. et al (1985) "Psychoeducational Principles in the Treatment of Bulimia and An N" in Handbook of Psychotherapy for Anorexia Nervosa and Bulimia. New York: The Guildford Press.

In conclusion, there were two major forms of intervention which happened early in the therapeutic encounter:

1. Information was given, which
   a) matched the requests for information which was often the presenting point of entry of the client and
   b) contradicted the basic beliefs and knowledge (regarding food and its effects) which clients brought to therapy.
2. Behavioural practices were discussed, which
   a) focused attention on food management and
   b) provided alternative ways of understanding and managing food and food related behaviours.

The next step in counselling focused on the process of exploring underlying issues for the woman. Exploration of self esteem, family relationships, sense of identity, and difficulties with the expression of feelings and self assertion were all important areas covered. This led into an eventual identification

of patient goals, both more comprehensive and more specific than those which the women originally may have brought to the clinic. As the process of gaining insight and awareness occurred for the individual, they could become clearer as to what kinds of changes they were interested in making in their lives.

The provision of adjunctive counselling service was also made available to the individual. Where appropriate, family or marital counselling was recommended or encouraged. A community-based support group for women with Anorexia or Bulimia was also used as an adjunct to individual counselling.

Preparation for termination was initiated by reviewing gains and setbacks, providing the client with verbal feedback of the work that was done in therapy. Future goals were set with each client. "Prevention", or the use of positive coping strategies, were discussed. A review of personal and professional helping systems was used to provide a safety net for the future. All clients were invited to contact the Eating Disorders Clinic in the event of a crisis, relapse of problems, or an interest in further counselling.

The next section of this report will comment on the use of cognitive therapy within and throughout counselling.

Cognitive Therapy (Approach)

The use of cognitive therapy was recognized as an important

part of the counselling process with the women. Examining the beliefs that were perpetuating the behaviours associated with Anorexia or Bulimia was an integral and continued theme of the work. Challenging the women to identify, reinterpret, and change destructive beliefs for healthier views was necessary.

The basic tenet of cognitive therapy is that changes in thinking will affect mood and behaviour (Burns, D., 1980). David Garner and Kelly Bemis have studied the contemporary use of cognitive therapy and reflect on its use and utility.

> At present, all conceptual and therapeutic models for Anorexia Nervosa must be considered tentative and provisional. Since the disorder was first recognized as a diagnostic entity, numerous etiological formulations have been proposed; however there is a remarkable absence of controlled outcome research evaluating the effectiveness of outpatient psychotherapy. One major obstacle in evaluative research has been that descriptions of the conduct of outpatient psychotherapy typically have not been detailed enough to allow replication. The techniques we have described have been applied unsystematically in clinical settings, and no rigorous tests have been conducted to support or refute our favourable opinion of their efficacy. Nevertheless, we do believe that the results obtained so far are encouraging enough to warrant further examination through a series of more systematic, clinical trials and comparative studies. (Garner & Bemis, 1985)

Cognitive therapy is based on cognitive learning principles and can be used as a model which assesses "dysfunctional" thinking. Cognitive therapy also offers techniques and suggestions to help facilitate changes in a client's thinking. Although no refined model of intervention currently exists, cognitive therapy can be used in a variety of ways with this

population.

It is widely believed that dysfunctional, or faulty thinking, is apparent in individuals who have eating disorders. Many women assume (and receive support for) dieting and other self destructive health habits. The need to debunk myths and provide examples for alternative lifestyles was addressed early on in and throughout the counselling experience. The introduction of new information and education set a stage for challenging beliefs. To uncover the specific rationale that guided the individual's behaviours and to introduce doubts about their basic premises was an integral part of the cognitive therapy.

In my own experience with providing community-based support groups for women with eating disorders, I have frequently been impressed with clients' attempts at changing their own beliefs. They were often successful in making positive changes in their lives. One such example was where a member was able to increase her food intake by convincing herself that she must eat in order to be healthy. This demonstrated an alternative belief to "food as = BAD" and eating as a sign of loss of control, or loss of willpower. Using "positive self talk" helped individuals to convince themselves of new attitudes towards eating and food, in general.

David Garner and Kelly Bemis have named six (6) troubling areas that they have seen as common among women with eating disorders. They refer to these as "logical errors". They name

the following areas as particularly relevant: "a) dichotomous reasoning (all or nothing thinking); b) personalization; c) superstitious thinking; d) magnification; e) selective abstraction; and f) overgeneralization." (Garner & Bemis, 1986) The cognitive therapy literature provides valuable information about techniques that may be employed to deal with such problematic thinking.

The following is a list of cognitive techniques that were used in the counselling process.

1. Two-column technique:

   See Appendix F. Once the particular negative beliefs were uncovered, this process could be used in brainstorming alternative, healthier responses.

   In my experience, clients responded poorly to attempts to "formalize" this process. By adapting this to a verbal exchange (i.e. What could you tell yourself instead?), made this technique become more usable.

2. Developing a self-respect blueprint:

   Once the client is in the process of developing an attitude of positive self-worth, a self-respect blueprint can be developed. Indeed, efforts at encouraging self-respect can begin by the therapist encouraging self-respect. For example, one client was encouraged to examine her work relationships as she was being treated in an underhanded way by her colleagues. Encouraging her to expect (and demand) better treatment fostered her self-worth.

Asking clients to identify their positive self attributes was also a way and means of initiating self-respect.

3. Decentering:

Often individuals were applying two standards of logic to problems - there was the standard applied to others, versus the standard they would apply to themselves. The technique of decentering allowed me to explore double standards with a view to guide the individual to apply reasonable, fair standards to themselves.

The women seen were particularly self-critical. This was very apparent in their lack of acceptance of their own bodies. Conversely, they often easily accepted a wide variety of body types on other women (and even perhaps more so with men). They were encouraged to apply the same standard (i.e. the acceptance and warmth towards others) to themselves.

4. Decatastrophizing:

This technique suggests following an individual's fears to their logical conclusion. It was used to help individuals to assess the possibility of their fear occurring in reality. A most common example where this technique was applied was towards women's fears of weight gain. A number of women held unrealistic fears (i.e. uncontrollable weight gain) if they were to begin eating three meals a day and quit the tendency towards dieting.

5. Reattribution Technique:

Providing a "reframing" of a situation was a technique used throughout counselling. This technique was particularly useful in conjunction with providing information about nutrition and eating habits (e.g. attributing postmeal bloating to the effect of starvation versus a common belief that the same bloating is an indicating of weight gain or the automatic presence of fat).

Reattribution was also used within a feminist orientation. Eating disorders as a psychiatric illness was generally reframed as representing coping mechanisms in response to identifiable events in the contexts of the women's lives.

6. Palliative techniques:

When particularly stuck, it was sometimes useful to have the client "parrot" coping phrases. This technique was very useful when employed to assist an individual to change eating patterns. Substituting self talk, which is positive, was used when a person was having difficulties eating (e.g. "I will finish this meal - this is part of getting better. I will not get fat immediately after eating." etc.).

The use of self talk was an important tool and is an integral part of cognitive therapy.

7. Reinterpretation of body image:

One of the most difficult pieces of work with the women

who had a negative body image was to create a healthy change in this regard. Where an individual was unable to rely on their own interpretations, it was sometimes useful to present external information (i.e. that others did not see her as fat, that we know clinically that part of the problem is that women overestimate their body size routinely). Attempts were made to aid the client in attributing her overestimation of her size to her present difficulties.

Once again, a feminist perspective emphasized the important (and acceptance) of the women's struggle with her body image.

In general, the application of a cognitive approach was done in a spirit of questioning, challenging, and providing encouragement. Specifically, the client was encouraged to express herself (both her needs, as well her emotions). Challenging was done in many areas including the meaning of the pursuit of thinness. Many clients had superstitious thinking in regards to "good/bad food" or had particular goals which warranted exploration. Challenging cultural values in regards to the thin, ideal shape was done with each individual.

Lastly, a good deal of the work was done around the denial of emotions which was so often seen as a key feature with the women. Their own particular rationale was often explored as to what they experienced as "safe" emotions. The conditions put on

themselves in order that they could feel in "control" were also often explored.

The individual in context of her family, other significant relationships, and in society in general, was explored (and challenged) with the use of the cognitive therapy techniques outlined above.

Selection of Clients and Intake Process

All clients were acquired from the Health Sciences Centre Eating Disorders Clinic waiting list. The Clinic Coordinator was responsible for initial contact (or phone intake) with client on the the waiting list. Clients were initially screened for their appropriateness for outpatient counselling. The following were factors considered in the initial selection of clients:

1. Clients who could benefit from the student's treatment approach were sought (i.e. they appeared somewhat insight-oriented, motivated, interested in outpatient counselling, asked for or could benefit from a feminist approach).
2. Clients who appeared to have mild physical complications and therefore were not requiring inpatient treatment were preferred.
3. A variety in ages of clients was sought in order to provide the student with exposure to differing developmental issues. A combination of clients who presented with different eating

symptoms (i.e. some with complications of Anorexia, others with Bulimia tendencies) were sought in order to maximize the student's experience.

4. Clients would have to be interested in (or accepting of) being seen by a student. The implications of being seen by a student were:
   a) A six-month time frame for counselling sessions.
   b) The use of audiotapes; the requirement that clients would be asked to evaluate the counselling they received.
   c) An understanding that the student's interest was focused on the socio-psychological aspects of the issue, rather than the medical-physiological aspects of the issue.

The following considerations made a client inappropriate for inclusion in the student's practicum:

1. Clients who exhibited psychotic tendencies were deemed to be inappropriate for outpatient counselling.
2. Clients who were assessed as having high health risks associated with their eating disorder were felt not to be appropriate for outpatient counselling. This included individuals where one, or all, of the E.D. team were recommending hospitalization due to excessive self-destructive practices or dangerously low weight.

Assessment - A Glimpse at Nine Women

The process of providing assessments at the Health Sciences Centre Eating Disorders Clinic was governed by specific protocol and procedure. The student, after viewing several assessments by various team members, performed nine assessments herself. The process of assessments will be outlined here before describing the actual individuals involved.

Assessment interviews were booked in advance and the women were asked to be in attendance at the Clinic for one entire morning. The procedure began by the women entering the Clinic, registering, and filling out information. Included in this package was an: 1) Eating Disorder Inventory; 2) Anorexia Nervosa and Bulimia Self-Report Questionnaire; 3) Beck Personal Inventory (short form); and 4) Consent Forms.

The women were then interviewed in a private room which contained a camera. Remaining members of the Eating Disorder team would view the assessment (on a television monitor, in a separate room). The interviews lasted 1 to 1½ hours, with a ten to fifteen (10 - 15) minute break available for the person performing the assessment interview to consult with the ED team.

All women who were seen for an assessment interview were prepared for the format of the interview in a number of ways. To begin with, they were informed of the process when they initially called and were placed on the waiting list for treatment.

At the time of booking their first interview, the women were told again of the format of the interview.

When they attended their first interview, the women were asked if they wished to meet the members of the team who would be viewing the interview. The women were therefore given the opportunity to meet people "behind the camera".

The assessment interview had a number of purposes. Information was reviewed which was derived from the written database. The person was asked to elaborate on these details and to share their perceptions of the difficulties that they were experiencing in their life. The usual areas covered included: 1) entrance complaint (the presenting problem from the patient's perspective); 2) the history of their present illness (background and development of "symptoms"); 3) previous medical or psychiatric illnesses (of the client, and/or in her family); 4) the client's personal history (early development, childhood, adolescence, and adulthood); 5) family history; and 6) their expectations for treatment. This interview followed a fairly standard psychiatric format - with emphasis put on the client's "eating disorder" (i.e. history of dieting, binging and purging, use of laxatives, exercising, body image concerning weight loss and gain, etc.).

This interview has as its two-fold purpose the gathering of information as well as the beginning of establishing trust and rapport with the client. The interviewer's impressions, feelings

and concerns, and treatment recommendations were then shared briefly with the members of the ED team. Feedback was given immediately to the interviewer in terms of process, information gathering, and treatment recommendations. The interviewer then returned to the client and shared appropriate information. The interviewer was sometimes accompanied by another team member, where this was deemed necessary. This often had the purpose of sharing medical information and concerns with the patient. This was also felt to be necessary where a client appeared to be minimizing or denying that there was a problem (and where, of course, it was felt strongly by the members of the team that there were significant difficulties apparent).

The interview was usually concluded by presenting the woman with treatment recommendations and eliciting her response to the recommendations (as well as feedback from the interview process). In some circumstances, the women were requested to return for a second assessment interview, if there was need for gathering further information. In each case, the women were given a package of educational articles on eating disorders.

Clients were also encouraged to return to view an educational videotape, "Understanding Eating Disorders", regardless of whether they wished to be seen further at the Clinic. For those who wished to continue their involvement, the next appointment included viewing the videotape and a brief session afterwards. Clients were also asked to begin filling out a food diary (see

Appendix G), which was reviewed at the beginning of each successive session.

The author assessed nine women over the period of the practicum experience. The following is a synopsis of the client profiles, as well as assessment information. Pseudonyms (disguised client initials) have been used. Along with the name changes, some identifying information has been changed in order to maintain confidentiality. The psychiatric diagnosis of "1) Anorexia Nervosa, 2) Bulimia Nervosa or 3) eating disorder not otherwise specified" (American Psychiatric Association: 1987, p. 65 - 69) was applied to each client. A critique of this labelling process follows in the next section.

CLIENT #1: Lorna (L)

The first client seen was a 21 year old, single, university student. She was 5'6" in height and weighed 117 lbs. She was the second eldest child in a family of four children. Her mother was employed casually outside the home and her father worked full-time within the school system. L was residing at home at the time of assessment, as well were two of her younger siblings. L also had been dating a man for six months and described this as a significant relationship.

L was concerned about having a long history of dissatisfaction with her body image and with having bouts of eating difficulties (binging and purging). Although by the time of

assessment she was able to exert better control of binging and purging, L was not able to leave behind her compulsions to diet and over exercise. She was worried that she would revert back to binging and purging at times of stress and wanted to develop new coping mechanisms.

Relevant details of L's history are as follows: She was at her heaviest weight at age 15 (5'6" and 140 lbs.) She recalled being 12 years old when she became preoccupied with her weight. She felt large and particularly awkward due to entering puberty before her female peers. She recalled a particular comment that an aunt had made to her at that time. It seems that this aunt gave her a pair of pants and remarked that she was surprised she fit them (as the aunt herself was 21 years old when she wore them). L responded to this hurtful comment by beginning to diet in an effort to "fit into" her family.

Dieting became the precursor to binge eating (which L and a friend began to do secretly at age 12). She learned to consume large amounts of "junk food" and vomit afterwards in order not to gain weight. At her worst period (in high school), she was vomiting two to three times a day. She became concerned for her health when she began experiencing nose bleeds and lightheadedness. L was able to stop vomiting around this time and subsequently replaced vomiting by exercising zealously. She remained an active dieter as well. L felt she had been able to stop binging and vomiting altogether, until she ended a

significant relationship which found her "out of control" once again. She then binged and vomited over a two week period.

L reported a healthy, non-eventful childhood otherwise, and stated that she felt loved by her family. She described her family life as stable. She had a large extended network of relatives who socialized together often. She was unaware of any psychiatric difficulties in her immediate, or distant relatives.

Based on the written and verbal information supplied by L at the time of assessment, it was felt that she would fall under the "eating disorder not otherwise specified" category, for an Axis I diagnosis. She would not meet the DSM IIIR criteria for either Anorexia Nervosa or Bulimia Nervosa. However, she displayed a significant history of Bulimia and certainly presented current difficulties with body dissatisfaction, self esteem, and displayed some maladaptive eating patterns.

L was not deemed to have an Axis II diagnosis and was generally felt to be a high functioning individual. Recommendations for treatment were for L to receive education on ED and to assist her to develop insight into her problems in order for her to develop healthier coping mechanisms. Underlying problems of low self esteem, family expectations and issues, and the healthy expression of feelings and assertiveness were all felt to be important.

L returned to the Clinic to view the educational videotape and decided to become involved in counselling. She was seen for

individual counselling for a six-month period. Her case will be elaborated on in the "Therapeutic Dilemmas" section of this chapter.

CLIENT #2: Nicky (N)

N was a 33 year old, married woman with no children. Her height was 5'2" and weight was 114 lbs. She was employed outside the home, as was her husband, who worked long hours. N was the second of four children in what she described as a middle class, strict, ethnic family. She indicated that one of her sisters had Bulimia. No other family history of psychiatric problems or problems with alcoholism were noted.

N described a history of chronic dieting, beginning when she was 24. She had been dissatisfied with her body shape for many years, which led to dieting and excessive exercise. Associated with her dieting were periods of binge eating. A binge was described by N as eating a whole pie or loaf of bread in one sitting. N also reported abusing laxatives (taking five to six Exlax after each meal). She tried using prescription diuretics on two occasions to lose weight.

At the time of assessment, N's exercise routine included one to two hours a day of aerobics with weights and/or jogging three to four miles a day. N was prompted to call the ED Clinic by her husband and family, and came to get assistance on how to "eat normally", however she was also interested in losing weight.

N described her childhood as a happy one, yet there was evidence that appeared to contradict this. Her father had been physically abusive to his children and remained physically aggressive towards his 25 year old daughter (who resided at home). N had also alluded to spousal abuse occurring between her parents. She described her father as "a hardworking and nonaffectionate" person. She felt loved, although love was not communicated directly to her.

N always felt that there was a lot of pressure put on herself to "be good" and to please others. She recalled giving emotionally of herself in her family and not feeling appreciated or given much attention in return. She described her mother as "caring and generous - always giving of herself for the family". She felt that her relationship with her mother was a positive one.

N dated minimally as a young girl. Her first significant relationship with a man occurred at age 24. She dated a man who was disapproved of by her family. She stated that she gave a lot of herself in this relationship. N also became pregnant unexpectedly. She did not receive any support from her boyfriend and decided to have an abortion. This experience was tremendously difficult for her. It was around this time that her contempt for her body began.

A few years later, she met a new man whom she subsequently married. Her husband was described as "hardworking, bright, sensible, and sometimes stubborn". She described having

a positive relationship with her husband, but also mentioned that she was sometimes fearful of him.

The assessment of N included the following considerations: An Axis I diagnosis of "eating disorder not otherwise specified" was given. The criteria for a label of Anorexia was not met, due to not fulfilling the 15% weight loss specification. Also, there was not an absence of three complete menstrual cycles in this case. Although N displayed features of Bulimia, she did not purge by vomiting, and therefore would not meet DSM IIIR criteria.

Recommendations for treatment included offering N individual outpatient counselling with provisions for adjunctive marital counselling, if necessary. It was felt that N demonstrated a poor body image, eating difficulties (with dieting and binging), probable difficulties with family issues, and difficulties with expressing feelings and in being assertive. There were also concerns about depression.

N returned to the Clinic (with her husband) to view the educational videotape and with some ambivalence, decided to continue with counselling. She was seen for six months for individual counselling and became involved in marital counselling as well. Her case will be elaborated on in the "Therapeutic Dilemmas" section of this chapter.

CLIENT #3: Dianne (D)

The third woman seen for assessment was a 25 year old,

single university student. D was 5'6" in height and weighed 124 lbs. D was living with her parents at the time of assessment. Her family consisted of her parents and two siblings. D was the youngest and only child remaining at home.

D's mother was not employed outside the home and was described as quiet (in groups), but expressive within the family. She was also described as overprotective and at times intrusive. Her father was described as quiet and sensitive, with some difficulties in expressing his feelings.

D's difficulties with eating began when she was approximately 16 years old. She recalls being pressured by a track coach to go on a diet. Along with dieting, D began to vomit occasionally after eating fattening or "forbidden" foods. D soon learned to use vomiting as a means of weight control. At the worst period, D recalls vomiting five to six times per week. D recalled periods of depression associated with her lack of control over binging and vomiting. At the time of assessment, she was vomiting anywhere from five to six times a week.

D stated that it was on the advice of a friend (whom she described as Anorexic) that she was prompted to come to the ED Clinic. She was interested in getting assistance with re-establishing healthy eating patterns. D also stated that she would find weighing more than 125 lbs. very difficult (if not intolerable).

Although D was somewhat guarded with information about her

family and her past in general, it appeared as though she had experienced her family life as "superficial" in nature. She also described having marked difficulties with peer relationships, as well as in dating. D stated that she has difficulty trusting others and that she was isolated socially. D also reported having experienced periods of depression. D had seen two counsellors in the past for assistance with her depression and interpersonal difficulties.

This client was given an Axis I diagnosis of "Bulimia Nervosa". D also met almost all the criteria for Anorexia Nervosa (i.e. she had been amenorrheic for six months, she displayed fear of weight gain, and had body image disturbance). However, she had not lost 15% of her body weight.

An Axis II diagnosis was deferred, with concern over ruling out depression and/or a personality disorder.

Outpatient counselling was recommended. It was felt that D might require more than six months of counselling, and therefore she was given the option of seeing a staff member of the ED team. While it was felt that D would require assistance with stabilizing her eating, it appeared that her difficulties with relationships preceded her struggles with food. Family issues (perhaps individuation), low self esteem, and feelings of loneliness and despair were all felt to be important components to address in therapy.

D chose to continue as an outpatient and was seen by Daryl

Johnston, the Clinic Coordinator.

CLIENT #4: Sally (S)

The fourth woman to be seen was a 21 year old women who was single (engaged) and living common-law. She was employed full-time. She was 5'2" in height and weighed 85 lbs. S was the second and youngest child in her natural family. There was 11 years difference between herself and her brother.

S's mother was also employed outside the home. She was described as a giving person - someone who found it difficult to receive from others. She was also said to be intrusive and often overbearing in nature. S's father was employed. He was described as kind, hard working, and generally not expressive with his feelings. He was known to abuse alcohol, until ten years ago when he quit drinking.

S came to the ED Clinic partially due to prompting from her fiancee and her mother. She also was aware that she had poor eating habits and that she was underweight. S described her difficulties with eating beginning at age 14. Although not making a concerted effort to diet, S described becoming "too busy" to eat. She reached her highest weight (105 lbs.) at age 16 and slowly began to lose weight from there. At age 19, she reached 78 lbs. and then she regained somewhat. She described periods of eating minimally and also "better times" when she was able to maintain her weight.

From age 17 to 20, S induced vomiting three to five times daily. She had been able to limit and control purging more successfully since moving in with her boyfriend (in a one-year period). She described vomiting occasionally at the time of assessment - typically after consuming large meals, or at times of stress. S used laxatives infrequently (three to six times a week) and did not exercise regularly.

Of relevance in S's history were a number of family difficulties. She recalled that her brother created a lot of tension for her family. He rebelled, took drugs, and left home at the age of 17 years. When S herself entered the teenage years, she also rebelled against her parents - whom she described as strict. Between the ages of 14 and 18 years, S recalled fighting daily with her parents. She felt controlled and overprotected. It was also at this time that her family moved to a small town, which S found difficult to adjust to. S began having problems with peer relationships.

At age 20, S met a man who was an immigrant. They were engaged after a few months of dating. This shocked and angered her family. They moved into S's family home in an effort to save money. S described this as disastrous and within a few months the couple moved on their own. S described her relationship with her fiancee as a stormy one, due to both of their "stubborn and opinionated natures".

At the conclusion of the assessment, the Axis I diagnosis of

"eating disorder not otherwise specified" was applied. S exhibited all the criteria for a diagnosis of Anorexia Nervosa, except for the fact that she was having regular periods. S's eating difficulties were felt to be closely linked to the power struggles she had experienced with her family, and more recently, with her fiancee. Underlying difficulties with low self esteem (and confidence), as well as emotional problems with dealing with conflict, were felt to be important issues.

It was recommended to S that she could benefit from individual outpatient counselling that would focus on her eating problems, as well as her difficulties with relationships and her family.

A further suggestion was for her fiancee to accompany her to the Clinic to view an educational videotape and to have an opportunity to express his concerns. The possibility of need for couple counselling was also considered.

S expressed an interest in counselling. A few appointments were set, which S cancelled or missed altogether. S chose not to engage in counselling at that time. She stated that she was too busy with making wedding plans and could not make a commitment to counselling.

S recontacted the ED Clinic in the near future, in crisis. Her weight was down again and she felt her health was deteriorating. Inpatient treatment was recommended at that time due to S's inability to maintain her weight and control binging

and vomiting. S was subsequently hospitalized.

CLIENT #5: Cathy (C)

C was a 21 year old, single woman who was recently employed. She was 5'6" in height and weighed 144 lbs. C was a middle child, having one brother who was three years older and one sister who was six years younger than herself. Her parents divorced when she was 18 years. Her mother was employed in a small town. She was described as moody, confused and was often verbally abusive towards C. C's father was described as a nice, patient, and loving man. He was unemployed and residing out of province at the time of assessment.

C's difficulties with eating began around age 17. She reached her highest adult weight (170 lbs.) at the same time as her parents separated. She recalls being emotionally distraught and going days without eating or eating minimally. She dropped to a weight of 115 lbs. in a matter of three months. She further recalled having difficulty "keeping food down" during this period and vomiting daily. This became a practice which she incorporated into her daily life. At the time of assessment, C was vomiting "occasionally" (one to two times per week). C stated that she had never gone on eating binges. She was taking an appetite suppressant (such as Ayds) routinely. She also occasionally fasted for two to three day durations.

C came to the ED Clinic for help in a variety of areas. She

wanted help in dealing with her eating difficulties (specifically vomiting and dieting). She was also making a concerted effort to break away from "unhealthy relationships". C described a history of involvement with a satanic cult. This was a significant struggle for C and will now be elaborated on (as part of relevant historical information).

At the age of 13, C questioned an uncle about faith and his belief in God. She recalled being disappointed with his explanations. She then met some friends who believed in the devil and had "a lot of the answers" she was looking for. They provided an instant peer support group. They began by playing "Dungeons and Dragons" and incorporating devil worship into the game. C was assigned a character who had powers of the mind. C took this character into her life and became confused at times as to whether the character had become a part of her. Her life on the outside, however, appeared normal.

During the latter part of high school, C went through a rebellious phase. She described herself as having gone through a marked personality change. She became a discipline problem at school. She began smoking, drinking, and taking drugs.

By the age of 18, C became involved with a married man. Their initial friendship soon deteriorated and the relationship resulted in a predominantly sexual union. C remained involved with this relationship for two to three years and had recently ended their affair. C had also been struggling to leave behind

friends who remained involved in the "cult".

Other significant information in C's background included that she reported having been physically abused by her male baby-sitter when she was seven years old. At the approximate age of nine, C was also sexually assaulted (on a number of occasions) by her maternal grandfather.

Assessment, in this case, focused on a number of issues. C did not demonstrate all of the criteria for either an Axis I diagnosis of Anorexia Nervosa, or Bulimia Nervosa. She was slated into the "eating disorder not otherwise specified" category. There were concerns regarding psychotic tendencies, as it was unclear at times whether C was in touch with reality. Examples in this regard are that C believed in "mind communication" and that others were sending her messages. She reported hearing demons scratching on the wall and feeling at times as though the devil could "reach down inside her and twist her insides". Ruling out psychosis therefore, was added to the Axis I diagnosis of eating disorder not otherwise specified. An Axis II diagnosis was simply deferred at assessment.

Outpatient counselling for the purpose of further assessment and to focus specifically on C's difficulties with eating was recommended. It was felt that C initially used eating (and not eating) as a response to dealing with the loss of her family. Before this, C was already experiencing significant personality difficulties, as well as problems with interpersonal relationships.

She had not been able to develop a healthy sense of identity as a result of a lack of involvement (emotional and otherwise) from her family. Having also experienced physical and sexual abuse, this left C with power and control issues. C became self abusive. Her involvement with the cult fulfilled needs to be powerful, to have purpose and an identity, and to be accepted by peers.

C was not seen by the student due to the concerns regarding psychotic tendencies. (It was questionable as to whether she could benefit from the student's cognitive-behavioural approach to counselling.) C was seen by Daryl Johnston in outpatient counselling.

The client's spiritual concerns were not a focus of treatment.

CLIENT #6: Josephine (J)

The sixth woman seen for assessment was a 15 year old, young woman who was 5'4" tall and weighed 99½ lbs. J was a high school student who was brought to the ED Clinic at her mother's insistence. J was the youngest of two children. She had one sibling (age 16) who was adopted. J also had one half sibling who is the natural child of her father. This half sibling was 15 years older than J and had never lived as a part of J's family.

J's mother was described as a "worrier", but a fun person nevertheless. She was also slightly overweight and "diet conscious". She was employed full-time and also helped with her

husband's business. J's father was described as a quiet, easy-going person. J felt that she got along well with her father and appreciated that he did not "pressure" her. He was self-employed.

J was involved with a boyfriend who was five years older than herself. She described this relationship as significant and was seeing her boyfriend four or fives times a week. Her parents had concerns about this relationship, however, were unable to influence her to not get seriously involved.

J described her eating patterns as having changed two years prior, at age 13. She began dieting at that time, and reached a low weight of 92 lbs. After restricting her food intake for one-half year, she became vegetarian (avoiding red meat primarily). At the time of assessment, J was choosing to exclude meat, poultry and fish from her diet. J also fasted once a month for three to four days in duration. She had been vomiting once a week over an eight month period, and had reportedly quit vomiting two months prior to her appointment at the ED Clinic.

J felt her ideal weight was 90 lbs. and reported experiencing her stomach, buttocks, and hips as "fat". J was exercising for approximately one hour per day (with aerobics, jazz class, or gym). J stated clearly that she did not feel she had a problem and was attending appointments at the Clinic to appease her parents.

J recalled her early years as positive ones. She described a

happy family life up until age 13. At this age, two significant events occurred. To begin with, she tried to run away from home. The reason she gave for this was that she felt "unnoticed", and that her sibling was favoured. Then J began dating and became attached to one specific boy. They dated for a short while and when the relationship ended, she slashed one of her arms. According to J, she did it because "she was upset, not because she really wanted to kill herself". J has gone through two such episodes of depression which have worried her parents and have led the family into counselling in the past.

J's assessment focused on her individual struggles, along with a recognition of family issues which were exacerbating her problems. She was given an Axis I diagnosis of "eating disorder not otherwise specified". She was displaying symptoms of AN and moderate symptoms of BN, however did not meet the strict criteria of the DSM IIIR. Of further concern was the inclusion of ruling out depression on the Axis I diagnosis. An Axis II diagnosis was deferred at the time of assessment.

A family meeting (including J and her parents) was held to share recommendations for treatment. Individual outpatient counselling was recommended for J, with adjunctive family counselling for the entire family. Individual counselling could focus on J's poor body image, sexuality, "control" issues, and feelings of being unloved. To begin with, J would have to consider her struggles with eating and food as legitimate

problems. Her family would be able to discuss their stress associated with J's poor eating. Family therapy was felt to be important to assist the family to explore underlying issues.

Although the author met with J individually three times in an attempt to engage her in counselling, she remained detached. Her family was open to counselling - mainly due to their hope that if they were involved in family meetings, that might motivate J to join family and/or individual meetings. They cancelled their appointment after it was clear that J was an unwilling participant in counselling.

CLIENT #7: Tannis (T)

The next client seen for assessment was a 20 year old, single woman. She was self employed and helped run a small business. She was referred to the ED Clinic after disclosing difficulties with eating to a Health Sciences Centre Emergency physician. She also was prompted to go to counselling by her mother.

T was adopted at birth and had limited information about the circumstances around her adoption, or about her biological parents. She had one adopted brother. Her adoptive father died suddenly when she was a child. Therefore, T had little memory of her father. Her mother was described as creative and emotional. She experienced chronic migraines. At the time of assessment, T's mother was appearing at Emergency rooms on a

weekly basis.

T's difficulties with eating began when she was approximately 14 years old. At this time, she began dieting, vomiting to control her weight, and using laxatives. At her worst, T reported taking 15 laxatives after meals. She also reported using diuretics and occasionally using appetite suppressants. She described her current eating patterns as variable, having periods of fasting and/or restricting, as well as periods of overeating. T was vomiting approximately two times a day, and using up to 15 laxatives a day sporadically (two to three times a month).

T generally offered little information about her past and her family. It was therefore difficult to get a sense of her experience. It appeared that after her father died, her life changed dramatically. Her mother and T's grandparents then moved to the United States. The next seven years were spent travelling. She returned to Winnipeg at age 12 and struggled to establish herself at school and with peer relationships.

T eventually dropped out of school and became involved with her mother's business. T had only dated sporadically, and reported having disappointing and casual relationships with men. T also had limited social contacts with women. It appears that T was socially isolated and somewhat dependent on her family. Within one year, Tannis lost both of her grandparents. It was unclear as to how significant these grandparents were to T, or the impact their deaths had on her.

T was given an Axis I diagnosis of "eating disorder not otherwise specified". She displayed signs of Bulimia and Anorexia, but did not fit all the criteria for either category.

Axis II diagnoses were phrased as "ruling out" depression, as well as concerns raised by the team regarding T's mood and affect. T also appeared to have many difficulties with relationships (i.e. connecting with people and sustaining relationships). Hence, it was felt that T may be experiencing other problems unrelated to the eating difficulties.

It was recommended that T return to the Clinic for further assessment, and for ongoing outpatient individual counselling. T was offered help with stabilizing her eating patterns (i.e. controlling binging and purging). It was also felt that exploring family issues, T's self esteem, and relationships would be important to focus on. Although T made a follow-up appointment, she chose not to follow through with counselling at that time.

CLIENT #8: Shawna (S)

S was a 19 year old, single woman who was employed as a retail sales clerk. She was 5'5" tall and weighed 112 lbs. She was residing with her parents and was coaxed to come to the ED Clinic, mainly by her mother. She was the youngest of three children from a middle class family. She had two sisters who were 13 and 16 years older than herself.

S described her mother as a wonderful person. She was

"giving, concerned, and would do anything for her family". She also stated that she was kind, sensitive, and a hard worker. S's mother was employed full time.

S's father was also described as "pretty wonderful". He was a "mild mannered, agreeable, and honest individual". He was working full time.

Weight consciousness and eating difficulties began for S at the age of 16. She did not describe a clear precipitating event triggering her desire to lose weight. Rather, she attributed "society's pressure on women to be thin" as an important factor in her initial difficulties with her body image.

S began binging and vomiting at age 16, in order to lose weight. She vomited approximately two times a day. She weighed 124 lbs. (and was 5'4" tall) at this time. She decreased her weight to a low of 108 lbs. by exercising (jogging) and continuing the practice of vomiting after binging or after eating meals. At age 18, she stopped exercising as well as vomiting. She attempted to "cope" with her weight, however, remained dissatisfied with her body.

S consciously made a New Year's resolution to lose weight again. She began to diet and vomit (approximately once a day, or three to six times per week). S came to counselling for assistance in controlling vomiting and to not feel guilty after eating. The prospect of gaining any weight was intolerable to her.

Although S painted a rosy picture of her family, there were glimpses of family difficulties. To begin with, S described the time around her sister's leaving home as a difficult and sad time for her. She was also open about the fact that her next eldest sister had "difficulties with eating", and was binging and vomiting herself on occasion. Both parents were described as "health conscious" - concerned with eating healthy, exercising, and dieting. Along with this, S's mother had a history of depression.

S recounted having two significant relationships with men. At age 17, she began seeing a man, whom she dated over a two year period. She ended this relationship, stating that he was a jealous, distrusting man, and overly attached to her. She had begun a new relationship a few months prior to coming to the ED Clinic. She felt that her new boyfriend was kind, considerate and from a "good background". Although S felt this was a good relationship, she discussed having sexual difficulties due to her own discomfort and dissatisfaction with her body.

S was given the diagnosis of "Bulimia Nervosa", as she met all DSM III R criteria in this regard. It was noted that she also displayed features of Anorexia (specifically an intense fear of weight gain, and disturbance in body image perception). There was no Axis II diagnosis given. Indeed S exhibited a lot of strengths and only moderate difficulties in everyday functioning. It was felt that she was attempting to deal with the developmental

issues of separating from her family.

A control issue within the family was also postulated. It was clear that S's eating problems elicited a concerned response by her mother (in particular) which locked S into a power struggle with her. An internal struggle with her emerging sexuality also appeared relevant in S's case. Her insecurities about her body in general were exemplified in intimate relationships.

Outpatient, individual counselling was recommended for S, in order to provide her with education on Bulimia and to make suggestions regarding establishing healthy eating patterns. It was also felt that assisting her to examine family issues and issues around her sexuality would be important. S expressed interest in pursuing a women's support group, which was encouraged as an adjunct to individual counselling.

S attended five meetings at the ED Clinic before a mutual decision was reached whereby she terminated counselling. Over a two month period, S cancelled four appointments and constantly struggled with her perception of whether she had a "problem" at all. S felt that what she probably needed was to see a nutritionist who could advise her how to eat and avoid weight gain. She inquired into a support group for weight preoccupied women (held at the Women's Health Clinic), attended a few sessions, and quit.

CLIENT #9: Jennifer (J)

Jennifer was a 24 year old, single women who was employed full time as an assistant to a health care provider. J was 5'4" tall and weighed 150 lbs. at the time of assessment. She was the oldest child in a family of three children (she had two younger brothers). Her family resided in a small northern town, which J left when she was 19. She lived alone in Winnipeg and visited her family approximately once a month.

J's mother was a women with limited education who had never been employed outside of the home. She was described as a nice person and generally insecure. J's father was employed and had attained a Grade IX education level. He was described as nice, funny, and respectable - when sober. He was also described as an emotionally and physically abusive person when drinking.

J's difficulties with eating first began three years previously (at age 21). Typically, she would eat a large amount of food during evenings. At this time, Jennifer had left her home and had felt lonely and isolated. She recalled turning to food for "comfort". She described a pattern of binge eating occurring over a two to three month period, followed by a period of strict dieting over a two to three week period. Over the next year, the amount of food J consumed during a binge began to increase. A typical binge might include eating six jam busters, one litre of ice cream, two small pizzas, a half bag of potato chips, and one half litre of soft drink. Along with binge eating, she continued

attempts to diet. She tried laxatives (five to six times a day for one week per month). She also attempted to vomit after binge eating, but was never successful. She temporarily tried using diuretics ("water pills"), but discontinued using them after one week.

Along with J's troubled eating came bouts of depression. J also admitted to drinking frequently in order to boost her confidence in social situations.

J came to the ED Clinic in order to stabilize her eating, and to feel better about herself.

Of primary significance in J's background was the impact that having an alcoholic father was having on her. She grew up in a family that had a multitude of problems. Over the years, she witnessed her father being emotionally and physically abusive towards her mother. As an adult, she remained caught in a destructive triangle with her parents. She acted as her mother's protector. She also colluded with her family's unspoken rule to deny that her father had a drinking problem.

J was left feeling tremendously responsible for her family, yet powerless to change the way in which the family was functioning. She recognized that her family was not emotionally available to her. She felt rejected and abandoned by them.

Jennifer was also experiencing difficulties in relationships with men. She had had one significant relationship beginning at age 17. They stayed together for six years in total - three of

those years were spent living together. By the time they began cohabitating, drinking and taking drugs became a weekend adventure. J smoked marijuana and experimented with "bennies" and "buds" (mushrooms). She attributed a lot of her drinking and drug use to this relationship (i.e. the influence of her partner and the lifestyle he maintained). She experienced this relationship as comfortable, self affirming (as her lover was very supportive), but also as boring.

J chose to end the relationship when she left rural Manitoba. Since moving, J experienced only fleeting, non-satisfactory relationships with men. She was developing a pattern of drinking in excess in social situations and then having casual sex with men who were largely unfamiliar to her. This pattern was exacerbating J's feelings of low self esteem.

J's assessment focused on her difficulties with eating, her low self esteem, and her feelings of depression. J was given an Axis I diagnosis of "eating disorder not otherwise specified". She exhibited all the DSM III R criteria for Bulimia, except for engaging in vomiting and/or significant laxative abuse. Ruling out depression was also important to include on the first axis. An Axis II diagnosis was deferred.

Recommendations for J included outpatient, individual counselling which focused on assisting her to stabilize her eating, as well as to examine numerous issues in her life. Her own abuse of alcohol, issues in relation to being an adult child of an

alcoholic, and her role in her family were all felt to be important. Sexuality and her intimate relationships would also be necessary to explore. In general, J's low self esteem and her lack of confidence (as well as lack of assertiveness) were central to her eating difficulties.

J was seen on an ongoing basis for a period of four months by the author. At that point, the practicum ended. J was referred to a women's self-help group which she ultimately found too intimidating to participate in. She was transferred to Daryl Johnston (nurse therapist) for continued individual counselling. See "Therapeutic Dilemmas and Themes" section of this chapter for a full description of the counselling process.

Assessment - The Complexity of Diagnosis

Upon reflecting on the process of assessing the nine women which were part of this practicum, it became clear that there were a number of difficulties associated with the practice of providing a "diagnosis". The following comments will outline these difficulties, as experienced by the writer.

It is interesting to note that eight out of nine of the women seen were given the diagnosis of "eating disorder not otherwise specified". This is significant for a number of reasons. There is difficulty using the diagnosis of "Anorexia Nervosa" or "Bulimia Nervosa" due to the rigidity of the criteria. For a diagnosis of

Anorexia to be given, a woman must have "a weight loss leading to maintenance of body weight 15% below that expected" (DSM IIIR 1987). For example, this would mean that a woman of 5'2" in height and a pre-morbid weight of 125 lbs. would have to lose 19 lbs. and weigh 106 lbs. (or less) for the label to apply. The application of a diagnosis could contravene a preventative approach (i.e. a women displaying all of the other psychological and behavioural manifestations of "Anorexia" would not be truly recognized as such previous to a 15% weight drop).

In addition, an "absence of at least three consecutive menstrual cycles, when otherwise expected to occur" (DSM III R: 1987) is required. It is very common for women to have irregular periods. Also, women who are on birth control pills may have "false" periods - periods induced by the administration of hormones. Therefore, women displaying all other diagnostic criteria except the absence of three menstrual cycles, are similarly not considered Anorexic.

There is generally less rigidity in the criteria applied for the diagnosis of "Bulimia Nervosa" to be given. There remains the standard of a "minimum average of two binge eating episodes a week for at least three months" (DSM III R: 1987). This is coupled with the criterion of "the person regularly engages in either self-induced vomiting, use of laxatives or diuretics, strict dieting or fasting, or exercise in order to prevent weight gain" (DSM III R: 1987). These symptoms are often seen in women

with diagnoses of "Anorexia". This undoubtedly creates confusion and leads to two diagnoses given at the same time, in some situations. It also means that women who binge eat and who do not adhere to strict dieting (let alone vomiting or laxative abuse) are not considered Bulimic. Nevertheless, these women may satisfy four out of five criteria outlined for the "Bulimia Nervosa" diagnosis.

It appears that the psychiatric diagnoses of AN and BN represent the extremes at the end of a continuum. This leaves many women (and certainly the majority of women seen by the writer) to fall into the catch-all category of "eating disorder not otherwise specified". This category can describe overeating, weight preoccupation, as well as milder forms of Anorexia and Bulimia. One might argue that a large majority of Canadian women could easily be so classified. One might further argue that it is very difficult to label women as either exclusively "Anorexic" or "Bulimic".

It is also impossible to ignore the woman's own perception of her eating difficulties. A woman experiencing (for example) body image difficulties, weight preoccupation, and who is a chronic dieter, may feel she has an "eating disorder". It would be anti-therapeutic to reframe her interpretation of her difficulties as not indicative of a problem. Therefore, I feel we must look beyond symptoms to the subjective distress of the woman. This is difficult to do, however, in the case where the evidence (so to

speak) suggests that a woman exhibits the psychological or behavioural manifestations of an eating disorder, and yet describes little (or no) subjective discomfort. We then label and understand this as "denial".

Providing a diagnosis is a process of understanding framing and labelling a person. For some women, the label of "eating disorder" was more palatable than a multitude of other psychiatric labels. Indeed, there was a clear sense that having an eating disorder was different from, and not indicative of, a psychiatric condition at all. This was demonstrated, for example, by a number of women's refusal to consider the inpatient ward of the ED Clinic as a "psychiatric" ward.

To be seen at the ED Clinic, a woman would have to be considered able to meet criteria for either AN, BN, or "eating disorder not otherwise specified". This meant that women who were obese were categorically refused to be seen at the Clinic. Regardless of difficulties they may be experiencing with binge eating (or vomiting), their body image, or chronic dieting (for example), being overweight would disqualify them from service. Strict interpretation of the diagnostic criteria can have the effect of limiting access to service.

To provide a psychiatric diagnosis also means that one has to rule out differential, or concurrent, diagnoses of relevance to the population of women with eating disorders. This would rule out depression ("Depressive Disorders"), "Borderline Personality

Disorder", "Psychotic Substance Abuse", "Obsessive/Compulsive Disorder", and "Narcissistic Personality Disorder". Teasing out the symptoms and understanding the person (in their entirety) made coming up with an "accurate diagnosis" difficult. Furthermore, the purpose and utility of labelling women in this fashion is questionable. Certain labels seemed to be more negative than others. Labels categorized people and often served a function of predicting the success or failure of therapy. The label of Borderline Personality Disorder, for example, held with it a connotation that the individual would be difficult to deal with and an expectation that therapy with this "type" of individual was more often than not, unsuccessful.

The process of diagnosing is undeniably an exercise in recognizing and focusing on an individual's weaknesses. This is in contradiction to strength oriented, feminist approaches. The process of diagnosing is pathology oriented and focuses on the intrapsychic manifestations of the individual. This means that the contexts of the family, the community, and society are minimized, if recognized at all.

Therapeutic Dilemmas and Themes (Three Cases)

In order to outline the therapeutic dilemmas and themes seen throughout the practicum, I will begin by elaborating on three cases where there was ongoing involvement. Then, I will

comment on themes apparent across the experiences of the women. Lastly, I will address the dilemmas present in engaging and counselling the women seen in this practicum experience.

Lorna (L) was the first person seen for assessment and was described previously in the "Assessment - A Glimpse at Nine Women" section of this chapter. The important issues that were discussed in L's case appeared to be family issues, her low self esteem, lack of assertiveness, and the need for developing healthier coping mechanisms.

For the purpose of simplicity, I have chosen to describe the counselling in terms of a beginning, middle, and ending phase. It is recognized that succinct categories imply that there is a line of progression of events, or progress. This was never the case in real life. The "issues" in the lives of the women seen were complex and occurring throughout counselling.

CLIENT #1: Lorna (L)

L could be described as an honest, somewhat serious and reflective individual. She possessed many characteristics which made her a "good" candidate for therapy. She was a bright, insight oriented, and articulate woman. She had some hesitations and fears towards counselling. Nevertheless, she generally possessed a real openness and excitement about personal growth. L also demonstrated an ability to problem solve and use her intellect to her advantage. Some of the difficulties she was

experiencing included her keen eagerness to please others, her strong avoidance of conflict, and lastly, her hesitancy and fear about expressing her feelings.

The beginning phase of counselling addressed L's use of food in her life. What was seen was that L was obsessive in her thinking about food. She ruminated about what she gave herself "permission" to eat, and then thought about what she had eaten for hours after a meal. She was restrictive with the amount and variety of food that she ate. She had engrained rules about "bad food", which had become practically second nature to her.

L responded to the scrutinization of what she was eating (and why she was eating) with guardedness and, at times, defensiveness. She also remained physically active (at times over exercising) in order to stave off any weight gain. L tried desperately to incorporate the healthier eating habits that were being suggested to her, however, she had great difficulty believing that not dieting would be "healthier". She increased some of the portions of the meals she was eating, and attempted to bring more variety into her diet.

L had difficulty identifying patterns in her eating, but began to recognize her vulnerable eating times (e.g. feeling like binging when under school related stress, feeling pressured to eat by her family). She also had difficulty filling in the food diary (required by all women in the beginning stages of counselling). She stated that filling out the food diary was difficult for

her because she realized, in a concrete way, how little she was eating. This created a discrepancy between how she felt (i.e. full, fat) and what she was seeing. Furthermore, she felt uncomfortable with being monitored by someone else.

By the middle phase of counselling, L began talking about difficulties she had experienced with relationships. She discussed unfinished business in regards to her last significant relationship with a man. She had had great difficulty in letting go of this relationship. She found it almost impossible to deal with the fact that this man was seeing another woman while seeing her. She could not assert how this made her feel and, although she felt she had just cause to terminate the relationship, she found herself overly concerned about how "he" would cope with the breakup.

This overconcern with other peoples' feelings and a lack of awareness and feeling comfortable with expressing her own feelings, was a theme running throughout L's life. It appeared that the expression of anger and sadness were particularly difficult for her. This became apparent when L began discussing her family.

L initially hesitated to discuss her family at all. She then made a concerted effort to explain that they were "wonderful". She eventually disclosed some of her family issues. She was struggling with differentiating from her family and was questioning their values, religion, and the strictness that was all

a part of her upbringing.

After about three months of counselling, L was able to cry, expressing some of her sadness and frustration. This appeared to be a breakthrough. By experiencing her sadness, she affirmed her feelings and gave herself permission to express herself. This "practice" in our session, gave her the courage she needed to begin expressing her feelings in her "real" world.

By this time in the sessions, food (and food related issues) became less and less a focus of the work. L commented that she felt more balanced with her eating and that she was thinking less about food, dieting and exercise. It was as if a shift had occurred from the external "symptoms" of her eating difficulties to the underlying core issues. The theme of sexuality became more prevalent at this time. Her struggle was with being recognized by her parents as a sexual being and with claiming to be (and being) comfortable with her own sexuality.

During this phase of counselling, L's insight became useful as a springboard to implementing changes in her life. Recognizing and expressing her feelings went hand in hand with becoming more assertive. She learned to say no instead of taking on everything that was asked of her. She also began to assert her needs in her relationship with her boyfriend and with her parents.

Towards the end of counselling, we reviewed L's progress. She had made significant gains. She was feeling confident about

coping with her life without resorting to binging and vomiting. Her weight and eating remained healthy and stable. L was feeling positively about continuing her self growth without the need for being in counselling. She was able to assert her need to terminate counselling (which in and of itself was a positive indication).

After our last session together, we agreed that L would be phoned in two weeks time, to share feedback from the ED Inventory. The positive changes that were also detected by this instrument were outlined. L was then left with an open invitation to call (and/or return) to the ED Clinic in the future, should the need arise. At the time of writing this report, there had been no further contact by L.

CLIENT #2: Nicky (N)

N possessed certain characteristics that made working with her very challenging. She communicated in an indirect fashion and often presented as unclear and confused. N was continually ambivalent about counselling throughout our six months together. She had ongoing difficulties with setting goals and creating a focus for herself.

In reflecting back to the beginning phase of counselling, I am reminded of the constant difficulties I experienced in an attempt to "engage" N in counselling. This struggle was apparent throughout our time together. Approximately 50% of the

time, N would miss appointments.

After our initial meeting, we entered the process of trying to negotiate our work together. One of the blocks we encountered was N's refusal (indirectly and directly) to change her eating behaviour, as well as other destructive habits (laxative abuse, over exercising, and dieting). It appeared that N was struggling with her understanding (intellectually) that what she was doing was truly unhealthy to her body. She was being powerfully reinforced for her behaviour. She belonged to a club where all of the other women were dieting and committed to exercising (one might argue, in a compulsive fashion). N had also been using her eating difficulties as a coping mechanism for the past eight years of her life. This made giving up her "eating disorder" extremely difficult.

She responded to the task of filling out a food diary (early in counselling) by using the diary in a dual fashion. She meticulously recorded her food consumption and also logged the feelings she was experiencing. Her food diary/feelings journal gave valuable glimpses of her underlying battle to feel good about herself (through what she was eating). She also underscored a struggle with her identity (Who am I? What makes me different from others?). N also expressed a lot of anger through her journaling. At first, her anger appeared directed at herself. Later, she began writing about being hurt and how, at times, she was angry at her husband and other family members.

By the middle phase of counselling, marital issues became very apparent. N's husband was interfering with counselling. He would give her mixed messages. He would tell her to "go more often - you need help", and then tell her that he thought the counselling was useless. He was also experiencing marked stress due to N's sporadic eating habits. It became clear that there was a power struggle (centered on eating) between them. The more her husband tried to control her, the more N rebelled. The need for marital counselling was discussed and N agreed to approach her husband about this. He agreed to try couple counselling if this would "help Nicky". They were referred to the family therapy department and were seen for three to four months by a psychiatric resident.

N continued with individual counselling, but her attendance became even more sporadic. By then, the eating was less a focus in counselling. N, however, seemed to be developing a lot of physical symptoms including headaches, stomach cramps and bloating, constipation, and vomiting.

Initially, N felt that the marital counselling was helpful. She enjoyed "talking openly with her husband for the first time". In individual counselling, she continued talking about her feelings towards her family. She also continued to discuss her body image difficulties (i.e. her "hatred" towards her body). In our twelfth session together (five months), N announced that she was pregnant. She had tremendously ambivalent feelings towards this

pregnancy. She felt that she was "expected" to have children and that she had little/no choice in the matter. Again, the issue of feeling "out of control" emerged. We negotiated to focus the counselling on how N could cope with her body image difficulties (given that being pregnant exacerbated these feelings).

The next three scheduled appointments were not attended by N. She continued to voice, however, that she was having difficulty with how she was feeling about herself and about the pregnancy. We decided together to terminate counselling at this time - given N's inability to attend sessions.

I felt that N was putting a lot of pressure on herself to "cope well" and to demonstrate to others that she felt positive about being pregnant. She isolated herself as a result of experiencing guilt for the "negative" feelings she was having. I encouraged her to contact the ED Clinic in the future. We agreed that after she had given birth (i.e. the post partum period), that this may be a particularly vulnerable time for her.

N recontacted the ED Clinic with a concern of feeling out of control of her eating, dieting, and purging once again.

CLIENT #3: Josephine (J)

J was a polite, young women who was "eager to please" in her life and in therapy. She came to counselling with very mixed feelings. She felt despondent and very much in need. This desperation left her feeling anxious that she was going "crazy".

J's case was initially described in the "Assessment - A Glimpse at Nine Women" section of this chapter. I will now expand on the process of counselling J over the period of 12 sessions (17 weeks).

At the beginning, there was a lot of emphasis put on debunking myths around what it meant to go for help. J felt that it was okay for other people, but did not apply this logic to herself. She felt somehow defeated (and weak) to be in the position of having to go for professional help. She was also quite concerned about what others would think if they found out. This was an important issue, as J had to negotiate with her employer to get time off to come to appointments.

Early on, we explored the meaning of thinness in J's life. It became quite evident that J felt that if she were thin, her life would be wonderful. She was trapped in a cycle of dieting in order to feel in control, and in order to alleviate the unhappiness she was experiencing. J's food journals reflected this struggle. Links between feelings of loneliness and sadness, with periods of overeating emerged. J was able to recognize this. Therefore, we began to explore her feelings and our sessions became less and less focused around food itself.

By the middle phase of counselling, J began discussing significant relationships in her life. She was feeling isolated from her family and from her girlfriends. J also focused on her hopes to become romantically involved with a man. She felt that having

a boyfriend was very important. She also felt poorly about herself, that she was not in a relationship at this point in her life. In the past, J had been in one long-term relationship (between the ages of 17 to 23). J missed the stability, comfort and protection that this relationship provided her.

J began to disclose her feelings about her family, which was prompted by a family crisis. Although she initially described her family quite positively, she slowly divulged a variety of problems. This came about as she was contacted by her mother. J felt a lot of distress after these contacts. J feared for her mother's safety. Her father was drinking and had been violent towards her (mother) in the past. J knew that her father also had guns in their house and had threatened to use them. J's parents lived in a small rural town and J felt "helpless" to do anything about this.

The family crisis opened the doors for discussion of J's role within the family. To begin with, J was denying her father's alcoholism. We explored her feelings towards his drinking and how the drinking had affected her as a child. As an adult child of an alcoholic, her father's alcoholism continued to affect her. J was becoming more aware of this. She began to struggle with how she could change her role in her family. She struggled with intense feelings of responsibility (towards her mother, father and her siblings).

By this time in the counselling process, J was less inclined

to define herself as the problem, and was more open to examining her family in order to understand some of the difficulties she was experiencing. She also examined her own drinking and substance abuse. By focusing critically on her father's drinking, she was able to be more critical of her own.

Towards the end of our time together, J remained struggling with a host of emotions (predominantly sadness and anger). She continued to use food as an emotional outlet, but became more aware of this and demonstrated the ability to discuss her binge eating. She had developed new insights into why she was struggling with food (and alcohol). We began to address the need for J to become more assertive - assertiveness in the sense of expressing her feelings and with practicing setting boundaries for herself. There was plenty of opportunity at work, with her family, and with friends to do so. J was able to try (in small steps) to be direct and assert herself. She needed encouragement and practice in order to do so.

Throughout our time together, J displayed unrealistic expectations regarding her progress in counselling. She put a lot of pressure on herself to feel better instantly. She felt hopeless a lot of the time (that her life would not change significantly). Allowing J to see the changes and steps that she had taken (however small) became very important. We prepared to end our meetings together with discussions about how J could develop new coping mechanisms. J continued to need food as an

emotional outlet. She became more resolved to this. She priorized to continue to work on her family issues, her own drinking, and with trying to become more comfortable with being an independent adult. J was given the option of continuing counselling with Daryl Johnston (Clinic Coordinator). She chose to continue counselling and to explore the possibility of joining a support group for women with eating disorders.

J saw Daryl Johnston for many more months. She was referred to A.F.M. (Alcoholism Foundation of Manitoba) as her drinking continued to be problematic. Her eating difficulties remained constant, yet only mildly disturbing to her.

Themes

Reflecting back on the three women that were seen in counselling, there appeared to be themes, or issues, in common that the women were struggling with. I have come to believe that this is not coincidental. The literature described typical "profiles" of women who developed eating disorders. To a large extent, this was seen in my clinical experience of this practicum. I will elaborate on themes seen across clients. Then, I will also discuss the commonalities that were seen in the process (i.e. stages) of counselling.

The question therefore arises: In what ways were the lives of Lorna (L), Nicky (N), and Josephine (J) similar? One predominant similarity was the struggle (i.e. push/pull) to

recognize that they were experiencing problems. Perhaps this reflects an element of denial. However, the strong social prescriptions for women to behave as dieters should not be underestimated. In a society that promotes thinness for women, it is not a surprise that women do not know when to recognize disturbed eating patterns (for example), as constituting a problem.

Further to this, even when there was recognition on the part of the women that something was wrong, they often chose to continue their practices because of the social payoffs. Lastly, there is another category of women who cannot dissolve their eating disorder symptoms, as they do not have the psychological wherewithal to do so. Stated another way, they lack the coping mechanisms (and the social support) to replace the function of the eating disorder. L, N, and J all had difficulty recognizing their dieting, exercising, and self-abusive practices as really constituting a problem. I believe that N, for example, made a choice (consciously and perhaps at times, less of a conscious choice) to maintain her eating disorder.

Each woman also focused on the symptoms (e.g. dieting, vomiting, binging) to originally become involved in counselling whether they were indeed out of control. It was easier to talk about and understand weight, food, and exercise than to connect these behaviours with their feelings. This was a natural (and substitute) form of expression for the women. Our society and

their particular social supports encouraged this.

Another underlying similarity between the women was the enormous pressure they all felt to be thin. This was a standard issue, whether they were (as was in the case of J) moderately overweight, or whether they were thin (as in the case of L and N). They all had bought the myth that "thinness equals happiness". As well, they all were unhappy with their bodies. The body dissatisfaction was highly personal. They experienced themselves as fat, or unappealing, regardless of what objective feedback they received. There was "body image distortion" apparent for all the women (to a greater or lesser degree). This was particularly evident in the case of N, who experienced her pregnant body as fat and disgusting. She could not distinguish between having a baby and being "fat".

Body image and sexuality issues were inseparable. For J, she felt so uncomfortable with her body that she became drunk in order to have sex. For N, she avoided sex. Of the three women, L expressed the most comfort with her sexual life, however she voiced a lot of discomfort with claiming her sexuality in the midst of her strict family.

The area of assertiveness was clearly difficult. This was seen in the arena of the family, as well as in the outside-working lives of the women. All of the women had difficulties asserting themselves due to the discomfort they were feeling about having emotions. They had also learned to compromise their own feelings

(and needs and wants) in their families of origin. For J, being raised in an alcoholic family meant that she learned to take care of her parents (and her siblings) from an early age. For N, she also was raised with needy parents who demanded that she behave and be a good daughter. Finally, we see L, who was taught to be a good girl at all costs. Anger, conflict, or disagreement was not tolerated in her family. She was to respect her parents and to act in an acceptable fashion. All of the women were conditioned to put the emotional needs of their parents first. As adults, they struggled to feel comfortable with their own needs and feelings and with expressing them openly and directly. Also, they struggled with differentiating or separating their needs from those of their parents.

Being "nice" people also meant that these women were vulnerable to becoming self-abusive. They directed anger inwards. They were more comfortable acting out their frustrations on their own bodies. L binge ate and vomited in order to purge herself of her frustration. She also exercised in an extended, punishing fashion. N abused laxatives, starved herself, and exercised compulsively. She also, at times, hit herself when she was angry and frustrated with "herself". J binge ate, drank, and isolated herself when she was upset.

The women acted out on themselves physically. They blamed themselves for the difficulties they were experiencing. They were each, in their own way, very protective of their

parents. They had personalized (i.e. directed inward) their struggles in order to feel in control.

Therapeutic Dilemmas

One of the biggest challenges of this experience was engaging the women into counselling. There obviously has to be readiness on the part of the individual. This can be created through the individual feeling that they are in crisis. Nevertheless, there has to be an openness to explore their life and an enthusiasm to be a part of a growing process. The task for the therapist is then to encourage and support the woman who is ready to do this.

In reality, the majority of women (if not all) of whom I came into contact with, were ambivalent about engaging in counselling. This challenged me to be "convincing" with the women (in terms of the need/importance for them to be in counselling). To do this in a way that did not emphasize pathology was difficult. This was difficult to do in a psychiatrically based hospital program. The women, after all, went through the procedure of assessment, which was largely a process of giving them feedback on whether they indeed had a "problem". Many women who could recognize that they had disturbed eating patterns were, therefore, interested in only "fixing" the eating problem. This often set up an unrealistic expectation.

Counselling was always offered in a "two-fold" fashion. On

the one hand, the symptoms were addressed, yet the underlying issues - that which caused the development of the disordered eating, were explored. This put the women in conflict if they were not interested in exploring "feelings" problems. Assisting the individual to move beyond focusing on the symptoms was, therefore, an intricate part of the work.

Another challenge in this type of counselling was addressing control issues, as they related to the therapeutic relationship. Being sensitive to the vulnerable position many of the women were in was important. Those women who lacked assertiveness skills could easily be manipulated in counselling. Assisting the women to establish goals and to have an active part in therapy was, therefore, necessary. There were other women who approached counselling in a controlling manner. They were used to manipulating family members and others through their behaviours. This dynamic was mimicked in counselling and could be frustrating for the counsellor. Recognizing attempts to control (often subtle) was equally as important. Commenting on controlling behaviour, bringing it into the conscious level, provided for rich material to use in sessions with the clients.

Exploring new coping mechanisms sometimes meant the women had to find new ways of dealing with people, which were not controlling in nature. This was very challenging. Old patterns of relating were often comfortable, ingrained, and served a function. Learning new ways that were positively focused was

important. There was always the danger present that the "eating disorder symptoms" could be replaced with other destructive means of coping. The experience of the practitioners at the ED Clinic was that many women became suicidal, or substituted substance abuse when they controlled their eating disorder.

Lastly, I would like to comment on the therapeutic dilemma which is present when a client is referred for adjunct counselling while in individual counselling. This demands that clear boundaries be set, otherwise the individual's focus can become contaminated. This was seen in N's case, where she began using the individual sessions to discuss the marital therapy. The counsellor was challenged to continue an individual focus and balance the need for the client to bring new insight and learning to the setting.

These were the major therapeutic challenges presented. In the last section of this report, "Reflections on the Experience", there will be further comments on the overall process of providing individual counselling.

CLINICAL ASSESSMENT AND EVALUATION

Introduction

Goals

The goals of clinically evaluating this practicum were as follows:

1. To use clinical evaluation as a means of measuring change (i.e. to comment on the effectiveness of the practicum intervention).
2. To use clinical assessment and evaluation as an adjunct to clinical judgment.
3. To experience using different clinical measures with this population so as to learn about the utility of the measures.
4. To learn about clinical assessment and evaluation.

Clinical Measurement Package

Rationale. Chart #4.1 graphically displays a demographic profile of all nine clients involved in this practicum experience. Chart #4.2 displays the total package used for clinical assessment and measurement of counselling impact. I will review a rationale for the selection of this package in the following section of this report.

Table 4.1

PATIENT INFORMATION

Assessments	Age	Height/Weight	Education	Age of Onset	Anorexic Tendencies	Bulimic Tendencies	Sexual Abuse Experience	Family Hx of E.D.	Family Hx of Alcoholism	Family Hx of Mental Illness
Client #1	21	(66) 5'6" 117 lbs	University	12		✓	n/k	no	yes	no
Client #2	32	(62) 5'2" 114 lbs	University	24	✓	✓	n/k	yes	yes	no
Client #3	25	(66) 5'6" 124 lbs	University	16	✓	✓	n/k (suspected)	no	yes	no
Client #4	21	(62) 5'2" 85 lbs	gr.12	14	✓	✓	n/k	no	yes	no
Client #5	21	(66) 5'6" 144 lbs	gr.12	19	✓	✓	yes	no	yes	no
Client #6	15	(64) 5'4" 99 lbs	gr.10	14	✓		n/k	no	yes	yes
Client #7	20	(62) 5'2" 109 lbs	gr.9	14	✓	✓	n/k	*n/k	*n/k	*n/k
Client #8	19	(65) 5'5" 112 lbs	gr.12	16	✓	✓	n/k	yes	no	yes
Client #9	24	(64) 5'4" 150 lbs	College	21		✓	n/k	no	yes	no

Note: Client 1 = L
Client 2 = N
Client 9 = J
(for ongoing counselling)

*pt. was adopted and had little information on her biological parents

Table 4.2

CLINICAL INTERVENTION PACKAGE

Measurement	Weeks 1	2	3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24
	Intake	Assessment Interview	Treatment
1. AN & B self report questionnaire data base	X	X	
2. E.D.I. Eating Disorders Inventory		X	X
3. Beck Depression Inventory (short version)		X	
4. Food Diary Record			X X X X
5. D.A.S. Dysfunctional Attitude Scale			X
6. C.S.Q. Client Satisfaction Questionnaire			X

As a member of the Eating Disorders Clinic team, it was appropriate and feasible that my work form part of the Clinic's service provision, and be evaluated similarly. Already in use in the Eating Disorders Clinic were three evaluative devices: Eating Disorders Inventory (Garner, 1983), food diaries and the "Anorexia Nervosa and Bulimia self report questionnaire". The Eating Disorders Inventory (hereafter referred to as E.D.I.) was used mainly for assessment, but could also be used in a repeated way to evaluate changes in the individual.

Food diaries were used routinely to monitor food intake, behaviours (such as vomiting) and as a therapeutic tool in counselling. The Anorexia Nervosa and Bulimia self report questionnaire provided a data base of information on the client and assisted with the assessment process. The questionnaire provided valuable information regarding how the client viewed her problem. As well, the questionnaire acted as a springboard to accessing further information during the assessment interview.

It was felt that all three tools would be beneficial to use. They would also be incorporated into the practicum experience. As will be stated later (in Section 3), the E.D.I. is a well known and "state-of-the-art" measure with this population. It is a contemporary and well trusted device for assessment, as well as for measuring outcome.

The use of the food diary was a welcome addition to the clinical evaluation package. The diaries provided the only direct

look at the "symptoms" associated with eating disorders. The food diaries were crucial in the beginning of counselling, to assess the nature and extent of the woman's difficulty with eating. According to Bloom and Fischer, tools such as food diaries can be very beneficial. "Direct observation of behaviours can be one of the most useful forms of measurement because of its potentially high validity and reliability, and because it can be especially useful for assessing behaviours." (Bloom, M. and Fischer, J. 1982, p. 130)

As an added benefit, the women were able to log their "feelings" as part of the food diary. This allowed me, as the clinician, to view how the woman was doing between sessions. Themes could also be detected from the diaries and therefore, brought forward during the counselling itself. I saw the food diary as a means of monitoring food intake (binge eating or restricting) as well as vomiting or purging behaviour. Changes in behaviour could be viewed in the collection and comparison of subsequent food diaries.

Added to these already used tools, the author chose three other complimentary measures. The Beck Depression Inventory (B.D.I.), the Dysfunctional Attitude Scale (D.A.S.) and the Client Satisfaction Questionnaire were added. The B.D.I. was used in order to screen for clinical depression. Depression is noted in the literature to be associated with eating disorders. The experience at the E.D. Clinic also verifies this link. The

E.D.I. does not have a subscale to measure depression. It was felt by the author to be important to use a measure of depression as an adjunct to this. The author also felt that screening for suicidal inclination and/or clinical depression would help select out clients who may be inappropriate for the practicum experience.

Lastly, if repeated, this measure would reflect change in an area which is not captured through the administration of the E.D.I.

The Dysfunctional Attitude Scale (D.A.S.) was added to the package as a clinical tool primarily. It is consistent with a cognitive approach, which looks at a person's thinking in order to assess, "psychological strengths and emotional vulnerabilities". The seven areas reflected by the scale were felt by the author to be clinically relevant to this population.

The D.A.S. is something that the women could also do on their own. It would supplement suggested reading on a cognitive approach to change. Lastly, the D.A.S. depicts strengths - which would be a different focus than all other measures. It was felt that experimentation with this tool would therefore be valuable and worthwhile.

The final addition to the clinical intervention package was the client satisfaction questionnaire. As a student, it was particularly important to me to receive feedback on how the women experienced the service provided them. Providing the women with a vehicle to do so (in writing) had two purposes.

Selecting a standardized measure meant that I could gauge and compare the responses to others. The main purpose - that of getting feedback from the clients (in a way that was comfortable for them) was also accomplished.

Assessment Measures

Beck Depression Inventory (Short Version), Psychometric Properties

Description.

A description of the Beck Depression Inventory (hereinafter referred to as the B.D.I.) will first be provided. Then the B.D.I.'s psychometric properties (i.e. reliability and validity) will be commented on. The B.D.I. short version is based on the original 21-item scale which was tested and validated on a population of 598 patients. These patients were psychiatric inpatients and outpatients from the Philadelphia General Hospital and the Hospital of the University of Pennsylvania. According to Aaron and Roy Beck (who developed the scales), the "selection of items for the short form was based on multiple regression analysis that permitted condensation of the inventory without loss of reliability and validity". (Beck, P and Beck, R., 1972, p. 82)

The scales were developed to assess "the presence and severity of affective, cognitive, motivational, vegetative and psychomotor components of depression". (Corcoran, 1987, p.

107) The B.D.I. short version is a pen and pencil, thirteen item scale. It asks the respondent to chose one of four statements that best describes their present feelings. The "O" level answer denotes no experience of the symptom and the "3"rd level answer denotes the presence of (most extreme indication of) the symptom.

Corcoran has reviewed the author's reports on the reliability and validity of the B.D.I. He states that;

> The B.D.I. has good to excellent reliability. Split half reliabilities ranging from .78 to .93 have been reported indicating good to excellent internal consistency. Test - retest reliabilities have been from good to very good, ranging from .48 for psychotic patients after three weeks to .74 for undergraduate students after three months. (Corcoran, 1987, p. 107)

The B.D.I. was also noted to have been compared to both clinical ratings of depression and other measures of depression. In both instances, the authors found statistically significant correlations.

Lastly, it should be noted that the B.D.I. is often described as "the most widely used measure of depression in clinical practice". (Corcoran, 1987, p. 107)

Utility / Critique. In terms of commenting on the utility of the B.D.I., it was my experience that this measure was easy to use and generally uncomplicated. Patients could complete the B.D.I. in approximately five minutes. Furthermore, the B.D.I. was easily scored. The most extrême response was scored a "3", the middle range response a "2", and the mild range response a "1". By simply adding the weighted scores one could derive a

total. The total could then be rated as to whether the individual was displaying none or minimal, mild, moderate or severe symptoms. This categorization gave an indication of the presence of depression, or a gauge to the severity of a depression.

Although the B.D.I. could never completely replace clinical judgment, it is an accurate and reliable measure to use in conjunction with clinical assessment. It was particularly helpful in cases where a woman scored in the "severe" category. This type of score necessitated discussing the possibility of suicidal thinking and/or plan with the individual.

Results.

Beck Depression Inventory:

Client #1	Raw Score	7
Client #2	Raw Score	6
Client #3	Raw Score	20
	(2nd Administration)	14

*

Estimated Degree of Depression According to B.D.I.	
Range of Scores	Degree of Depression
0 - 4	None or Minimal
5 - 7	Mild
8 - 15	Moderate
16+	Severe

* Source: Beck, A and Beck, R. (1972), "Screening Depressed Patients in Family Practice" in Postgraduate Medicine. Dec.1972, p. 81-85.

Client #1 and #2 both scored within the mild category of degree of depression. Client #3 (J) however, scored within the severe range of depression. This was noted and she was asked about suicide. Her depressive symptoms were therefore monitored closely throughout counselling.

Dysfunctional Attitude Scale

Description.

The Dysfunctional Attitude Scale (or D.A.S.) is a pen and paper tool to "measure cognitive distortion". (Corcoran, 1987, p. 143) Arlene Weissman developed this tool based on the cognitive therapy model of Aaron Beck. After filling out the 40-item scale, clients score their answers and are given feedback in seven categories. The seven categories are approval, love, achievement, perfectionism, entitlement, omnipotence and autonomy. The personalized scores can be plotted on a map (i.e. bar graph). When scores are plotted, they designate "psychological strengths or emotional vulnerabilities".

The psychometric properties of the D.A.S. were reported by Arlene Weissman in her 1980 paper entitled, "Assessing depressogenic attitudes: A validation study". This paper was presented at the 51st annual meeting of the Eastern Psychological

Association in Hartford, Connecticut. The D.A.S. instrument is published in David Burns' book, "Feeling Good - the New Mood Therapy". (Burns, 1980, p. 241) It was reported that:

> The D.A.S. was developed in a series of studies ultimately involving some 216 male and 485 female, predominantly white undergraduate students. Other research involved 105 depressed outpatients, 30 manic-depressive outpatients and their spouses and 107 depressed outpatients. No actual norms were reported since the number of D.A.S. items varied among these studies. For nonclinical respondents, the mean score is approximately 113. (Corcoran, 1987, p. 143)

The reliability and validity of the D.A.S. are both described as excellent.

> The D.A.S. has excellent internal consistency with alphas on the form of the D.A.S. reproduced here ranging from .84 to .92. The D.A.S. also has excellent stability with test-retest correlations over eight weeks of .80 to .84. . . . The D.A.S. has excellent concurrent validity, significantly correlating with a number of other measures of depression and depressive-distortions such as the Beck Depression Inventory, the Profile of Mood States, and the Story Completion Test. (Corcoran, 1987, p. 143)

The D.A.S. takes anywhere from 15 to 20 minutes to fill out. The D.A.S. profile (i.e. mapping cumulative scores) takes approximately 30 minutes to complete.

Utility / Critique. Using the D.A.S. was helpful in many ways and not very helpful in others. I will begin by commenting on the positive aspects and conclude by discussing the negative.

The D.A.S. is a client centered tool. It allows the woman to respond honestly and privately. It also allows her to see how the scale is scored and to get immediate feedback. The D.A.S. is

easily understood and used. It also is less focused on pathology than other instruments. It does this by depicting strengths and by calling weakness "vulnerabilities".

A clear strength of the D.A.S. is that it is easily used as a therapeutic tool. It also fits nicely with women's issues. It identifies areas that are common struggles for women (e.g. seeking approval, feeling entitled to assert oneself, etc.). So, the content of the D.A.S. itself can facilitate discussion on a number of relevant topics. Furthermore, going through the process of filling out the D.A.S. stimulates self awareness.

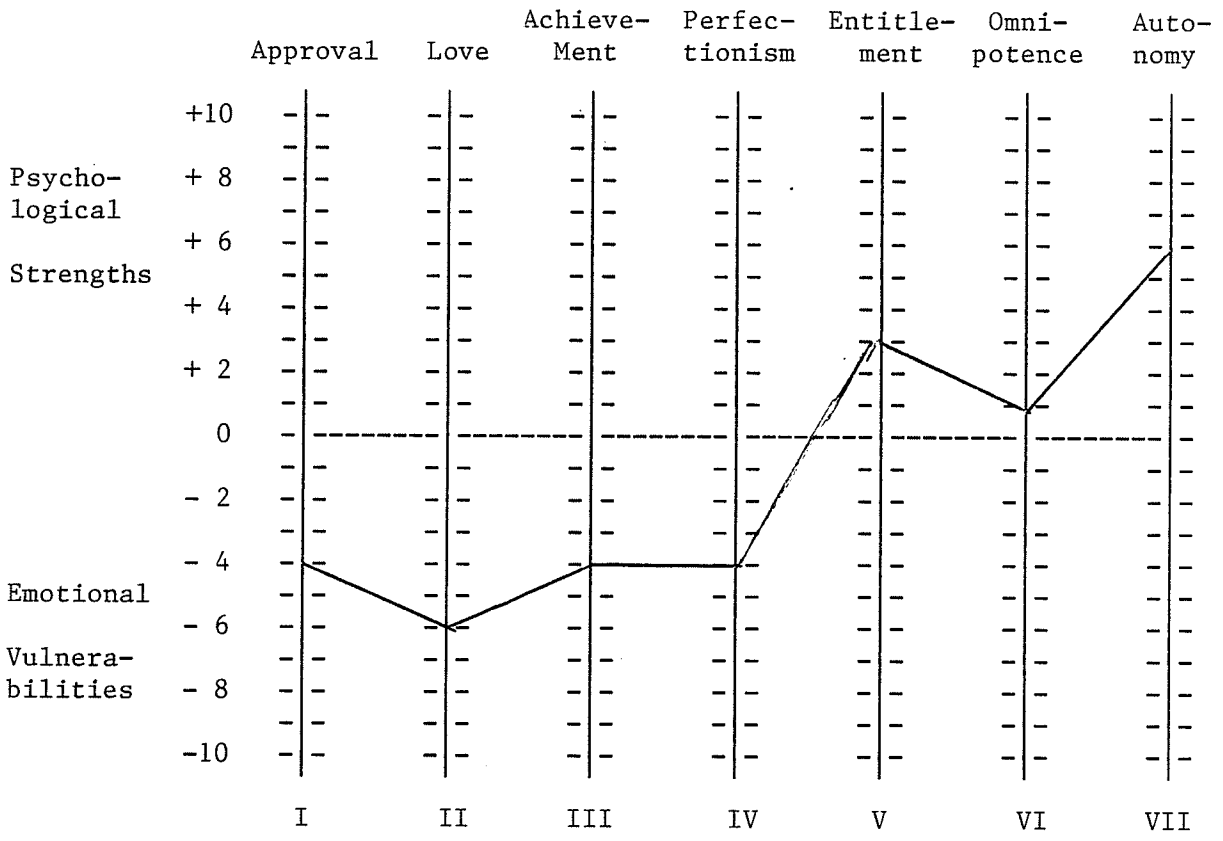
There are three criticisms I would make of the D.A.S. It is not "technical" in that you can not compare client scores with norms. It has limited use as an assessment tool because it does not screen for depression or other symptoms.

Secondly, the results of the D.A.S. scale can be potentially upsetting or damaging to a client. The results can be interpreted too literally. The scale is plotted in either a positive or negative direction. Too many "negative" scores can be very disheartening to an already self critical person.

Lastly (with my limited use of this measure), it appeared that intellectually oriented, insightful and well motivated women responded best to using the D.A.S. Most of these women were given adjunctive reading material (on cognitive therapy) to blend together with doing the D.A.S. This would obviously not be appropriate to do with all clients.

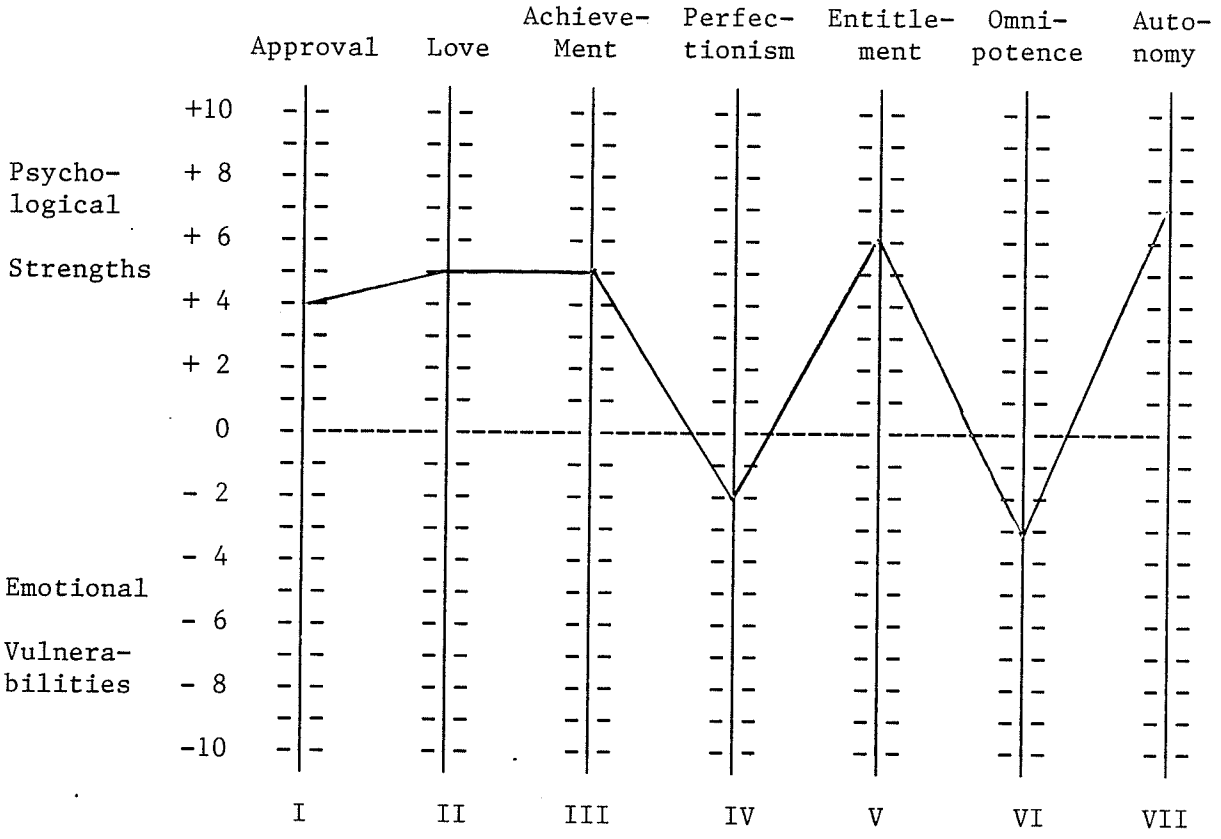
Client #1 ("L")

Personal-Philosophy Profile



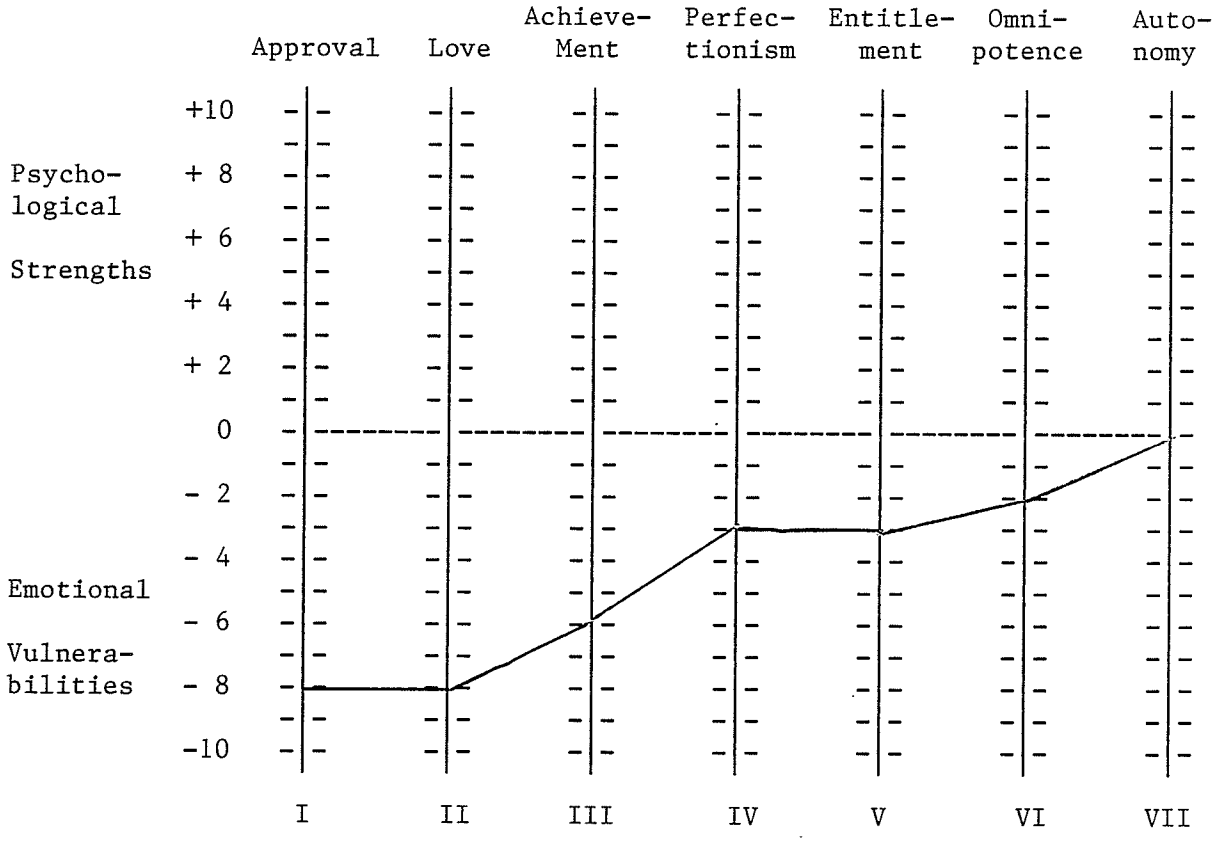
Client #2 ("N")

Personal-Philosophy Profile



Client #3 ("J")

Personal-Philosophy Profile



Results.

Client #1 As reported below

Client #2 As reported below

Client #3 As reported below

Client #1 ("L") (Personal-Philosophy Profile)

(See page 134)

L's personal map reflected many strength oriented areas (i.e. five out of seven). In some areas it appeared, however, as though L had answered in an "ideal" fashion - that is, how she thought she should be thinking. We discussed the discrepancies between her thinking and her behaviour. We also looked at her independence (e.g. entitlement and autonomy categories) as a definite asset. Lastly, her personalized map demonstrated that her perfectionistic tendencies could be looked upon as an emotional hazard. L was therefore encouraged to try to relax the pressure she put on herself to be perfect - at all costs.

Client #2 ("N") (Personal-Philosophy Profile)

(See page 135)

N's personal map reflected a cluster of emotional vulnerabilities. They evolved around her strong need for approval and affirmation by others. She also displayed perfectionistic tendencies. Her strengths were her independence and sense of entitlement. In counselling, we used N's map to balance

strengths and weaknesses. It was also a tool used to emphasize that perfectionism could be a self destructive attribute. N was encouraged to be gentler with herself and to accept that no one is perfect.

Client #3 ("J") (Personal-Philosophy Profile)

(See page 136)

J's personal profile unfortunately indicated all vulnerabilities. I anticipated that all profiles would have a combination of strengths and weaknesses and therefore was ill prepared to focus only on vulnerabilities. Nevertheless, we used this D.A.S. profile to look at some of J's beliefs and thinking patterns. We underscored some negative and exaggerated attitudes that she held. Lastly, the exercise was used to reinforce the assumption that thoughts and feelings are inseparable. Therefore, J was encouraged to examine (and change) some of her negative thinking in an effort to aid her in feeling better about herself.

Evaluative Measures

The Eating Disorders Inventory (A Rationale and Report of Psychometric Features)

Garner, Olmsted and Polivy developed and validated the Eating Disorders Inventory (or E.D.I.). They describe it as a

"64 item, self-report, multiscale measure designed for the assessment of psychological and behavioural traits common in Anorexia Nervosa (AN) and Bulimia. The E.D.I. consists of eight subscales measuring; 1) Drive for thinness, 2) Bulimia, 3) Body Dissatisfaction, 4) Ineffectiveness, 5) Perfectionism, 6) Interpersonal Distrust, 7) Introceptive Awareness and 8) Maturity Fears". (Garner Olmsted, & Polivy, 1983, p. 15)

They began the construction of the E.D.I. by creating a questionnaire. Then they selected and validated the individual questionnaire items. Lastly, the scale was empirically tested by comparing patients (i.e. a clinical population) with control groups. The E.D.I. was developed after the "Eating Attitudes Test" (E.A.T.) - one of the first standardized measures widely used with eating disorder populations. The E.D.I. is generally considered to be an improvement over the E.A.T. The E.D.I. appears to be more rigorously tested. The psychometric properties of the E.D.I. will be given at the end of this section.

The E.D.I. has as its purpose:

> The Eating Disorders Inventory (E.D.I.) which is a multi-faceted instrument designed to assess psychological characteristics relevant to Anorexia Nervosa and Bulimia. Justification for the development of the E.D.I. is based on the growing recognition that Anorexia Nervosa is a multidimensional disorder with considerable psychological variability across the heterogenous patient population . . . Identifying distinct psychological typologies may reveal features which discriminate individuals with Anorexia Nervosa from those who display significant symptoms of the disorder, but who may be less psychologically disturbed. (Garner et al, 1983, p. 16)

The E.D.I. therefore assesses Anorexia as well as Bulimia. Its focus is to differentiate between levels of disturbance and to offer a profile of the individual, giving the practitioner a variety of areas to examine. The authors have suggested that the E.D.I. is first and foremost a prognostic screening instrument, but caution against using this tool in isolation. The E.D.I. demonstrates (through the subscales) areas of clinical concern. The limitations of the use of the E.D.I. are also documented and important to recognize.

> Finally, the E.D.I. should not be employed as the sole means of screening for or diagnosing Anorexia Nervosa. Although the E.D.I. may be useful as preliminary screening tools for identifying groups in which a high proportion of subjects have formal eating disorders, these must be confirmed by clinical diagnosis; psychological tests should be an adjunct, not a replacement, for clinical judgments. (Garner et al, 1983, p. 32)

Therefore, the importance of using the E.D.I. in conjunction with a broad based interview is advisable. The E.D.I. should not be used as the sole assessment device. Considering a person's physical health status, as well as their ability to function in a variety of other areas in their lives, in an important adjunct to using this clinical measure. It is also important to note that the E.D.I. was developed with an all female population. The clinical population used to standardize the E.D.I. consisted of 113 patients derived from Toronto's Clarke Institute. Also, the initial comparison group was one of female university students. Only after initial scale validation did the authors

compare to a larger sample (included was a comparison of 166 male university students).

Keeping the above comments noted, let's turn now to examining how this measure is administered, its directness and ability to be sensitive to change. As mentioned earlier, the E.D.I. is a pen and paper, self-report measure. It is interpreted and scored by the clinician. It is relatively easy to administer and to manually score. At the E.D. clinic, computer software was used to enter and print out E.D.I. results which further simplified its use.

Exceptions to the use of the E.D.I. would be with clients who are illiterate, or who are significantly younger than the norm (some interpretations would have to be used and appropriate clinical norms would have to be used for comparisons). Also, caution would have to be used in accurately using the E.D.I. with male clients, given that the instrument was developed with an all female population.

Being a self report measure, the E.D.I. is of course, bound to the honesty and openness of the individual. At the time of administration, clients should be instructed to reflect their feelings as accurately as possible. (Some women may be eager to demonstrate "health".)

The client is asked to choose between six categories to reflect her response to a variety of statements. The response will be in one of the following categories:

Always	Usually	Often	Sometimes	Rarely	Never
( )	( )	( )	( )	( )	( )

This makes for ease in scoring the questionnaire, but perhaps not always for clarity in what is meant from the response. The items of the questionnaire are scored as follows:

> . . . the most extreme "anorexic" response (always or never depending on the keyed direction) earning a score of 3; the immediately adjacent response 2; the next response 1 and the three choices opposite to the most "anorexic" response receiving no score - 0. Scale scores are the summation of all item scores for that particular scale. (Garner et al, 1983, p. 19)

The flavour of the results indicates the level of pathology of the individual. The higher the score, the more closely aligned it is to the clinical population. Individuals receive an aggregate score and subscores for the various scales within the questionnaire. Raw scores are compared to the established norms.

Let's move now to examining the strengths of the features inherent in the E.D.I. Wear and Pratz comment on the reliability of the E.D.I.:

> Test-retest reliability for the E.D.I. was obtained with a sample of 70 university undergraduates. Test-retest reliability was also obtained with a restricted group drawn from the original sample who were considered to be at risk on the basis of their E.D.I. scores. The interval between test administrations was three weeks. With both samples, test-retest reliability for the eight subscales was, with one exception, within the usual range of acceptability. (Wear & Pratz, 1987, p. 767)

Therefore, it appears that we can administer the E.D.I. with assurance of its reliability. The E.D.I. can be said to be an

indirect measure. It is a contemporary, standardized measure of Anorexia and Bulimia. It has the ability to measure different dimensions of eating disorders (e.g. body dissatisfaction, perfectionism, maturity fears, etc.) which are believed and demonstrated to be components relevant in this area. The E.D.I.'s self reporting nature lends itself to a more direct approach.

Lastly, I will discuss validity and further comment on reliability of the E.D.I. measure. The E.D.I. appears to have been rigidly tested for validity and reliability. The questionnaire items themselves were tested. "The average item total correlation was .63 (SD = 0.13) indicating substantial within scale common variance among items." (Garner et al, 1983, p. 21)

They also reported a coefficient of reliability (standardized Cronbach's Alphas) from .82 to .90 to demonstrate internal consistency. They looked at criterion related validity in two separate ways (by comparing samples and other sources) and their findings once again, are as follows:

> An attempt was made to establish criterion related validity for some of the subscales by demonstrating that the comparison groups described scored in the theoretically expected manner on specific subscales. One-way analysis of variance and subsequent t-tests were employed . . . A question of further interest in determining the validity of the E.D.I. is the agreement between the self report patient profiles and the clinical judgments of experienced clinicians familiar with the patient's presentation. All correlations are significant at the p is less than 0.001 level. (Garner et al, 1983, p. 25)

The authors examined convergent and discriminant validity. They chose an alpha level of p is less than 0.001 as demonstrating significance. (Garner et al, 1983, p. 26) Lastly, they felt they had demonstrated construct validity by showing congruence in the clinician's ratings and the patient's subscale scores.

In conclusion, the E.D.I. is a tested, valid instrument. It is a valuable assessment tool to be used with a female population demonstrating signs of Anorexia and/or Bulimia. The utility and strength of the E.D.I. are its ease in administration, its self reporting nature and the ability to measure a multitude of areas relevant to eating disorders.

Results.

In order to comment on the E.D.I. results, I will examine each client's pre and post measurements. I will then comment on whether changes that were found were clinically or statistically significant. Each subscale of the E.D.I. will be examined. How the E.D.I. results fit with the clinical picture (i.e. discrepancies, explanations) will also be explored. The eight subscales of the E.D.I. are broken down and depicted in the graphs found on the following pages. The graphs display a visual representation of each subscale before and after scores.

Garner and Olmsted have made two points to consider when looking at the interpretation of E.D.I. scores. They warrant commenting on now, before the examination of actual scores.

They instruct that, "when evaluating change for an individual patient, the differences in subscale scores must be larger than the standard errors of measurement for each subscale". (Garner, P. and Olmsted, M., 1984, p. 12) They report that the standard errors of measurement as follows: 1) drive for thinness AN = 2.3, 2) Bulimia AN = 2.2, 3) body dissatisfaction AN = 2.5, 4) ineffectiveness AN = 2.3, 5) perfectionism AN = 2.1, 6) interpersonal distrust AN = 1.9, 7) introceptive awareness AN = 2.9, and 8) maturity fears AN = 1.9. (Garner, D. and Olmsted, M., 1984, p. 24 & 25) Therefore, in order for a change to be labelled significant, the subscale scores (when subtracted) would have to be larger than the above reported standard errors of measurement.

The second point for consideration is that "the authors have identified college women as weight-preoccupied if they scored at or above the mean score for Anorexia Nervosa patients on the Drive for Thinness subscale, and this is judged to be conservative". (Garner, D. and Olmsted, M, 1984, p. 12) This percentage is calculated at between 38 to 43 percent. This is another useful guideline that can be used as a comparison. The 38% or above criteria will add a perspective regarding whether there has been movement towards a decrease or increase in weight pre-occupation.

Client #1 (L)

In L's case, she displayed the most dramatic changes (in comparison to the two other women reported on in this practicum experience). Her E.D.I. results nicely reflected changes that had been seen throughout the counselling experience. Each subscale will now be commented on. (See page 147 for bar graph)

1. Drive for Thinness

Pre-measure score was at the 83rd percentile indicating extreme weight preoccupation. The post-measure score dropped to the 4th percentile. The difference in raw scores is considerably higher than the standard error of measurement on all subscales. This score reflects a numerically significant change, as well as a clinically significant one. Furthermore, the pre-measure score can be described as representing significant weight preoccupation, whereas the latter score shows little or no weight preoccupation.

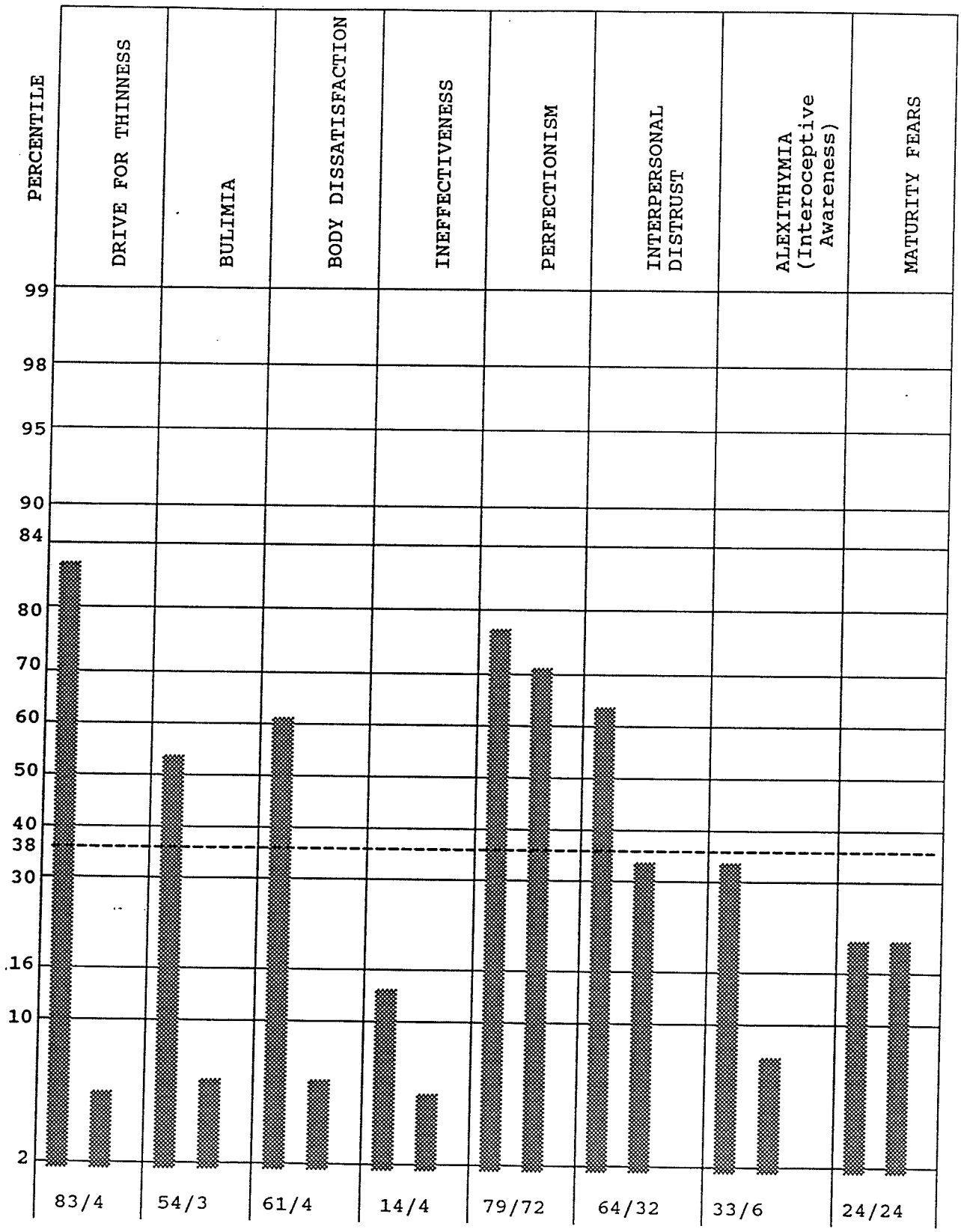
In counselling, L went from being a constant ingrained dieter to working hard at breaking free of dieting altogether. She was capable of reframing her thinking regarding the important of thinness in her life. This was a pivotal change for her. She was successful with refocusing away from dieting and reflecting on her "feelings" problems.

2. Bulimia

The pre-measure score was at the 54th percentile and

NAME: Client #1 (L)

PRE-POST SCORES
EATING DISORDER INVENTORY PROFILE



post-measure dropped to the 3rd percentile. This score change reflects a significant change. The pre-score was above the mean for the clinical population and the post-score dropped well below the mean.

The main concern (or presenting issue) for L when she began counselling was binging and vomiting. The clinical picture reflected important changes in this regard. She started counselling as a chronic dieter who binged approximately three times per week. She was able to decrease the number of episodes of binge eating. She developed skills in dealing with her underlying anxiety, anger and frustration. This dealt with her need to abuse food. She had also completely avoided vomiting for a successful period of six months.

3. Body Dissatisfaction

Pre-score was at the 61st percentile and post-score was at the 4th percentile. The change is considered a significant one. The pre-score is above the mean for a clinical population and the post-score is well below the mean.

This was a very encouraging change to see from a clinical perspective. Although L's weight had not changed over a six month period, her dissatisfaction with her body had decreased tremendously. This change in her attitude and feelings towards her body reflects an attempt to resolve a long held critical approach towards her body.

4. Ineffectiveness

L's pre-score was at the 14th percentile and dropped to the 4th percentile. This does not reflect a significant change. She scored below the clinical mean initially, which would therefore not indicate pathology.

Clinically, L displayed a sense of control and effectiveness in her life. This was a strength which she developed before entering counselling. It was also a strength that was reinforced and built on throughout the course of therapy.

5. Perfectionism

Pre-score was at the 79th percentile and dropped slightly to the 72nd percentile. This does not reflect a significant change. Her initial score was quite high and above the clinical population mean. Although there was some decrease reflected, this subscale score remained well above the AN mean.

Perfectionistic tendencies remain resistant for L. Perhaps these tendencies were well rewarded by others. They can be considered strengths also. Nevertheless, placing high expectations on herself was what caused her to be vulnerable to develop an eating disorder in the first place. Such scores can reflect a need for further work in this area.

6. Interpersonal Distrust

Pre-score was at the 64th percentile and dropped to the 32nd percentile. This change reflects a significant numerical decrease and a clinical change worth noting.

The clinical relevance relates to the importance of this area. Interpersonal distrust reflects a sense of isolation and a general difficulty in forming close relationships. An improvement in this area reflected important changes for L. She showed willingness to share her feelings and in self assertion. This meant that her ability to tolerate intimacy was improving. Family relationships were also changing for her as she allowed herself to be more of her own person.

7. Interoceptive Awareness

Pre-score was at the 33rd percentile and post-score decreased to the 6th percentile mark. Again, this reflects a significant change. Clinically, this is worth noting because this change is a good indicator that L had developed some recognition of her feelings, as well as an ability to listen more carefully to messages from her body (such as hunger). For women with Bulimia, being able to respond to body hunger in an appropriate fashion is an important step. Being more aware of feelings is critical in order to deal with uncomfortable feelings. Without accomplishing this, a woman remains likely to use food to deal with her feelings.

8. Maturity Fears

Pre-score was at the 24th percentile and remained constant at the post-score measurement. The absence of change meant that there was no significant movement seen.

This score was well below the clinical norm at the pretest

and post-test points. Despite this fact, I would argue that this could reflect a need for further work in this area. L was observed to be dealing with many family of origin issues and to be in the process of separating from her family. This reflects a developmental process of change that is usual for young women.

Client #2 ("N")

It is worth noting that N experienced many difficulties throughout counselling. Along with her ambivalence towards committing to counselling, she became depressed, frustrated and unable to let go of her obsessions with dieting and exercising. I believe that she made minimal gains and this is reflected in the evaluative component of the E.D.I. Each subscale of the E.D.I. will now be examined to look at any changes apparent. (See page 152 for bar graph)

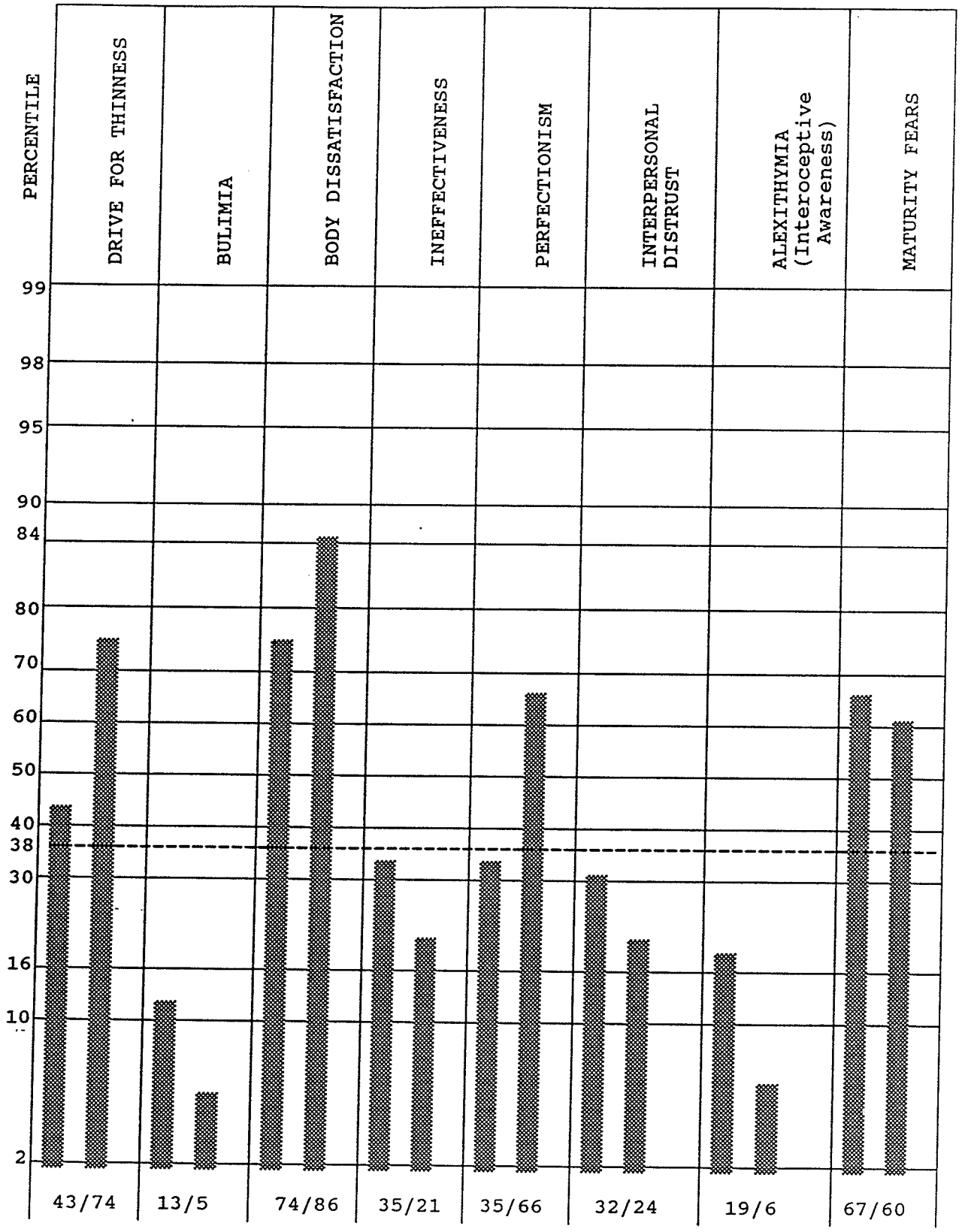
1. Drive for Thinness

Pre-score was at the 43rd percentile and post-score increased to the 74th percentile. This represents a significant change in a negative direction. Changes of this sort are always of clinical importance. They indicate a worsening of symptoms or increase in negative feelings towards self.

N began with a score above the clinical mean and therefore could have been described as already weight preoccupied. She became significantly worse in this regard. This change may be attributed to two factors. Becoming pregnant exacerbated her

NAME: Client #2 (N)

PRE-POST SCORES
EATING DISORDER INVENTORY PROFILE



feelings of wanting to control her body and to remain thin. Additionally, this whole struggle with thinness became heightened in the process of counselling. She was unable to develop other coping mechanisms to replace this reliance on food, dieting and exercise.

2. Bulimia

Initial score was at the 13th percentile and post-score was at the 5th percentile. There is little clinical significance seen in this regard. This low score is consistent with a restricted subtype of dieter - more alike the profile of an anorexic. These particular scores therefore are helpful with diagnosis and were less helpful to monitor change.

3. Body Dissatisfaction

N initially scored within the 74th percentile. Post-score results showed an increase to the 86th percentile. This change is significant, both numerically and clinically. Once again, a negative change is seen. These scores are very high and above the clinical mean in both situations. The increase in body dissatisfaction can be partially (if not completely) attributed to N's negative feelings towards her changing, pregnant body. It is difficult to tease out what other factors may have been impinging on this change.

4. Ineffectiveness

Pre-score was at the 35th percentile and post-score was at the 21st percentile. This reflects a slight significant change and

clinically there is little to say about a minor change of this sort. It appears that N had a fairly well developed sense of adequacy and worth to begin with. This may have increased somewhat in relation to her feelings about being able to reach out for help, when needed. This, in and of itself, can give a sense of some control of a situation.

5. Perfectionism

Initial score was at the 35th percentile and the post-score increased to the 66th percentile. This is a negative change and is of concern because the post-score is well above the clinical mean. This was not the case at initial measurement. In the clinical realm, it is my opinion that this change reflects the high expectations that N placed on herself to "master" the pregnancy experience. Perhaps she also became more aware of her perfectionistic tendencies by the process of counselling.

6. Interpersonal Distrust

Pre-score was at the 32nd percentile and post-score was at the 24th percentile. This change was minor and not statistically significant. Therefore, forming close relationships did not appear to be a significant problem for N. The minor change could be attributed to mere motivation, or perhaps an increased trust experienced by N as a by product of counselling.

7. Interoceptive Awareness

Pre-score was at the 19th percentile and dropped to the 6th percentile. This change was once again minimal, although

representative of a significant numerical change. Both scores were well below the clinical norm. It would appear that N demonstrated confidence in her ability to recognize and identify her feelings.

8. Maturity Fears

Pre-score was at the 67th percentile and a slight decrease to the 60th percentile at the post-measure was seen. This change is significant and in fact, was above the clinical cutting score at pre-test and fell below the score at post-test. It is hard to comment on the significance of this from a clinical perspective. However, it is interesting to note that N is a 33 year old, married women. The mean age of the clinical population used to construct the E.D.I. was 22½ years. Given that her comparison group were women ten years her junior, maturity fears may still remain a significant problem.

Client #3 ("J")

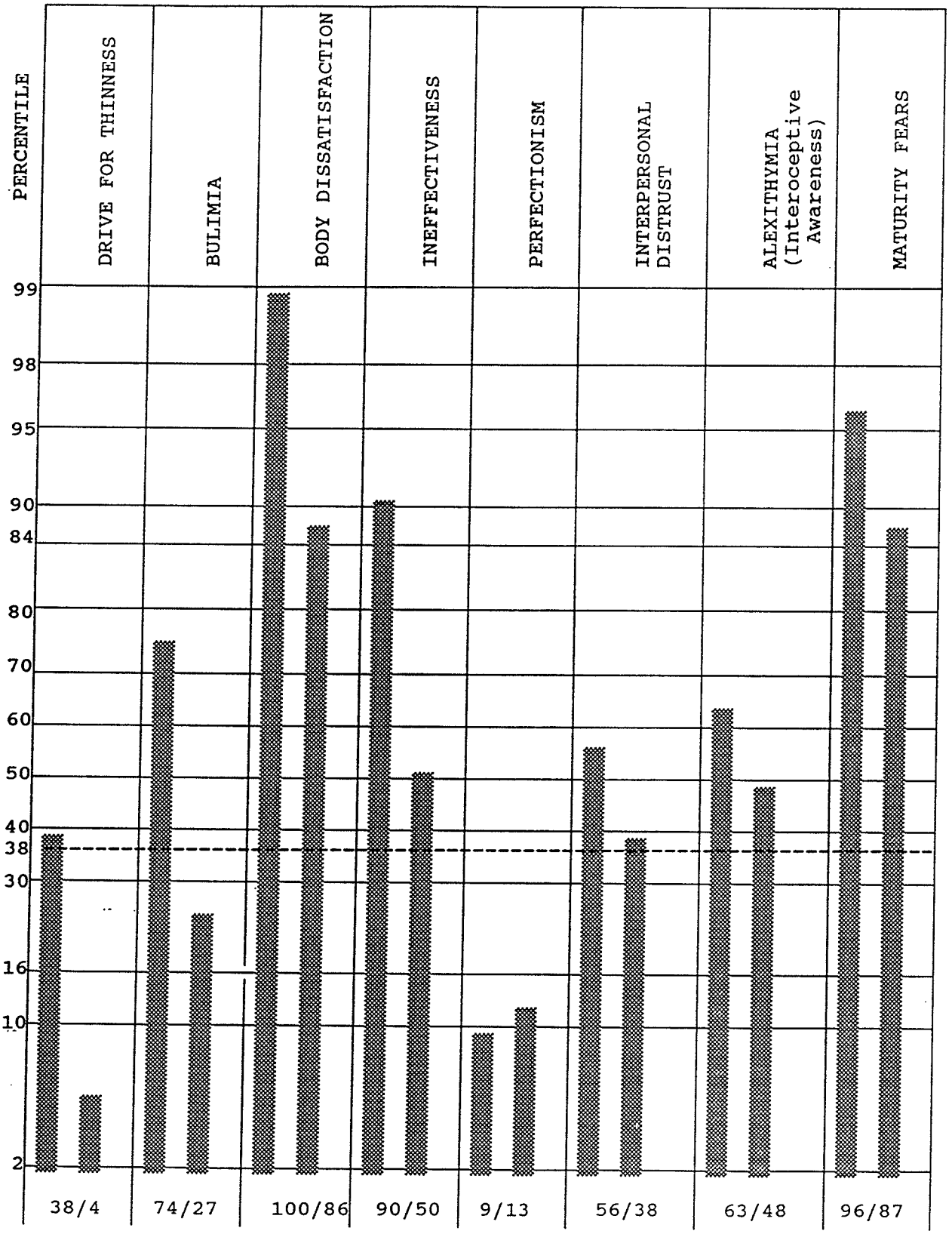
J progressed in counselling to a point where she felt improvement. However, she recognized that she needed to continue to work on issues that were unrelated to "food" issues. Her E.D.I. results show several positive changes (see page 156). I will comment on the clinical relevance of these results.

1. Drive for Thinness

Initial score was at the 38th percentile. Post score dropped to the 4th percentile. It is important to note that J's initial score

NAME: Client #3 (J)

PRE-POST SCORES
EATING DISORDER INVENTORY PROFILE



was at the clinical mean and therefore put her in the category of weight preoccupied. Dropping to the 4th percentile indicates significant change. This would correspond with J's attempts to discard dieting and her obsessions with food. It was a very encouraging change.

2. Bulimia

Pre-score was at the 74th percentile. Post-score dropped to the 27th percentile. This was a clinically and numerically change given that J's profile was consistent with Bulimia as a major difficulty. Although she did not vomit or purge herself, she binge ate and used food as a coping mechanism. A decrease in the tendency towards episodes of binging as seen here, was therefore very encouraging.

3. Body Dissatisfaction

J's initial score was extremely high and translated to the 100th percentile. Although a decrease was seen at the post measure, her score remained high - at the 86th percentile. This clearly outlined a need for further work in this area. The decrease was minimal and still reflected a score which was well beyond the clinical mean. As J was remaining in counselling after the end of my involvement with this practicum, this was an area that would have to be explored and challenged.

4. Ineffectiveness

Initial score was at the 90th percentile. Post-score was at the 50th percentile. This reflected positive change and a move

towards J experiencing more control in her life. This corresponded with the declining symptoms of depression seen throughout counselling. J felt helpless and hopeless initially. She gained new understanding of herself and also began to feel less isolated in relation to others. This was the largest change reflected in her E.D.I. results.

5. Perfectionism

Initial score was at the 9th percentile. Post-score result was at the 13th percentile. This is a significant change and reflected a clinical improvement. Clinically, low scores of this nature can be used for differentiation of subgroups of women with eating disorders. High scores would be more consistent with women who hold excessively high expectations of themselves. This subgroup would be more typically "anorexic" in nature.

J demonstrated low expectations of herself and therefore the increase (however small) seen in this regard is favourable. Once again, this may relate to the lifting of the depression she experienced. More likely, the small change here may be attributed to maturation.

6. Interpersonal Distrust

Initial score was at the 56th percentile. Post-score was at the 38th percentile. Although a small change, the change was significant and in the direction of improvement. It mimicked what was seen clinically. J challenged herself to connect more with others in order to deal with her feelings of loneliness and

isolation. Her efforts were met with some success, which was apparently reflected here with a decrease seen in "interpersonal distrust". Confronting family members were also an important factor in this regard.

7. Interoceptive Awareness

Initial score was at the 63rd percentile. Post-score was at the 48th percentile - another small change, however one of numerical and clinical significance. This category reflected the ability to identify and respond to feelings. Feelings such as hunger and fullness were crucial to identify for a women struggling with Bulimia. Learning to understand the link between uncomfortable feelings and eating for comfort was an important step in therapy. J showed some progress in this regard.

8. Maturity Fears

Initial score was at the 96th percentile. Post-score was at the 87th percentile. While change seen here is significant, the implications of these findings lies with the dramatically high scores seen in this category. J is a 24 year old woman who was finding the demands of adulthood very challenging. Her struggle to be comfortable with independence is exemplified here. Further work to assist her with finding comfort and strength in this regard was necessary. Family of origin issues remained prominent and necessary to address further.

General Comments regarding the use of the E.D.I. as an evaluative tool: The E.D.I. was most helpful in assisting with diagnosis and with examining changes that occurred for the individual women involved in this practicum experience. It is more difficult, however, to attribute the changes seen to the actual counselling process. This is an inherent limitation of the single case design. The sample of cases was small and there was no control group for comparison. Therefore, there were a multitude of other factors to consider when looking at change. The impact of other relationship, external pressures and internally motivated changes for example, all could have contributed to the change process.

One can also be skeptical regarding the changes seen, even in the E.D.I. pre/post comparisons themselves. There is a social desirability factor to consider, particularly as the women were aware that I was a student and therefore being evaluated. Perhaps they wanted to show positive changes both for their own sense of well being and to demonstrate "success" on my part.

The authors of the E.D.I. have set test criteria regarding what constitutes statistical significance. Their instructions (and the E.D.I. manual in general) was at times unclear and difficult to follow. I found the process of looking for statistical significance less illuminating (and less helpful) than evaluating clinically significant change.

In reflecting on the evaluation process, I am aware of how

the addition of "harder" evidence would have added collateral support to evaluating changes. A specific example could have been to examine weight changes. Weight maintenance (or gain or loss) speaks to the ability of the woman to change dieting or binging behaviour. Getting a collateral report of such behaviour would, perhaps, even have been more powerful evidence of monitoring change. These options, however, would have focused on the "symptom" and would have been arguably anti-therapeutic.

In conclusion, the E.D.I., along with clinical judgment, was a helpful tool to monitor changes seen within the women involved in this practicum experience. Only if there had been significantly larger numbers of women involved, could I have begun to comment on the effectiveness of the chosen treatment approach. As stands, even where positive change could be demonstrated, it is unclear as to whether these changes can be directly attributed to the counselling process.

Client Satisfaction Questionnaire

Psychometric Properties. The Client Satisfaction Questionnaire (hereafter referred to as the C.S.Q.) was designed to assess client satisfaction with service. It is a standardized pen and paper measure. It asks clients to rate their satisfaction with service by responding to eight (8) questions (scaled from one to four). The scale is graduated with responses ranging from poor to excellent.

The author reports that;

> The C.S.Q. has been extensively studied, and while it is not necessarily a measure of client's perceptions of gain from treatment, or outcome, it does elicit the client's perspective on the value of services received. The C.S.Q. has been used with a number of populations. The largest single study involved 3,268 clients from 76 clinical facilities, including inpatients and outpatients. (Roberts and Attkisson, 1984)

The C.S.Q. has excellent internal consistency with alphas that range from .86 to .94 in a number of studies.

The C.S.Q. has very good concurrent validity. Scores on the C.S.Q. are correlated with clients' ratings of global improvement and symptomatology, and therapist's ratings of clients' progress and likability. Scores also are correlated with drop-out rates (less satisfied clients having higher drop-out rates).

Utility/Critique. The C.S.Q. asks very general questions in order to give clients the opportunity to express their satisfaction or dissatisfaction with service. Using the C.S.Q. was easy to do. It does not require a lot of time to respond to, or to score. It is a simple, effective, well-tested satisfaction measure.

My only criticism is that, due to the C.S.Q.'s generalized nature, the questions are so broad that perhaps it doesn't tell you specifically about the individual's experience with counselling. Therefore, in order to gain further, more indepth feedback, I added five open-ended questions to the C.S.Q. They were as follows:

1. What was it about the particular counsellor that was helpful?

(Please comment on his/her knowledge, understanding and skill.)

2. What was it about the particular counsellor that was not helpful?
3. Was the Eating Disorders Clinic program helpful to you? (If yes, how so?)
4. Was the Eating Disorders Clinic program not helpful to you, in any way? (If not, how so?)
5. Any additional feedback you would like to give can be written here.

By doing this, I could still gather the clinical results of the C.S.Q., while getting further written feedback. In retrospect, I found that the clients' responses to my open-ended questions were often more revealing than their scores on the C.S.Q. In the future (unless there is need for using a standardized measure), I would develop an agency specific questionnaire instead of using the C.S.Q.

Results.

Client #1 ("L")

L's score on the C.S.Q. was 32 (out of a possible 32). This reflects that all answers were indicative of maximum satisfaction. Mean scores have been reported for large groups of surveyed clients, anywhere from 26.35 to 27.23. (Attkisson, 1979) A perfect score is, therefore, above the mean. I responded to this

with caution and some skepticism. I wondered whether awareness that I was a student (and being evaluated) factored into the perfect appraisal.

L's open-ended comments revealed more to me than her scoring of the C.S.Q. Of particular interest to me was one comment that L had made. She expressed a viewpoint that the therapist could afford to be "more assertive" and less soft with her. This comment on my style was very valuable feedback. She also commented that she appreciated the individualized nature of the counselling program. As a sometimes floundering student, knowing that the counselling received was perceived as relevant, was also useful.

Client #2 ("N")

Nicky ("N") scored the C.S.Q. with 28 (out of a possible 32). This score lands slightly above reported mean scores. This level of satisfaction was interesting to see, given that N was sporadic in her attendance and had great difficulty with committing to counselling. Her comments to the open-ended, added questions illuminated that she felt strongly responsible for solving her own problems. This, she added, the Clinic could not do for her. Nevertheless, she felt that the Clinic was somewhere where she felt supported and cared about.

Client #3 ("J")

Josephine ("J") scored 27 on the Client Satisfaction Questionnaire. This score would be considered within the mean area. It reflects positive satisfaction. Once again, I found that the additional comments added to the C.S.Q. were more illuminating than the answers given to standardized questions.

J did not provide any negative criticisms of the E.D. clinic, or of myself as a counsellor. Of interest to me was that she appreciated information she received on "wife abuse and self esteem". Being able to address issues other than the eating disorder was obviously important and appreciated.

J's other comments were self disclosing in nature. She described herself as being "close to suicide" when she first began counselling. She had progressed well beyond this, even if at times she still experienced depression. Subjective feedback such as this outlined her feelings regarding the changes she had experienced. These comments also were consistent with changes that were reflected in her Beck Depression Inventory Scores. Furthermore, she outlined her need to continue counselling. Transferring J to a new therapist was therefore facilitated.

Conclusion

It is worthwhile to reflect on the goals that were established at the beginning of this chapter, in order to make concluding remarks regarding the experience of using clinical measurement.

In the broadest sense, the goals outlined were; to learn about clinical assessment and evaluation, and to experiment with clinical measurement in an effort to provide an accountable service.

The author learned that using clinical measures was a worthwhile endeavor. They were particularly helpful as an adjunct tool for clinical assessment.

Clinical impressions could be legitimized (or disproved) through examining pen and paper measures. The assessment process was complimented and enhanced by the use of clinical measurement. In general, the women did not find the requirement of using clinical measurements burdensome or intrusive. At best, they received valuable feedback for their efforts. Therefore, both the clinician and the client benefited.

Evaluating change, through the use of clinical measurement however, had both positive elements as well as drawbacks. Using clinical measures gave the opportunity for comparison to be made. Therefore, the clinician had more to rely on than anecdotal evidence of a change. To monitor where someone began in counselling and to evaluate where they have gone by the end of counselling is therefore a valuable process. The difficult part is attributing changes that are seen to the counselling itself. Many factors contribute to change. To state that a change is directly as a result of counselling is nearly impossible to do. Only when using a larger clinical population with a rigorous research design (i.e. using a comparison group) can stronger statements of

causation be made.

The final note I wish to make is that I feel that counselling is truly more of an art than it is a science. It is a process which is difficult to define or to describe or quantify. I feel it is important therefore, to use clinical measurement in a balanced fashion. If clinical measurement is overemphasized, then this detracts from (and perhaps misrepresents) the complex nature of problems and the process of change.

CONCLUSION OF THE PRACTICUM

Reflections on the Experience

This chapter is devoted to the author's comments on the experience of the practicum. In this section, I will address major areas of learning. I will then comment on the strengths and limitations of the practicum setting from the student's perspective.

The exposure to the Eating Disorders Clinic was valuable, particularly for learning the psychiatric perspective of this problem. I observed the process of diagnosis and was exposed to the ongoing process of "psychotherapy". The approaches seen were intrapsychic in nature and "multidimensional" in that they were attempting to deal with the behavioural and cognitive manifestations of the problem. I was given direction from the Clinic team members in terms of understanding the women whom I was working with. I was also given many suggestions regarding how to try to affect changes of behaviour, diet and ultimately attitude. The suggestions given regarding changing eating behaviour were particularly useful. It was through capitalizing on the experience of others, that I was able to make concrete suggestions about how to change disturbed eating habits. Attempting to help affect changes in attitude however, was a more challenging part of the counselling.

A big area of learning throughout this practicum experience occurred due to the contact with the medical component of the Eating Disorders Program. I became cognizant of the many medical complications associated with eating disorders. This created a new and important awareness. Additionally, it provided me with guidelines regarding what kinds of situations require medical intervention.

Lastly, in being part of a specialized clinic, I became knowledgeable about what resources were (and were not) available in this area. Now I will comment on the Eating Disorders Clinic, as a setting for student learning. I will comment on the strengths and weaknesses of this setting.

To begin with, it is important to note that the Eating Disorders Clinic is part of the larger Health Sciences Centre complex which has affiliation with the University of Manitoba. It is a committed, teaching hospital. Although there was no organized field unit of Social Work students attached to the Clinic, there was openness and support for receiving and developing a program for a student in advanced practice. A few years previously the Clinic welcomed its first Master's practicum student. No doubt that this having been a positive experience helped to pave the road for future students (such as myself). The commitment towards supporting and encouraging students was very much a strength inherent in this setting.

As outlined earlier, the exposure to the medical setting made

for a rich learning experience. Having access to (and an orientation in) the inpatient unit, added to my knowledge of physical consequences and the treatment thereof. It was also comforting to know that medical back-up was available where necessary.

Being part of an outpatient Clinic also had its advantages. I was afforded flexibility in the approach I chose towards counselling. I was also given the opportunity to chose patients (from the waiting list) that would be appropriate for my learning experience.

Furthermore, I was given full reign to practice as a clinical social worker. What this meant was that there were no strict role expectations. I was able to to carve out my own role (both with clients and within the outpatient team). A weakness was that there was no social work model, colleague or support directly related to the practicum. The social work perspective would have been very valuable input to have. I was afforded psychiatric nursing and predominantly medical and psychiatric support. Direction and collaboration from a social worker could have served to strengthen my sense of the social work role (and identity).

Given the psychiatric nature of the Clinic, the approach to counselling was primarily individual in focus - this focus traditionally is complimented by the social work perspective. I see the exclusive focus on the individual as having been a limitation of the setting. It appeared as though a family or

couple perspective was taken only as an adjunct to individual therapy. A challenge for the Clinic could be to incorporate a family-centered approach to counselling. I could also have chosen to see individuals in the context of their families.

The psychiatric perspective can also be criticized as a fairly rigid perspective. The medical model (which is inherent in the psychiatric perspective) can be criticized in a number of ways. It is pathology oriented. It has to "label" people in order to "treat" them. It is different than a feminist perspective which acknowledges (and emphasizes) that behaviour takes place in a sociocultural context. The psychiatric perspective largely ignores the sociocultural perspective and looks within the individual for a source of maladjustment.

The last criticism I would aim at the setting is that they are not available to see women who are obese. Largely, this is a practical decision due to a work overload situation. In addition, obesity is not viewed as a mental illness in and of itself. However, if we truly conceptualize eating disorders to be on a continuum, then clearly women who overeat (e.g. women who binge and feel that this is related to emotional difficulties they are experiencing) fall somewhere on the same continuum as women who abuse food in a similar fashion, but manage not to become overweight.

A Social Work Role

There were many challenges present in the experience of negotiating and carrying out this practicum. In this section, I will reflect on these challenges. I will examine my role as a clinical social worker. I will further discuss the influence of having provided service in a psychiatric setting. Lastly, I will reflect back on the goals of the practicum and provide final comments.

One of the major difficulties in trying to provide service was grappling with my need as a social worker to act as a catalyst for change. Sometimes this was at odds with the client's own desire and motivation to change. Therefore, I often felt as though I was working at cross purposes. There was always strong ambivalence on the part of the women. Giving up dieting, exercising and weight preoccupation went against everything that the women had been "taught". The process of change was slow and difficult. I experienced the cognitive-behavioural component as a valuable, effective therapy. However, six months was not sufficient time to allow for substantial, lasting change.

A larger issue was bringing a feminist component/perspective to the counselling. Working from a psychiatric perspective meant that practices such as labelling, focusing on symptoms, and emphasizing an individual (versus sociocultural) perspective were impossible to avoid. The psychiatric perspective follows the

medical model which is pathology oriented. This contradicts a feminist perspective which attempts to be strength-oriented in nature. The same woman (for example) can either be described as neurotic, having a personality "disorder" or eating "disorder", or she can be understood as having weaknesses that are understandable and acceptable. Labelling is avoided altogether from the feminist perspective.

Feminist perspectives incorporate a sociocultural explanation of women's issues. Efforts are directed at incorporating this sociocultural context within counselling itself. In a practical fashion, the "how to" do this was an ongoing struggle. At best, I tried to challenge and broaden the individual woman's understanding of "her" problem.

I believe, however, that the optimum arena for decreasing isolation (and thus for developing an appreciation for the common issues among women) is a group format. A support group through the Anorexia Nervosa and Bulimia Foundation, or the Women's Health Clinic was offered to the women as an adjunct to their individual counselling.

Clearly, there are limits to what can be accomplished in one-to-one counselling. In reflecting back to the treatment goals that I set for this practicum, I am struck with how all encompassing I attempted to be. Perhaps in conceptualizing how to "treat" and "cure", I became too broad in order to capture the complicated nature of these problems. Indeed, in choosing a

"multidimensional" approach to treatment, I selected a broad based modality which attempted to combine two approaches to treatment. Furthermore, I challenged myself to sculpt this into an approach which was consistent with feminist practice.

Altogether, I created a variety of goals which were nearly impossible to accomplish in a six-month period. The multi-dimensional aspect was comprehensive from a theoretical point of view, but too broad and not clearly defined from a practical point of view. In short, experience taught me that I bit off more than I could chew!

Recommendations

It was an exciting experience to be involved in researching and practicing in an area where there had been an explosion of interest within the last ten years. A historical look at the problem of eating disorders provides us with a convincing argument that modern day Anorexia or Bulimia have developed (minimally) in response to the incredible pressure on women to be thin and to conform to the North American body ideal. Having gone through the experience of researching, negotiating and carrying out this practicum has helped me to develop opinions about which direction this field should continue to grow in. I will conclude the practicum with my comments in this regard.

Recent literature is exploring two very important women's

issues which are appearing to be linked to eating disorders. The area of sexual abuse and its direct effect on women is very relevant. Many women who present in clinical settings (and particularly psychiatric settings) have experienced sexual abuse. Addressing this painful legacy may therefore be an important part of a treatment package. Issues such as depression, self anger and mutilation, body image disturbance, and control issues are interrelated to both areas. This reality challenges professionals working with women who have eating disorders to broaden their conceptualization of the problem. Sensitivity to, as well as an ability to respond to issues related to a woman having experienced sexual abuse are therefore necessary.

I also feel that the research being done in the addiction field is an extremely relevant woman's issue. Much to my surprise, 7 out of 9 women who I saw in the practicum, came from backgrounds where at least one family member had an alcohol/drug addiction. Exploring the literature on adult children of alcoholics would be very relevant in this regard. Learning about the effects of growing up in dysfunctional families (in general) is important.

Furthermore, some authors are now beginning to conceptualize eating disorders as an addictive behaviour in and of itself. Methods for treating alcoholism are being applied to the treatment of Bulimia. The success and/or failure of such approaches needs to be monitored and reported on to the

researchers and clinicians working in this area.

In general, the richness of the area of research in eating disorders could well be supplemented by these two other areas. A more holistic look at, and approach to, the woman with an eating disorder is necessary. Further attempts to place women in context of their families (both their families or origin and their present day families) is needed. I feel that if we are to help to arrest this problem, we also have to address the societal conditions that cause and promote eating disorders.

Lastly, I feel that more diligence should be demanded in studying the effects of treatment with this population. Clearer clinical direction is needed. Clinicians need information about treatment packages that are being used, with success. They also can learn from and share their experience by evaluating their own practice.

Learning that an approach is not being met with success is equally important. In this regard, I challenge us to listen more attentively to the women who are the recipients of our service.

Bibliography

American Psychiatric Association (1987). Diagnostic and Statistical Manual of Mental Disorders (3rd Edition). Washington, D.C.

Ardell, Maureen, and Ardell, Corry-Ann (1985). Portrait of an Anorexic - A Mother and Daughter's Story. Vancouver, B.C.: Flight Press.

Beck, Aaron, and Beck, Roy (1972). "Screening Depressed Patients in Family Practice - A Rapid Technique" in Post-graduate Medicine, Dec. 1972, pp. 81 - 86.

Bemis, Kelly M. (1978). "Current Approaches to the Etiology and Treatment of Anorexia Nervosa." Psychological Bulletin, Vol. 85, No. 3, pp. 593 - 617.

Berlin, Sharon (1982). "Cognitive Behavioral Interventions for Social Work Practice" in Social Work, Vol. 27, No. 5, p. 218 - 226.

Blinder, B. J.; Chaitin and Goldstein, R. (Ed.) (1988). The Eating Disorders. New York: PMA Publishing Corp.

Bloom, M. and Fischer, J. (1982) Evaluating Practice: Guidelines for the Accountable Professional. New Jersey: Prentice-Hall, Inc.

Borgen, Joruun, and Corbin, Charles (1987). "Eating Disorders Among Female Athletes" in The Physician and Sportsmedicine, Vol. 15, No. 2, Feb. 1987, pp. 89 - 95.

Boskind-Lodahl, Marlene (1981). "Cinderella's Stepsisters: A Feminist Perspective on Anorexia Nervosa and Bulimia" in Women and Mental Health. New York: Basic Books, Inc., pp. 248 - 262.

Boskind-White, Marlene, and White, William C. (1983). "The Binge/Purge Cycle. Thin is never thin enough." Bulimarexia The Binge Purge Cycle. New York: W. W. Norton and Company.

Brown, Catrina, and Forgay, Don (1987). "An Uncertain Well Being: Weight Control and Self Control" in Healthsharing, Winter, pp. 11 - 15.

Brownell, Kelly (1988). "Yo-Yo Dieting" in Psychology Today, January, 1988, pp. 20 - 23.

Brownell, Kelly E., and Foreyt, John (1986). Handbook of Eating Disorders Physiology, Psychology and Treatment of Obesity, Anorexia and Bulimia. U.S.A.: Basic Books.

Bruch, Hilde (1982). "Anorexia Nervosa: Therapy and Theory." The American Journal of Psychiatry, 139, Dec. 1982, pp. 1531 - 1538.

Bruch, Hilde (1979). The Golden Cage / the Enigma of Anorexia Nervosa. Cambridge, Mass.: Harvard University Press.

Bruch, Hilde (1978). "Anorexia Nervosa." Nutrition Today, Sept./Oct., pp. 14 - 18.

Bruch, Hilde (1976). "Anorexia Nervosa: A Review." Journal of the American Medical Association, Nov. - Dec.

Bruch, Hilde (1974). "Perils of Behavior Modification in Treatment of Anorexia Nervosa." Journal of the American Medical Association, 230, pp. 1419 - 1422.

Bruch, Hilde (1973). Eating Disorders: Obesity, Anorexia Nervosa and the Person Within. New York: Basic Books, Inc.

Burns, David (1980). Feeling Good - The New Mood Therapy. New York: NAL Penguin Inc.

Calam, R., and Slade, P. (1989). "Sexual Experience and Eating Problems in Female Undergraduates" in International Journal of Eating Disorders. John Wiley and Sons. Vol. 8, No. 4, pp. 391 - 397.

Cameron, Elspith (1983). "Starvation Diet" in Saturday Night, Dec. 1983, pp. 15 - 17.

Carpenter, Richard (1983). "A Brother Remembers - An Account of Karen Carpenter's brave battle over the years against Anorexia Nervosa" in People, Nov. 21, pp. 151 - 158.

Chaiken, S. and Pliner, P. (1987). "Women, But Not Men, Are What They Eat: The Effect of Meal Size and Gender on Perceived Femininity and Masculinity" in Personality and Social Psychology Bulletin, Vol. 13, No. 2, June 1987, pp. 166 - 176.

Chernin, Kim (1986). The Hungry Self Women, Eating and Identity. New York: Times Books.

Chernin, Kim (1981). The Obsession: Reflections on the Tyranny of Slenderness. New York: Harper and Row.

Collier, Helen (1982). Counseling Women - A Guide for Therapists. New York: The Free Press.

Corcoran, Kevin, and Fischer, Joel (1987). Measures for Clinical Practice: A Sourcebook. New York: The Free Press.

Crisp, A. H. (1983). Anorexia Nervosa Let Me Be. London: Academic Press, Inc.

Densmore - John, Jean (1988). "Nutritional Rehabilitation and Normalization of Eating Pattern" in Blinder, et al (Ed.) The Eating Disorders (pp. 415 - 421). New York: PMA Publishing Corp.

Eichenbaum, L., and Orbach, S. (1983). Understanding Women: A Feminist and Psychoanalytic Approach. New York: Basic Books.

Garfinkel, P., Moldofsky, H., and Garner, P. (1977). "Prognosis in Anorexia Nervosa as influenced by clinical features, treatment and self-perception" in Canadian Medical Association Journal, 117, pp. 1041 - 1045.

Garner, D. and Bemis, K. (1982). "A Cognitive-Behavioral Approach to Anorexia Nervosa" in Cognitive Therapy and Research. New York: Plenum Publishing Corp., Vol. 6, No. 2.

Garner, D., and Bemis, K. (1982). "Cognitive Therapy for Anorexia Nervosa" in Handbook of Psychotherapy for Anorexia Nervosa and Bulimia. New York: The Guildford Press.

Garner, D., and Garfinkel, P. (1985). Handbook of Psychotherapy for Anorexia Nervosa and Bulimia. New York: The Guildford Press.

Garner, D., Garfinkel, P., and Bemis, K. (1982). "A Multidimensional Psychotherapy for Anorexia Nervosa" in International Journal of Eating Disorders, 1, pp. 3 - 43.

Garner, D., Olmsted, M., Bohr, Y., and Garfinkel, P. (1982). "The Eating Attitudes Test: Psychometric features and clinical correlates" in Psychological Medicine, Great Britain, 12, pp. 871 - 878.

Garner, D., Olmsted, M., and Polivy, J. (1983). "Development and Validation of a Multidimensional Eating Disorder Inventory for Anorexia Nervosa and Bulimia" in International Journal of Eating Disorders, Vol. 2., No. 2., Winter, 1983, pp. 15 - 33.

Garner, D., Rockert, W., Olmsted, M., Johnson, C., and Coscina, D. (1985). "Psychoeducational Principles in the Treatment of Bulimia and Anorexia Nervosa" in Handbook of Psychotherapy for Anorexia Nervosa and Bulimia. New York: The Guildford Press.

Gilligan, Carol (1982). In a Different Voice. Cambridge, MA: Harvard University Press.

Goldfarb, Lori (1977). "Sexual Abuse Antecedent to Anorexia Nervosa, Bulimia, and Compulsive Overeating: Three Case Reports" in International Journal of Eating Disorders, Vol. 6, No. 5, pp. 675 - 680.

Gordon, Richard A. (1988). "A Sociocultural Interpretation of the Current Epidemic of Eating Disorders" in Blinder, J., et al (Ed.) The Eating Disorders (pp. 151 - 163). New York: PMA Publishing Corp.

Greenspan, Miriam (1983). A New Approach to Women and Therapy. U.S.A.: Library of Congress Cataloguing in Publication Data.

Hall, Alyson (1985). "Group Psychotherapy for Anorexia Nervosa" in Handbook of Psychotherapy for Anorexia Nervosa and Bulimia. New York: The Guildford Press, pp. 213 - 238.

Hedblom, J., Hubbard, F., and Anderson, A. (1981). "Anorexia Nervosa: A Multidisciplinary Treatment Program for Patient and Family" in Social Work in Health Care. The Haworth Press Inc., Vol. 7 (1), Fall, 1981, pp. 67 - 86.

Hotelling, Kathy (1987). "Curative Factors in Groups for Women with Bulimia" in Women's Therapy Groups: Paradigms of Feminist Treatment. New York: Springer Publishing Co.

Kano, Susan (1987). Making Peace with Food - A Step-by-Step Guide to Freedom from Diet/Weight Conflict. Danbury CT: Amity Publishing Co.

Kaufman, M., and Heiman, M. (1964). Evolution of Psychosomatic Concepts - Anorexia Nervosa: A Paradigm. New York: International Universities Press, Inc.

Kramer, S. Z. (1988). "Family Structure of Interpersonal Relationships in the Eating Disorders" in Blinder, J., et al (Ed.) The Eating Disorders (pp. 165 - 176). New York: PMA Publishing Corp.

Kuechler, J., and Hampton, R. (1988). "Learning and Behavioral Approaches to the Treatment of Anorexia Nervosa and Bulimia" in Blinder, J., et al (Ed.) The Eating Disorders (pp. 423 - 431). New York: PMA Publishing Corp.

Lawrence, M. (1984). The Anorexic Experience. London: The Women's Press.

Leichner, P. (1985). "Detecting Anorexia Nervosa and Bulimia" in Diagnosis, Jan. 1985, pp. 31 - 47.

Leichner, P., Harper, D., and Johnston, D. (1985). "Adjunctive Support Group for Spouses of Women with Anorexia Nervosa and/or Bulimia" in International Journal of Eating Disorders, Vol. 4, No. 2, 1985, pp. 227 - 235.

Levenkron, S. (1982). Treating and Overcoming Anorexia Nervosa. New York: Warner Books, Inc.

Levenkron, S. (1978). The Best Little Girl in the World. Chicago, Illinois: Contemporary Books, Inc.

Mazur, Dorothy Conrad (1981). "A Starving Family: An Inter-actional View of Anorexia Nervosa" in Women and Mental Health. New York: Basic Books, Inc., pp. 240 - 247.

Meisner, L. (1988). A Feminist Approach to the Concepts of Environment and Competence in the Ecological Perspective: Application in a Body Image Group with Bulimic and Anorexic Women. (Practicum Report, University of Manitoba, 1988). School of Social Work, Winnipeg, Manitoba.

Minuchin, S., Rosman, B., and Baker, L. (1978). Psychosomatic Families Anorexia in Context. U.S.A.: Harvard University Press.

Mitchell, J., Pyle, R., Hatskami, D., Goff, G., Glotter, D., and Harper, J. (1989). "A 2-5 year follow up study of patients treated for Bulimia" in International Journal of Eating Disorders, Vol. 8, No. 2, March, 1983, pp. 157 - 165.

Neuman, P., and Halvorson, P. (1983). Anorexia Nervosa and Bulimia, A Handbook for Counselors and Therapists. New York: Van Nostrand Reinhold Co., Inc.

O'Grady, T. J., and El-Sobky, A. L. (1987). "Eating Disorder as Mental Illness: Popular Conceptions" in International Journal of Eating Disorders, Vol. 6, No. 3, pp. 433 - 446.

Orbach, Susie (1986). Hunger Strike. The Anorexic Struggle as a Metaphor for our Age. New York: W. W. Norton and Co.

Orbach, Susie (1978). Fat is a Feminist Issue. New York: Paddington Press.

Orbach, Susie (1978). "Accepting the Symptom: A Feminist Psychoanalytic Treatment of Anorexia Nervosa" in Handbook of Psychotherapy for Anorexia Nervosa and Bulimia. New York: The Guildford Press.

Ramchandani, D., and Whedon, B. (1988). "The Effect of Pregnancy on Bulimia" in International Journal of Eating Disorders, Vol. 7, No. 6, pp. 845 - 847.

Rosen, J., Silberg, N., and Gross, J. (1988). "Eating Attitudes Test and Eating Disorders Inventory: Norms for Adolescent Girls and Boys" in Journal of Consulting and Clinical Psychology, Vol. 56, No. 2, pp. 305 - 308.

Sacker, Ira, and Zimmer, M. (1987). Dying to be Thin, Defeating Anorexia Nervosa and Bulimia - A Practical Life-saving Guide. New York: Warners Communications Company.

Schaefer, C., Briesmeister, J., and Fitton, M. (1984). Family Therapy Techniques for Problem Behaviors of Children and Teenagers. San Francisco, California: Jossey-Bass Inc., Publishers.

Schechter, J., Schwartz, H., and Greenfeld, D. (1987). "Sexual Assault and Anorexia Nervosa" in International Journal of Eating Disorders, Vol. 6., No. 2, pp. 235 - 242.

Schneider, J., and Agras, W. Stewart (1987). "Bulimia in Males: A Matched Comparison with Females" in International Journal of Eating Disorders, Vol. 6, No. 2, pp. 313 - 316.

Scrignar, C. (1971). "Food as the Reinforcer in the Outpatient Treatment of Anorexia Nervosa" in Journal of Behaviour Therapy and Experimental Psychiatry. Great Britain: Permagon Press, Vol. 2, pp. 31 - 36.

Stern, C., Whitaker, C., Hagermann, N., Anderson, R., and Bargman, G. (1981). "Anorexia Nervosa: The Hospital's Role in Family Treatment" in Family Process. 20, pp. 395 - 408.

Sternhell, C. (1985). "We'll Always be Fat but Fat Can Be Fit" in Ms., May, 1985.

Strober, M. (1986). "Anorexia Nervosa: History and Psychological Concepts" in Handbook of Eating Disorders: Physiology, Psychology, and Treatment of Obesity, Anorexia and Bulimia. New York: Basic Books.

Stunkard, Albert J., and Steller, Elliot (editors) (1984). Eating and Its Disorders. New York: Raven Press Books Ltd.

Sturdivant, Susan (1980). Therapy with Women - A Feminist Philosophy of Treatment. New York: Springer Publishing Co.

Szekely, Eva (1988). Never Too Thin. Toronto, Ontario: The Women's Press.

Turner, J., and Emery, L. (1985). Perspectives on Women in the 1980's. Winnipeg: The University of Manitoba Press.

Van Buren, D., and Williamson, D. (1988). "Marital Relationships and Conflict Resolution Skills of Bulimics" in International Journal of Eating Disorders, Vol. 7, No. 6, pp. 735 - 741.

Vandereycken, Walter (1987). "The Constructive Family Approach to Eating Disorders: Critical Remarks on the Use of Family Therapy in Anorexia Nervosa and Bulimia" in International Journal of Eating Disorders, Vol. 6, No. 4, pp. 455 - 467.

Vandereycken, Walter (1990). "The Addiction Model in Eating Disorders: Some Critical Remarks and a Selected Bibliography" in International Journal of Eating Disorders, Vol. 9, No. 1, pp. 95 - 101.

Weiss, L., Katzman, M., and Wolchik, S. (1985). Treating Bulimia: A Psychoeducational Approach. Oxford, England: Pergamon Press Ltd.

Willmuth, M., Leitenberg, H., Rosen, J., and Cado, S. (1988). "A Comparison of Purging and Nonpurging Normal Weight Bulimics" in International Journal of Eating Disorders, Vol. 7, No. 6, pp. 825 - 835.

Woodman, M. (1980). The Owl was a Baker's Daughter - Obesity, Anorexia Nervosa and the Repressed Feminine. Toronto, Canada: Inner City Books.

Wooley, Susan, and Wooley, O. Wayne (1986). "Ambitious Bulimics: Thinness Mania" in American Health, Oct., pp. 66 - 74.

Appendix A

Treatment Stages and Staff Responsibilities

Stage I - Treatment of Starvation

Medicine

1. Assess degree of starvation
2. Assess secondary complications
3. Determine diagnosis
4. Refeeding/treatment plan
5. Anti-anxiety medicine, if needed
6. Supportive psychotherapy regarding nutritional rehabilitation
7. Dental evaluation
8. Daily feedback to staff
9. Weekly anorectic luncheon group
10. Bi-weekly community meeting

Nursing

1. Patient observation, one-to-one
2. Assess refeeding complications
3. Nursing plan developed and implemented
4. Support and supervision at meals - arms length
5. Discouragement of binging, vomiting, and exercising
6. Dietitian orders daily meals, caloric amounts

7. Weekly anorectic luncheon group
8. Bi-weekly community meeting
9. Daily feedback to staff

Social Work

1. Reduce family self-blame
2. Family education regarding illness and planned treatment
3. Prepare family on how to handle patient demands/threats
4. Assess family
5. Develop a family treatment/education plan
6. Bi-weekly community meeting
7. Feedback to staff after each family/patient contact
8. Weekly social work rounds

Stage II - Psychotherapy

Medicine

1. Re-feeding treatment continues
2. Assess psychological traits in absence of starvation
3. Psychotherapy plan: goals and methods
4. Psychological treatment weekly to bi-weekly
5. Behavioural treatment plan for special behavioural problems, if needed
6. OT implemented
7. Anti-anxiety medicines, if needed

8. Daily feedback to staff
9. Goal weight range identified
10. Weekly anorectic luncheon group
11. Bi-weekly community meeting

Nursing

1. Continued patient observation - medical and psychological
2. Psychological issues addressed with patient (individual, family and social issues)
3. One-to-one meals
4. Implementation of specific behavioural program, if needed
5. Continued encouragement of eating and psychological gains
6. Nutritional instruction
7. Goal weight range identified
8. Weekly anorectic luncheon
9. Bi-weekly community meeting
10. Daily feedback to staff

Social Work

1. Continue to reduce family blame
2. Family to understand: patient's treatment, patient's vulnerabilities, family interactional style
3. Patient to understand herself, family styles and how she responds to family
4. Issues/interactions occurring during visits discussed

5. Bi-weekly community meeting
6. Feedback to staff after each family/patient contact
7. Weekly social work rounds.

Stage III - Return of Controls to Patient

Medicine

1. Goal weight range agreed upon
2. Medical assessment and treatment continues as in Stage II
3. Psychotherapy, three times per week
4. Observation and encouragement of patient's ability to handle responsibility of diet, weight, exercise
5. Daily feedback to staff

Nursing

1. Goal weight range agreed upon
2. Nursing assessment and treatment continues as in Stage II
3. Observation of patient's ability to manage more and more responsibility
4. Recommending timing and type of responsibility patient can assume
5. Shopping for clothes with patient
6. Practice meals out with patient
7. Discuss body image, maturity, sexuality
8. Weekly anorectic luncheon group

9. Bi-weekly community meetings
10. Daily feedback to staff

Social Work

1. Social work assessment and treatment continues as in Stage II
2. Family give feedback regarding patient's ability to manage more control
3. Family and patient practices agreed on changes in pattern of communication or other "homework" (between family sessions)
4. Family practices taking less responsibility for patient
5. Encourage family leaves of absence
6. Bi-weekly community meeting
7. Feedback to staff after each family, patient contact
8. Weekly social work rounds

Stage IV - Planning and Implementing Follow-Up

Medicine

1. Treatment continues as in Stage II and III
2. Plan for medical and psychological follow-up treatment
3. Search and confirm follow-up in patient's community
4. Discussion of practice visits home, meals out
5. Daily feedback to staff
6. Post discharge:

a) monitor weight

b) frequent phone contact with patient/family

c) modification of plans as needed

d) discussion with treating professionals or outpatient treatment

Nursing

1. Treatment continues as in Stage II and III
2. Planning for discharge: daily activities, school/work, management of diet, weight
3. Insures plan is confirmed
4. Feedback to staff
5. Post discharge:
   a) nurse initiates frequent phone contact
   b) monitor weight
   c) patient initiates phone contact
   d) discussion of specific problems
   e) readjustment of plan (medicine, family interactions)
   f) Repeats basic principals
   g) Anorectic luncheon group
   h) Phone contact once a week, diminishes gradually thereafter

Social Work

1. Treatment continues as in Stage II and III

2. Planning for discharge: family/patient fears, daily activities, school/work, management of diet/weight, meals/eating
3. Plan for family treatment follow-up, search and confirmation
4. Bi-weekly community meetings
5. Feedback to staff after each family/patient contact
6. Weekly social work rounds
7. Post discharge:
   a) assessment/treatment interaction back home
   b) re-education, clarification
   c) modification of plan as needed
   d) encourage support goal weight maintenance
   e) consider referral to outside agency for longer treatment, when needed

PRACTICUM AGREEMENT

The following is a list of conditions and requirements for the proposed practicum. The agreement is between the student; Kym Cuthill and Health Sciences Centre representatives. The list will be comprised of the practice elements to be considered for the implementation of the practicum.

Orientation:

The student will participate in the following activities to prepare herself for practice within the outpatient department of psychiatry - Eating Disorders Clinic.

1. The orientation will be organized through Daryl Johnston (Clinic Coordinator). As such the student will follow and consult with Daryl Johnston throughout a 4 week period.

2. It is recommended that the student begin by observing assessments. The student will view 5 assessments (minimally) performed by a variety of practitioners (representing Social Work, Nursing, Psychiatry and Psychology).

3. The student will familiarize herself with the psychoeducational literature presently given to patients at the time of assessment. The student will also view videotapes and read other pertinent literature available through the practice setting.

4. The student will observe some inpatient activites with a view to understanding how outpatient treatment is consistent with approaches and recommendations flowing from the inpatient program. Specifically, this will entail observing 3 inpatient unit "kardex" contract meetings.

5. The student will enter team supervision meetings to observe and prepare for the supervision component of the practicum.

6. The student will be oriented in the areas of charting and procedures of data recording and history taking.

7. The student will attend the conferene, "A Workshop on Body Image and Eating Disorders" to review current issues in identifying and treating anorexia nervosa and bulimia.

THE PRACTICUM:

1. The student will begin by performing assessment interviews. These will be observed minimally by 1 HSC employee and wherever possible by all members of the outpatient department (Daryl Johnston, Sheila Levin, Dr. Kurt Buller).

A. The students' advisor will observe 2 assessment interviews minimally and attend more where possible.

B. The student will see clients taken from the HSC waiting list. Clients who appear in need of inpatient treatment (due to medical or psychiatric implications) will be seen by other members of the HSC team.

C. The student will continue with conducting assessment interviews until 5 appropriate clients are chosen for the practicum experience.

2. The student will commence seeing clients after initial assessment, on a weekly basis for a commitment of 6 months of counselling.

3. The student will participate in clinical supervision with her advisor on a bi-weekly basis, initially. The supervision requirement will be adjusted during the practicum to be responsive to the needs of the student (i.e. to include unscheduled meetings perhaps, or postpone bi-weekly meetings if appropriate).

4. The student will participate in team supervision meetings on a weekly basis with the members of the HSC outpatient team.

5. The student will meet on a monthly basis with Dr. Larry Scyner, Department of Social Work. The student will consult with Dr. Scyner in regards to a number of issues arising from the practicum experience. Dr. Scyner will be given a patient list and will be updated as to how the student's counselling efforts are progressing.

6. The student will volunteer to participate in teaching rounds. As such, the student will view presentations and prepare a 1 hour presentation herself. The topic will be chosen by the student and negotiated with the Eating Disorder team members.

7. During the termination phase of counselling, the student will make recommendations (where necessary) in regards to the provision of additional services needed for clients. Client treatment needs will be discussed and negotiated with the members of the HSC outpatient team.

8. Upon completion of the writing of the practicum experience the student is committed to reporting and sharing findings with interested members of the HSC outpatient and inpatient teams.

Agreement signed this 2nd day of ~~January~~ February KC, 1989, by the following:

_____

Professor Shirley Grosser, Advisor
School of Social Work
University of Manitoba

_____

Daryl Johnston, Coordinator
Eating Disorders Clinic
Health Sciences Centre

_____

Dr. Kurt Buller, Staff Psychiatrist
Eating Disorders Clinic
Health Sciences Centre

_____

Dr. Giselle Morier, Staff Psychiatrist
Eating Disorders Clinic
Health Sciences Centre

_____

Kym Cuthill, Social Work graduate student
University of Manitoba

Appendix C

Support Groups for Families of Anorexics

Part I - Themes of Sessions

1st Session: Effects of the illness on the family.

1. Parents are encouraged to discuss feelings (e.g. frustration, rage, guilt) and the kind of parental behaviours they provoke
2. Discussion around "coping behaviour"

2nd Session: Caring and affection in the family system.

1. Discuss style and degree of verbal and physical affection
2. Examine the quality of affection between husband and wife

3rd Session: Authority in the family system.

1. Who does decision making, tasks, scheduling, etc.?
2. Is child asked to rescue parents?

4th Session: Focus within the family.

1. Who is focused on?
2. Is there balance?

5th Session: Supportive caring within the family system.

1. Where and how does nurturing function in the family?
2. Does a child play this role with siblings, parents?
3. Are openness and intimacy expressed among members of the family?

6th Session: Rating the family system.

1. How overwhelmed is the family regarding the anorexic?
2. Is offering care and affection a problem?
3. Is allocation and style of authority a problem?
4. Is there a family focus?
5. Is there a shortage of reassurance or support within the family?

Part II - Restructuring for a More Nurturing and Authoritative Family Environment

7th Session: Strengthening an affectionate stance.

8th Session: Redelegating authority.

9th Session: Refocusing on the children.

10th Session: Developing supportive behaviour.

SOURCE: Steven Levenkron (1982). Treating and Overcoming Anorexia Nervosa. (Published in Canada and U.S.A.: Charles Scribner's Sons).

Appendix D

Anorexics' Support Group Topics

1. Success, loneliness and competition:
   - (Including discussing barriers to group consolidation)
2. Safety mechanisms:
   - What we have learned to feel safe about?
3. History of food in our lives:
   - When and how did weight become an issue?
4. Ability to receive care:
   - Comfort or discomfort
   - Each member's strength in offering care and support is discussed
5. Control and helplessness:
   - CONTROL is a big issue
6. Perfection, inadequacy and self-distrust:
   - Learning to trust oneself and accept oneself for the good and the bad
7. Confronting others and acting out on one's own body as the last arena
   - Ability to confront their parents
8. Adult roles and intimacy
   - To become an adult female . . . (career roles, family roles, sexual activity)

9. Separating from parents / running back and forth
   - Do they maintain childlike roles?
10. Pursuing one's "walking papers"
   - Reducing overdependency on parents
   - Identifying appropriate life goals

SOURCE: Steven Levenkron (1982). Treating and Overcoming Anorexia Nervosa. (Published in Canada and U.S.A.: Charles Scribner's Sons).

Appendix E

Anorexia Nervosa

Symptoms

1. Phobias (concerning bodily appearance)
2. Obsessional thinking
3. Obsessive-compulsive rituals
4. Feelings of inferiority
5. Splitting or perceiving decisions and consequences in terms of polarities
6. Passive-aggressive behaviour
7. Disinterest in sexuality
   a) general immaturity
   b) fear of intimacy, physical/emotional
8. Delusional thinking develops
9. Paranoid fear
10. Depression
11. Anxiety
12. Denial

Clinical Diagnosis

1. Loss of 20% of body weight
2. Loss of menstrual period (ammenorhea)
3. Thinning hair

4. Dry, flaking skin
5. Constipation
6. Lanugo (a downy growth of body hair)
7. Decrease in blood pressure, body temperature, chloried levels (if vomiting), decrease in potassium level, lowered pulse rate

Demographics

1. 10% to 15% mortality rate
2. Currently affecting over 3% of female population
3. Until recently, the victims of Anorexia Nervosa were almost exclusively upper middle class adolescent girls (i.e. 97% white, ages 11 - 60 [most commonly 13 - 22])

Profile

1. Anorexics are generally not the firstborn child. In 80% of Levenkron's cases, the anorexic is the second or third child.
2. History of high achievement in school and is compliant and cooperative within the family.
3. Levenkron uses the word "depleted" to describe the families of anorexics. External demands on their energies have outstripped their emotional resources.
4. Parents have been prevented from offering healthy nurturing to their child.

5. Often results in an implicit reversal of dependance between parent and child.
6. Child sees herself being loved for NOT having needs of her own (pleases others constantly).

SOURCE: Levenkron, Steven (1982). Treating and Overcoming Anorexia Nervosa. (Published in Canada and U.S.A.: Charles Scribner's Sons), pp. 3 - 19.

Appendix F

Client Record of Thoughts/Beliefs (Double Column)

Name of Client: _____

Date of Session: _____

Negative Thoughts/Beliefs	Alternative Thoughts/Beliefs

Appendix G

Food Diary

Name of Client: _____

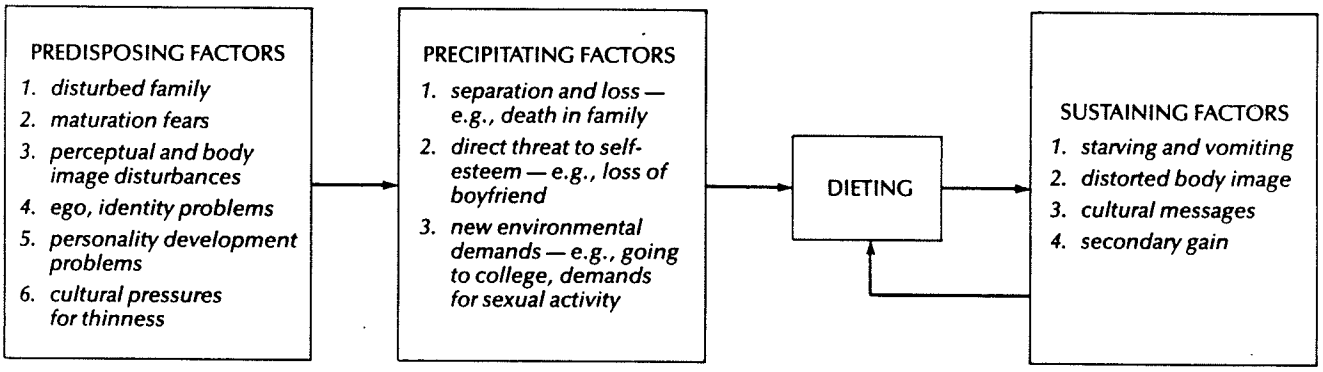
Date/ Time	What and How Much?	Feelings or Circumstances?	Vomit	B	L	D

Appendix H

A Model Proposed for Understanding the Causes of Anorexia

FIGURE 14.2

A model proposed for understanding the causes of anorexia.



Source: After Garfinkel and Garner, 1982