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

by

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A PRACTICUM SUBMITTED TO THE FACULTY OF GRADUATE STUDIES
IN PARTIAL FULFILLMENT OF THE REQUIREMENTS
FOR THE DEGREE MASTER OF SOCIAL WORK

SCHOOL OF SOCIAL WORK

WINNIPEG, MANITOBA

ISBN 0-315-47963-9

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A practicum submitted to the Faculty of Graduate Studies of the University of Manitoba in partial fulfillment of the requirements of the degree of

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Abstract

A ten session body image group with women with anorexia nervosa and bulimia is described. The group was offered to seven women who were on an inpatient ward at the Health Sciences Centre, Department of Psychiatry, Eating Disorders Clinic, Winnipeg, Manitoba. A feminist approach to the concepts of environment and competence in the ecological perspective is developed and utilized in facilitating the group. The group sessions include a focus on personal, familial and environmental influences that impact on women's body image. Evaluation feedback suggests that this approach to social work group practice is beneficial to women with body image concerns. The integration of feminism and ecological social work practice provides a rationale for an intervention that focuses on women's strengths while challenging environmental demands on women to conform to a narrowly defined stereotype.

ACKNOWLEDGEMENTS

There are several people I would like to acknowledge for their contribution to this learning experience. Thank you to:

- my committee members: Joan Turner, Daryl Johnston, and Kim Clare. Joan, my primary advisor, has made this process so much more than an academic endeavour. She has encouraged me to be both creative and critical in my thinking and has been a constant support in my personal and professional growth. Daryl and Dr. Pierre Leichner shared their knowledge and expertise in their work with women with anorexia nervosa and bulimia and provided me with a valuable practicum site. In addition, Daryl's feedback on this report has been greatly appreciated. I am grateful to Kim who agreed to be on my committee with little notice, but nevertheless, gave of her time and knowledge to provide me with valuable feedback.

- the women in the Body Image Group for sharing their experiences and allowing me to learn from them.

- Karen Morrow who typed this report with a momentum that kept me on my toes! Karen's genuine interest in my writing made her typing the report so much more meaningful.

- the women at 'the house', Joan, Jo and Sandi, for their encouragement and support and special thanks to Jo for the coffee, the meals and the laughter.

- my long time friend, Dorothy, who has taught me through her life experiences the true meaning of commitment and perseverance.

- my good friend, Craig, for the music and conversation that relaxed and inspired me . . .

Lucille

September, 1988

TABLE OF CONTENTS

INTRODUCTION

Practicum Objectives

The choice of a practicum experience by social work graduate students is often influenced by specific populations they have worked with during their B.S.W. years of employment. It was the author's personal experience in the fitness industry that inspired the decision to work with women with anorexia nervosa and/or bulimia. Being a woman, it is not difficult to relate to and understand women's non-acceptance of their bodies and the stress that can result from living in a culture that places a high value on beauty, image, youth and outer appearance. In the author's experience, it is rare to find a woman who lives in a state of peace and harmony with her body.

The intent of this practicum was to provide a social work perspective in the treatment of women with anorexia nervosa and/or bulimia. An ecological approach to social work practice was proposed as the method of intervention. The practicum objectives were:

> to support and assist women with anorexia nervosa and/or bulimia in the task of rediscovering the self and learning to manage without anorexia nervosa and/or bulimia;
>
> to assist partners and families in understanding anorexia nervosa and/or bulimia and why it has manifested in their partner/daughter/mother;
>
> to provide, through group experience, a forum for the discussion of feelings, and a sharing of

attitudes and commonalities specifically relating to body image concerns.

A six month placement was negotiated with the Health Sciences Centre, Department of Psychiatry, Eating Disorders Clinic. During that time period, individuals and to a lesser extent, their families were counselled on an ongoing basis and a ten session body image group was initiated. The author has chosen the body image group experience as the focus of this practicum report.

Rationale for Interventive Approach

The ecological approach to social work practice was the proposed intervention because of its commitment to the relationship between individuals and their families, their culture and their environment. An ecological perspective necessitates that the dynamic and ongoing interaction between these systems be the focal point of intervention. The perspective, therefore, suggests the strengthening of relationships and a striving for equilibrium and reciprocity between all interacting systems. It also suggests challenging social attitudes and values that may be adversely affecting the person-environment interactions. The author saw this orientation to practice as compatible with her beliefs regarding social work practice, women, weight and body image concerns. It is asserted in this report that North American socialization of women through our culture's preoccupation with the thin

ideal and environmental factors such as the mass media promotion of the thin ideal stereotype, breed body insecurity in women. The ecological perspective represented for the author a practice orientation that would focus on these environmental influences that play a part in women's health. It also represented a movement away from a disease orientation to one of growth, change and strength.

It was not long into the practicum experience that the author's feminist view of women's health issues resulted in both frustration and growth as a social worker. Applying the concepts of the ecological approach and attempting intervention based on its competence orientation raised many more questions than the approach or the literature could answer. Jenson's (1985) critique of the ecological approach provided clarity in her discussion of Germain's (1980) failure to move away from a problem focus to one of strength and forward movement. The author's concern was and is the rather simplistic view of the environment in the ecological approach and the underlying message that in order to achieve a 'good fit' with the environment, change still seems to imply adjustment on the part of the individual. The obstacle that became a challenge for the author was addressing the issue of environment. The environment, specifically the culture in which women are socialized including the

advertising and the fashion industries, promote hostility towards women's bodies that do not conform to the narrowly defined stereotype. The insidious nature of an environment that gives out very clear messages of rejection if one does not 'fit' could not be overlooked. The fact that women struggle to achieve a balance with this very environment was also felt to be a crucial consideration. The challenge became one of introducing a feminist approach to the ecological perspective resulting in a rationale for an intervention that would not only focus on women's strengths but also raise questions about the environmental obstacles we face. The body image group was established from this orientation. An approach to working with women with anorexia nervosa and/or bulimia is offered that with minor modifications can be used with any clients presenting with body image concerns. The author firmly believes that this would be the vast majority of the female clients seen by those in this profession. Body image is an integral part of all issues social workers address and therefore, it is important to be aware of how our clients' body image can affect their self-esteem and feelings of well-being.

The Role of Social Work

Wetzel (1986) asserts that "(T)he primary difference between social work ideology and feminism may be that

feminists insist on applying their philosophy, ethics and values" (p. 167). Social workers and feminists espouse the values of the intrinsic worth and dignity of all human beings, the removal of obstacles to self-realization and the prevention and elimination of discrimination, but in practice feminists appear more apt to treat these as core principles. Berlin et al. (1981) suggest that:

> . . . (H)ardly any self-respecting social worker writes anything these days without giving a nod to the social context. However, the usual pattern is to acknowledge the contribution of economic, family, and cultural-attitudinal factors to the despair of clients and then to describe interventive strategies designed to influence only personal adjustment and accommodation.
>
> (p. 448)

Sex bias and sex role stereotyping pervade clinical theories and literature and their prevalence is likely to affect practice (Israel, 1984). Berlin et al. (1981) state that in their efforts to eliminate sexism, social workers have been influenced by the women's movement. As women social workers began to incorporate feminist principles into their personal and professional lives, approaches to practice became more focused on empowering women to make changes in their lives as opposed to adjusting to the status quo. Feminist authors (Chesler, 1972; Berlin, 1976; Miller, 1976; Levine, 1983) greatly influenced changes in social work perspectives. Feminist analysis has provided social workers with an understanding of the dominant patriarchal ideology of the culture and

how in overt and covert ways it precludes equality for women. The social work profession, in the ecological approach, does affirm the relationship between private concerns and public issues. However, feminist theory explains the "intricate relationships between women's personal experiences and sex-role norms, discriminatory practices, and oppressive social circumstances . . . how the same beliefs that engender male dominance and male privilege promote the victimization of women by men, protect victimizers, and place all women at risk" (Berlin, et al., 1981:447).

The role of social work presented in this practicum report is an integration of feminist and ecological approaches to social work practice. The practicum is an attempt at developing and then applying this synthesis. The ecological approach to social work practice provides a way of organizing and considering the many components of the environment and how they impact on women's lives. A feminist perspective provides a way of thinking about and seeing the world. It enhances the ecological model by incorporating a political analysis of women's role in society. This added dimension allowed the author to provide commentary about the components of the environment that are oppressive to women's health.

CHAPTER 1

A FEMINIST REFLECTION

Introduction

The literature on body image, anorexia nervosa and bulimia is vast. Explanations for women's body preoccupation and the predominantly women's health issue of eating disorders, range from the traditional psychoanalytic to the dysfunctional family to sociological orientations. The psychoanalytic approaches focus on the individual psyche; the family therapy approach moves beyond the individual to the family system and the sociological perspective addresses societal and cultural factors in their attempts to explain and treat those who are anorexic, bulimic and body preoccupied.

It is not within the scope of this report to review the various explanations and treatment orientations that are available in understanding and/or treating women with anorexia nervosa and/or bulimia and body image distortion. It is the author's contention that a feminist perspective on women and weight offers an explanation that is the most comprehensive in its analysis. The rationale for this perspective is offered in Chapter 3.

This first chapter is organized so as to familiarize the reader with the issue of women's body image and then moves into a discussion of anorexia nervosa and bulimia-

both often the end result of extreme body image and weight preoccupation.

BODY IMAGE

Women's Bodies and Social Control

> "My daughter has become so modest, I haven't seen her undressed in over a year now," says a mother of a thirteen year old. "She's always worrying about herself, always bathing, always washing her hair. Suddenly all she wants to do is diet. She has a beautiful little figure, but she's never satisfied with it." Everything seems to happen at once in puberty. How can anything feel right? Of course, we want our privacy. Then, simultaneous with pubic hair, the lift of a breast, the curve of a thigh, comes menstruation . . . we begin our life pattern of dieting and unhappiness about our bodies . . .
>
> (Friday, 1977:148)

In an attempt to understand the behavior of this Mother's daughter and that of most Mothers and daughters in our society, we must understand the social expectations of women. The relationship between personal troubles and public issues is basic to feminist perspectives of society and the experience of women and men within it. The cultural environment shapes what persons become, what opportunities in life are available to them and their perception of the world they live in (Andersen, 1983). The environment conditions what our experience is and how we incorporate that into our thoughts. Feminism asserts that social institutions and social attitudes are the basis of women's position in society.

Socialization refers to "the pressures rewarding, punishing, ignoring, and anticipating - that push the child toward evoking acceptable responses" (Bardwick & Douvan, 1971:226). Socialization is the process by which social roles are learned. The learning of sex roles through socialization plays a significant part in the process of moving from childhood to adolescence to adulthood. Sex roles are "those expectations for behavior and attitudes that the culture defines as appropriate for men and women and sex role socialization refers to the process by which sex roles are learned by a society's members" (Andersen, 1983:49). It is through sex role socialization that different behaviors and attitudes are encouraged and discouraged in women and men. Social expectations about what is considered feminine and masculine are communicated to us through the socialization process. Agents of this process include our families, our colleagues, our peers and the media. Andersen (1983) explains that socialization acts as a powerful source of social control. The characteristics associated with feminine and masculine sex stereotypes are those that are considered worthy or valuable by the dominant social institutions. The result is that society is significant in establishing our definitions of ourselves by influencing our self-concept or the way we think of ourselves and our self-esteem or the way we feel about

ourselves. Our definition of who we are, our place in the world and our relationships with others are, to a large extent, determined by the socialization process.

Lawrence (1984) in discussing why body image and weight preoccupation are women's issues, points out that women are the sex which we all look at. Girls learn at a very young age that there is a social expectation, one might suggest an obligation, that women will strive to be physically attractive to others. It follows then that we must rely on the approval of other people and that it will be forthcoming if we conform to the rules about women's bodies and how they should appear. The approval of others is supposed to make us feel good resulting in a self-esteem that is not based upon our own assessment of ourselves and our accomplishments but rather upon the opinions and perceptions of others. Orbach (1986) describes a woman's body as the subject of scrutiny and the recipient of constant observation. She asserts that North American and European women live with a tension regarding their place in the world and that the tension is created by being pushed and pulled in opposing directions. She sees women as "transforming their bodies in their attempts to deal with the contradictory requirements of their roles in late twentieth century America and England" (p. 24). Brown (1987) presents a similar perspective in her discussion on women's weight preoccupation in

contemporary society as an expression of an identity crisis resulting from the current contradictory social expectations for women. Brown asserts that women's sexual role presently dominates women's reproductive function and, therefore, thin body ideals are highly valued. Mayer (1983) suggests that making women fear fat is a form of social control; that the starvation of women in today's society is the present day equivalent of foot-binding and lip-stretching. Greenspan (1983) states that "(T)he flipside of male adoration of the female body is, and always has been, male fear and hatred of the female body" (p. 165). In The Obsession. Reflections on the Tyranny of Slenderness, Chernin (1981) connects the adoration of thin female bodies with both child pornography and second-wave feminism. She argues that it is no coincidence that as feminism grew, the ideal female body became younger and thinner. She states that a culture that is based on the suppression of women will reject whatever is perceived as powerful in women. The fashion industry's promotion of the thin ideal reflects this rejection of female power as does the male shift in perception of female beauty to underdeveloped bodies. Garner et al., (1980) demonstrated the shift in the cultural standard for feminine beauty through analyzing data collected from Playboy Magazine, Miss America Pageants and diet articles from popular women's magazines. They found that there has been a

significant decrease in women's weight and bust and hip measurements and an increase in waist measurements over the past twenty years. A trend toward a more 'tubular' shape, typically associated with adolescence, was identified. Chernin identifies this shift as simultaneous with the women's (weight) reduction movement and sees it as an expression of a fear of women's power. A woman's body, therefore, becomes her source of power. The more beautiful a woman's body, the more power she has - either to be successful in her career or in attracting a male partner. It is suggested that "(W)omen are fashion crazy not because we are frivolous but because we know that our bodies are our only power and we take them as seriously as men take their work . . . cosmetics and clothes are the female tools of the trade - the weapons women need in the battle for survival" (Greenspan, 1983:163). The irony and tragedy for women is that our bodies 'betray' us; weight loss is gained back, cosmetics cannot forever mask aging, and thus, women's greatest source of power becomes her enemy. Stannard (1971) comments that "(T)he very cause of women's glorification - her presumptive beauty - is at the same time the stigma of her inferiority" (p. 201). Greenspan (1983) concurs stating that if woman's body is her only asset in society, it is also her greatest liability. The female body grows old, ceases to reproduce and loses its power.

Rigorous dieting and constant scrutiny of our body shape and size keep us preoccupied with food and exercise fads and deplete our energy. The message is that the less space a woman takes up in the environment the more socially acceptable she will be. Henley (1977) explains "(N)ot only women's territory and personal space, but their very bodily demeanour must be restrained and restricted spatially . . . their femininity is gauged, in fact, by how little space they take up, while men's masculinity is judged by their expansiveness and the strength of their flamboyant gestures" (p. 38). Orbach (1986) states that anorexia nervosa is not only about being thin but is also an expression of women's confusion about how much space she may occupy in society. She suggests that "anorexia nervosa is perhaps the most dramatic outcome of the culture's obsession with regulating body size" (p. 23). Any amount of 'extra' weight carried on the body is seen as the outward manifestation of deep character defects, lack of self-caring and lack of self-discipline. Fat people are judged as weak-willed because they indulge themselves. It is suggested that the presence of fat people touches people's fears of their own appetites (Boston Women's Health Collective, 1984). Fat activists assert that much of their ill health as fat women results "from the <u>stress</u> of living with fat-hatred - social ridicule and hostility,

isolation, financial pressures resulting from job discrimination, lack of exercise due to harassment and, perhaps most important, the hazards of repeated dieting" (Boston Women's Health Collective, 1984:8). This form of oppression has been termed 'looksism' - "the standardization of a look (body image) and the discrimination against those who do not meet or conform to the prescribed image" (Fonfa, 1975:20). Society creates the illusion that as individuals we choose our personal aesthetics. In reality, we have much less choice over our shapes and sizes than we are led to believe. Lawrence (1984) asserts that "fat, and fat people, are used by our society as the emotional dumping ground for all kinds of aspects of ourselves and/or our culture which we do not want to own" (p. 39). She suggests that we project on to fatness bad qualities which do not belong to it but rather to ourselves. The thinking process is that we are safe from the very worst of ourselves if we just avoid being fat:

> Thank heaven for fat people. All the time they are around, we can be quite sure that it is not our fault.
>
> (Lawrence, 1984:40)

Healthism, Looksism and the Body/Mind Dichotomy

The concept of healthism is important to consider when discussing women's body image. Healthism means an

overemphasis on keeping healthy. Crawford (1980) believes that people in today's society, particularly the affluent, are too focused on their health. He argues that people feel powerless to change major factors such as financial insecurity or the threat of nuclear disaster so they become preoccupied with such health factors as dieting, exercise and smoking cessation. In The Culture of Narcissism, Lasch (1978) suggests a similar hypothesis. He believes that the present obsession with work-outs, aerobics, pumping iron and other forms of strenuous exercise is a sign of a culture that has lost touch with its past and holds no positive focus for the future. He asserts that this obsession is an indication of desperation and despair. Looksism and healthism in society are necessary for the billion dollar image industries to profit as they do. They benefit from the body insecurity and self-loathing created by looksism and healthism. Image industries include fashion, cosmetics, and the diet and fitness organizations. It is interesting to note that the image industries have recently infiltrated the aerobic studios and bodybuilding gyms. Fashion and health have become interrelated giving a strong message that getting fit, especially for women, is for looks or appearance as opposed to health reasons. It is the appearance of health that is really important, not health itself, or women would not be literally killing

themselves in the pursuit of thinness. Women get the message that one must be fit and fashionable before buying a gym membership! If a woman ignores this message she finds herself not measuring up, feeling ugly and out of place and soon finds herself disliking her body even more than when she first began her workout routine. She also learns a language if she perseveres at the aerobic studio that encourages punishment and disrespect for her body as though it were something to be disciplined; as though it is not part of her but rather her enemy. She is yelled at with phrases like "No pain, no gain", "Burn that fat", "Whip it into shape", "Trim that fat", "Suck in that tummy", "Hold in that rear-end"; hardly a positive experience! Treating the body as enemy sets up a dualism or split between the body and the spirit or the psyche. Lawrence (1984) discusses this dualism in the context of asceticism or self-denial. She states that asceticism, and the complex history of the attempts by people to achieve moral perfection rests on the notion of the dualism of the body and spirit. Fasting has been a common practice in societies with a more overt religious base. The purpose of this self-denial is described as the freeing of the soul from the prison of the body. The physical self is regarded as inherently sinful and impure. We are encouraged to regard self-denial as a 'good' thing. Self-indulgence is seen as a sign of moral weakness. It

is suggested that this dualism between body and spirit is fundamental to women's socialization (Lawrence, 1984). Historically, women's bodies, much more so than men's, have been regarded as impure, unclean and morally bad:

> . . . ever since Eve tempted Adam to sin, women have lived under the shadow of our dangerous bodies. In the pursuit of moral worthiness, women must find a way to dissociate ourselves from our bodies.
>
> (Lawrence, 1984:34)

If a woman sees her 'self' and her 'body' as two separate and distinct entities, she may believe that strict discipline, denial and abuse of her body through rigid dieting and strenuous exercising is actually doing 'herself' good. These assaults upon her body can make her a better person - a message that is reinforced by the fitness/image industries.

The body/spirit dichotomy is further exemplified by the advertising/image industries emphasizing women's body parts. Advertising is one of the most pervasive forms of representation in our society. It emphasizes and celebrates stereotypical views of gender roles. It "constantly dissects women and uses 'significant' parts of them in its attempts to 'glamorize' products and manipulate consumption . . ." (McRobbie & Nava, 1984:82). Once the body parts have been divorced from the person they can be used in derogatory and degrading ways- sagging breasts, lumpy thighs, fat ass - all of which can be remedied if you buy the product promising firmer

breasts and smoother legs and hips. The contradictory message is obvious. The woman in the advertisement has body parts that are glamorized and most often altered in appearance with cosmetic and photographic cover-up while the woman observing is criticized and critical of herself for not achieving this ideal. Stannard (1971) states that every day and in every way, the profit making image industries tell women they are monsters in disguise. She explains that "(I)n this culture women are told they are the fair sex, but at the same time that their 'beauty' needs lifting, shaping, dyeing, painting, curling, padding . . . women are really being told that 'the beauty' is a beast" (p. 192). The ideal body that we are socialized to make our lifelong struggle to achieve has little resemblance to what women naturally look like. Even the small percentage of women who fulfill the ideal of beauty are not allowed to be natural - they are creatures of artifice through seductive lighting and airbrushing. Stannard (1971) argues that "their beauty is kept at the highest possible artificial polish because they are performing an essential service in our society" (p. 194). It is through these women that we learn our role in society. We learn that women are articles for consumption in the male market. Looks are a commodity to be bartered in exchange for a man and the security he supposedly can provide. Because the ideal beauties that we are bombarded

with on magazine covers and television advertisements are not as nature made them, we are being encouraged to artificially aspire. The goal is never achieved because it is not real; it is an illusion, a fantasy. We learn at a very early age that if we are 'unattractive' we are not loveable and so we relentlessly pursue the ideal. The image industries have their profits in mind when they promote the ideal beauty. She has to be unattainable, never within our grasp but ever so present on billboards and popular media so as to keep us striving and buying. Women are the sex we look at. We learn as small girls that we must make ourselves attractive to others. We are socialized to rely on the approval of others and to feel validated when we are approved of, especially by men. Our sense of self-esteem is often based upon the opinions of others and how readily we please them. Stannard (1971) suggests that "(W)omen's exhibitionism is socially approved because the culture wants to keep women infantile, to keep her identity focused on her physical person, not on her accomplishments" (p. 202). Maturity in women is not valued, but rather, feared and rejected. By keeping our identity focused on our bodies we are sure to feel insecure.

Woman's Body and Consumer Consumption

The many images and meanings that women's bodies represent form a part of each woman's relationship with her own and other women's bodies. Orbach (1986) explains that "women's bodies have come to be used as titillating palliatives in the forging of a society whose economic rationale is consumption. Commodities from cars to Cokes to chemicals are displayed with young women close by signalling availability and sexuality . . ." (p. 34). Selling and serving up the goods with young, stereotypically attractive women has been at the forefront in the drive to advertise, to attract consumers and to sell. The female body is used because the act of consuming has to be pleasurable. Buying is not based on direct physical need, but rather the more nebulous areas of choice and desire. McRobbie & Nava (1984) suggest that since sex is most intimately connected with pleasure, it is used as a lure to encourage consumption. Sex in selling a product means the availability, or at least the fantasy of availability, of the woman's body for male consumption. The message for women is conflicting and confusing, degrading and dehumanizing. We learn from an early age that we are to be sexy and inviting as well as virginal and monogamous; to be consumed and not to be consumed. When the female body is not being displayed alongside goods for consumption, it is used to promote

fashions that also give us conflicting messages. Thinness is necessary for the fashion industry "because if one wants to emphasize the clothes rather than the woman, it is a great help if she closely resembles a clothes hanger" (Lawrence, 1984:38). Fashion designers want us to notice the clothes unhindered by the contours of a woman's body. The conflict for women is that unless they are pre-adolescent or anorexic, many of these fashions will reveal their bodies and its contours. The clothing really is designed to do just that. Henley (1977) poignantly states:

> In a society . . . in which women are ogled, whistled at, and pinched while simply going about their business; in which they see advertisements in magazines, on billboards, on televisions in their own homes, showing revealingly clad women; in which tactual information about them is freely available, their bodies accessible to touch like community property; in which even their marital status is the first information by which a stranger identifies them - in such a society it is little wonder that women feel 'observed'. They are.
>
> (p. 167)

It is suggested by the author of this practicum report that women's body image distortions can be partially explained by this constant surveillance and scrutiny. The ideal bodies that we are bombarded with by the image industries, and are expected to strive for and maintain, are presented to us through a male perspective. McRobbie & Nava (1984) point out that the ideal is located in the masculine gaze, for example, eyes are drawn to a woman's

legs with a short skirt. The body ideal that we are urged to aspire is mirrored in the gaze of men and since we cannot see through their eyes, it is difficult to perceive our bodies accurately and without distortion.

Female and Male Socialization

Given women's socialization experience, it is not surprising that we so intimately link our bodies with our sense of self and that body attitude becomes self attitude. Devaluing ourselves because our body does not measure up is tragic. Greenspan (1983) asserts that "(A)s long as a woman is essentially defined by her body and as long as her body is appropriated by men, she will always have a problem of feminine identity" (p. 181). Orbach (1986) states that a women's experience of her body stems from the interaction of two sources: how she believes it compares with the images of women that she is bombarded with through the media and the image industries, and how she has come to relate to her body from early on in her life. Socialization for gender roles is imperative to this discussion. From the moment of birth, female and male infants receive different treatment resulting in them being set on two different paths. Parents' expectations for their children are based on their own acceptance of cultural stereotypes about the differences between females and males (Lipman-Blumen, 1984). Parents'characterization

of baby boys and baby girls within their child's first twenty-four hours of life were studied by Rubin, Provenzano & Luria (1974). Results showed baby boys being characterized as more alert, stronger, more coordinated and having larger, firmer features. Baby girls were described as less attentive, weaker, softer, smaller, prettier, less coordinated and possessing finer features. These findings were in spite of the researchers finding no significant differences between the newborns with respect to weights, length, strength and alertness. Parental perceptions of their daughters as more vulnerable and fragile than their sons, and therefore more in need of protection, also gives a message about what it means to be female and feminine. From an early age, females are more physically protected than males and some of this protection is in the form of restrictions on freedom. The classic studies of Maccoby & Jacklin (1974) demonstrated that although females and males do not differ in exploratory behavior up to three years of age; between the ages of three and six boys began to out-distance girls in exploring new environments. Boys were allowed to wander further from home; girls were being protected. The pattern of keeping girls closer to home has been observed by anthropologists in preliterate and post-industrial societies (Lipman-Blumen, 1984). This pattern is also associated with assigning girls household and childcare

tasks at an early age. Girls are encouraged to stay indoors helping mother with meal preparation while their brothers play outdoors until they are hungry or they are summoned because the table is set. Rindskopf & Gratch (1982) discuss the early socialization for femininity that is reinforced in patterns for appropriate clothing. The delicate clothing that girls are often encouraged to wear create further limitations on their physical activity. There is an early and subtle emphasis on appearance with high value placed on prettiness and neatness. The physical meaning of being male means "to move with freedom, energy and strength . . .(T)o be female is to be quiescent, to be protected, and to move in only carefully limited ways" (p. 17).

Females learn, even as children, to pay attention to what the males are doing; to admire, applaud, appreciate and encourage the males in their active, chivalrous endeavors. In grade school, high school, college campuses and in stadiums "girl cheerleaders whip the audience into adulation of male physical prowess" (Lipman-Blumen, 1984:103). The female/male power differential is obvious. While teenage boys are encouraged to explore ability and strength, girls are encouraged to absorb themselves in the life long task of being attractive for their male cohorts. Teenage magazines for females focus on dating, dieting and cosmetic tips; for males the focus is sports

and cars. It is in early adolescence that notions of masculinity and femininity become crystallized. Given the socialization of adolescent males that emphasizes physical ability and that of adolescent females that emphasizes physical beauty, it is not surprising that a study of adolescent body image concerns found males primarily concerned about their size and strength and females about their appearance, weight and desire to be slender (Frazier & Lisonbee, 1960). Vigersky (1977) found that adolescent males attribute excess weight to muscle while adolescent females attribute it to fat. A study of overweight adolescent females and males found that the male choice of weight loss was increased exercise and the female choice was to lose weight through dieting (Dwyer, Feldman & Mayer, 1967).

Socialization for adult gender roles is powerful and pervasive. For males, the body is to be developed and strengthened which gives a message of competence. For females, the body is to be preserved, protected and most importantly, beautified. Male self-worth is dependent upon the capacity to physically and intellectually participate in society. Female self-worth is intimately linked to the capacity to meet society's standard of attractiveness. Rindskopf & Gratch (1982) assert that men are required to 'do' while women are required to 'be'.

Women's Body Image Socialization

It is from our perceptions and experience of our bodies that we construct our body image. Body image is the way we see and feel about our bodies; it has very little to do with our physical body. Body image is a very subtle and complex aspect of ourselves; it is dynamic and it is changeable. Hutchinson (1985) explains:

> . . . it is that piece of psychological space where your body and mind come together . . . (I)t is the way <u>you</u> see and experience your body, not necessarily how the world sees it - although how others experience your body can be very strongly influenced by the verbal and non-verbal messages you communicate about and through your body . . . body sensations and your knowledge of where your body parts are in relation to each other and in relation to space contribute to your body image.
>
> (p. 48)

Body image is experienced on a visual level - how we see our body; a kinesthetic level - our felt sense of being in our body; and on an auditory level - how we think about and talk to ourselves about our body. Hutchinson (1985) states that the visual level of the body image experience is the most distorted and prone to scrutiny. When we gaze in a mirror we do not necessarily see what is there rather we see an image laden with past associations, feelings, criticisms and unrealized aspirations that have nothing to do with our reflection. Body image encompasses our ideas feelings, attitudes and values about our body. Orbach (1986) points out that "the individual woman can feel a pronounced variation during the course of an hour, a day

or a week towards her body . . . . (H)ow she feels about her body will frequently affect how she is feeling about herself at that particular moment . . . . (H)ow she feels within herself influences how she feels about her body" (p. 70). Every time we look in a mirror or see our reflection as we walk down a street or look directly, and with a critical eye, at areas of our body, what we see is influenced by our body image. Body image is not the same as the body, but is rather "what the mind does to the body in translating the experience of embodiment into its mental representation" (Hutchinson, 1982:59). Body image is influenced by cultural norms. From a social learning perspective, women internalize cultural values in the form of self-statements and cognitions which they believe originate within themselves and which they experience as objective reality. Therefore, negative self-evaluation and feelings arise from what may appear as individual problems, but in reality originate from the socio-political environment in which women are socialized (Bergner et al., 1985). Feminist writers (Chernin, 1981, 1985; Greenspan, 1983; Lawrence, 1984; Hutchinson, 1985; Orbach, 1986) assert that this is the etiology of negative body image since the majority of women in our society are dissatisfied with their bodies and have a distorted body image. Living in a society that validates women based on a culturally defined notion of physical attractiveness

promotes this body dissatisfaction and distortion. Our body image is formed out of every experience we have including:

> . . . the way your parents related to and touched your body as a baby and a growing child; what you have learned from your role models about what it is like to live in and value a body; the acceptance and rejection you have felt from your peers; every negative and positive piece of feedback you and your body have ever received from people whose opinions count to you; and the ways you have perceived your body to fit or not fit the cultural image.
>
> (Hutchinson, 1985:63)

Our experience in our family environment is crucial to our body image. If families give their children a positive sense of their bodies and themselves both through example and through their actions toward them, their children will be able to accept similar messages from the environment outside the home. If children experience inadequate touching or if their bodies were violated by a parent or other authority figure through physical abuse or incest, they may have dissociated from their bodies to protect themselves. They may have violent memories or gaps in time that they have blocked. If their body was abused as a child they may not have learned another way to be with their body. Parental valuation or devaluation of their own bodies also plays a significant role in a child's learning to accept or reject her own body and its functions. As women we often incorporate our mother's body image into our own. Because the socialization

process, as discussed earlier, keeps young girls close to home, they may have witnessed their mothers' diets, exercise routines and heard critical remarks their mothers may have made about their bodies. Alternatively, their mothers may have alienated themselves from their bodies to the extent that their bodies seemed foreign to them. Millman (1980) expresses this as common with fat people who disown their bodies thinking of themselves only from 'the neck up'.

Preoccupation with women's bodies is a given in our society but few women, fat or thin, feel comfortable living inside the body they possess (Chernin, 1981). A woman who is at peace with her body is rare indeed. A woman's body often becomes the symbol or target for everything that is wrong in her life. It becomes the object of intense scrutiny, contempt and shame. Hutchinson (1982) states that "(W)hen the body image is negative it can manifest on a continuum from complete dissociation or denial of the body to open warfare with the whole or parts of the body" (p. 59). She further explains that a state of disembodiment occurs. The body is lost to awareness; it becomes a foreign object:

> It becomes something to ignore, deny, deprive or otherwise whip into shape or get under control . . . The pain of separation of mind and body ranges from the dull ache of deadness and depression to the excruciation of self-torture.
>
> (p. 60)

It was a desire to acknowledge and heal the 'pain of separation of mind and body' that was the catalyst for the Body Image Group intervention discussed in this practicum report. The women in the group were experiencing anorexia nervosa or bulimia and, therefore, could be considered at the extreme end of Hutchinson's (1982) continuum. These women had moved beyond dissociation from their bodies to a self-torture that required hospitalization.

ANOREXIA NERVOSA

Historical Background

The history of self-inflicted starvation and weight loss has been traced back to the Middle Ages. The first recorded case seems to be the fasting of the Buddha Bodhisattva Lahore in the third century A.D. Religiously inspired aesthetic practices like self-denial through starvation, were considered to introduce the human being to a superior sphere (Sours, 1980). A Leichester nun (circa 1225) is recorded as having ingested only the eucharist for seven years (Strober, 1986). The first well-documented case of female anorexia nervosa is the thirteenth-century life of Princess Margaret of Hungary. She lived in a cloister dedicated to a religious life, subsequently rejecting marriage and initiating a 'bodily penance' that ended in death at twenty-six years of age. She was frail from food, exercise and sleep deprivation

but was obsessed with, and energetic about, food preparation until her demise. Her starvation yielded none of the serene quiescence that is associated with spiritual self-denial. Rebellion, as opposed to submission, characterized her refusal of food; her regime was self-imposed rather than prescribed by her religious order (Halmi, 1982). The spiritual rather than medical perspective of these first case recordings are suggested by Morris (1985) to have set an important precedent in that purification, power, and pleasure from self-denial are part of the modern day anorexic's motivation.

Sours (1980) explains the history of anorexia nervosa as having four distinct phases. Familiarity with the phases is important because they demonstrate to the reader that anorexia nervosa has been interpreted according to what seems to be in vogue at the time. The author believes that this is a significant observation and its influence should not be underestimated. Phase one, 1600-1910, was a time period when interpretation of illness had a religious or spiritual overtone, particularly in the first half of this phase. MacLeod (1981) explains that anorexia was not uncommon among women who were persecuted as witches. She asserts that "they were especially resented and feared by the male-dominated religious establishments, who claimed to have a monopoly of all knowledge and to whom the female body was, according to

the traditional Judaeo-Christian view, a mysterious, unpredictable and even evil thing unless it were kept in its proper place and confined to its proper roles: chastity or incessant childbearing within marriage" (p. 3). Witches did not conform; they were healers and were skilled at midwifery and were a threat to the male-dominated establishments of the time. It is interesting to note that anorexia was manifested in women who were considered 'saintly' (Princess Margaret of Hungary was canonized after her death) as well as in women who were considered to be possessed by the devil! While the interpretation for the former was one of ascetism and purification, the anorexic witch was identified as displaying hysterical behavior and professing to have complete control over the human body. For the 'saintly' woman to have power and control was not a threat for it was only affecting her own body. Witches, however, possessed the knowledge that could assist other women in controlling their bodies. One could make some assumptions about why alienating the latter group was desirable during this time period.

The latter half of phase one saw the introduction of clinical diagnosis focusing on the gastric nerves. However, Morris (1985) points out that the psychological aspects of anorexia were not ignored and that as early as 1789, the impact of family conflicts was identified. A

division in the diagnosis of anorexia arose during this time period into 'gastric' and 'hysterical' variations. In 1873, Lasegue argued that the anorexic suffered from an inability to eat, while in 1895, Tourette suggested that the anorexic was not suffering from a loss of appetite but rather was blatantly refusing to eat (Morris, 1985). Gull coined the term anorexia nervosa in 1874 noting its characteristic onset during adolescence, its presentation in the female population, its psychological component, the influence of prolonged starvation on the bodily functions and the need for professional supervision (Strober, 1986). From 1903 to 1909, case studies published by Pierre Janet added sexual self-denial, fear of feminine sexuality, deliberate reduction of flesh from the developing body and denial of the womanly role to his diagnostic criteria (Morris, 1985).

The second phase identified by Sours (1980) was 1910-1938. Research produced by Simmonds, a pathologist, suggested that anorexics were suffering from pituitary insufficiency. These findings challenged the conviction that anorexia was a psychological disturbance. Twenty-five years of confusion followed (Garfinkel & Garner, 1982)!

In phase three, 1938-1960, encouraged by the assimilation of psychoanalytic concepts into psychiatric theory and practice, there was a return to the

psychological status of anorexia. Anorexia nervosa was identified as "symbolic of fixated unconscious conflicts relating to oral-sadistic fears, oral impregnation, and other regressive wishes and primitive fantasies" (Strober, 1986:236).

The contemporary phase from 1960 to present, has witnessed a fusion of clinical, psychological and sociocultural factors resulting in a multidimensional perspective and a plethora of treatment approaches (Bruch, 1973, 1978; Minuchin, 1974, 1978; Orbach, 1978, 1983, 1986; MacLeod, 1981; Chernin, 1981, 1985; Garfinkel & Garner, 1982, 1985; Lawrence, 1984; Selvini-Palazzoli, 1985).

Definition and Characteristics

The clinical definition and diagnostic criteria for anorexia nervosa is as follows:[1]

A. Intense fear of becoming obese, which does not diminish as weight loss progresses.

B. Disturbance of body image, e.g. claiming to "feel fat" even when emaciated.

C. Weight loss of at least 25% of original body weight, or, if under 18 years of age, 25% of expected normal weight.

D. Refusal to maintain body weight over a minimal normal weight for age and height.

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[1]The diagnostic criteria used here was current during the practicum experience. At the time of the writing of this report, it has been revised to include loss of the menstrual cycle.

E. No known physical illness that would account for the weight loss.

(DSM III, 1980:69)

Anorexics display a preoccupation with food; they are often gourmet cooks and frequently prepare food for others while denying themselves the products of their efforts. The term "anorexia" is a misnomer since loss of appetite is rare until the latter stages of the eating disorder. Encouragement to eat by friends and family and signals from the body (hunger pains, dizziness) are ignored. There is an intense fear of losing control should they accept food into their bodies; dichotomous thinking is common. Fears often expressed by anorexics include: fear of weight gain and being unable to stop; fear of being observed while eating and therefore, consuming food privately; fear of food as though it wields power and fear of eating more than others. One of the most alarming aspects of anorexia nervosa is the lack of awareness and/or distortion of the emaciated state of one's own body. The relentless pursuit of thinness that characterizes anorexia nervosa becomes necessary for the individual to feel mastery and control over her body (Garfinkel & Garner, 1982). MacLeod (1981) asserts that anorexia is a positive strategy aimed at establishing autonomy and resolving what would otherwise be unbearable

conflicts in the life of the adolescent with anorexia. She states that these conflicts are in part related to, and arising from, the anorexic's individual history and personality structure, that is, they are intrapsychic. They are also existential, that is, related to being-in-the-world, which means being-in-the-body, and for women, being-in-a-female-body. The adolescent with anorexia is trying to resolve something, trying to prove something and through her symptoms, trying to say something. It is obvious from the outside that what she is trying to tell us is of tremendous importance to her because some anorexics would sooner die than stop saying it. MacLeod (1981), Chernin (1981, 1985), Lawrence (1984) and Orbach (1986) are feminist authors who present thorough discussion on the notion that what female anorexics are trying to say concerns being a girl and being a woman and the passage from one to the other. Bruch (1973) states that the anorexic's issues are autonomy and mastery over her body; that the anorexic experiences an overall sense of personal ineffectiveness. This occurs for her at a time in adolescence when the sense of being one's own person is supposed to be established. She suggests the anorexic's inability to be independent and to accept herself as a worthwhile person keeps her from setting her life goals; a task which is expected of adolescents. The adolescent who receives conflicting messages and role

instruction from society and her family may feel like she has no control, no power. Garfinkel & Garner (1982) suggest personality traits of adolescents who may be predisposed to anorexia nervosa. They describe the female anorexic as a dependent, compliant, perfectionist who is a "model" child excelling at school and with few, if any, problems at home prior to the onset of anorexia. They describe the anorexic female as a conscientious conformist who seeks the approval of others while not responding to her inner needs. She has extremely high personal expectations and a need to please others so as to maintain a sense of self-worth. It is suggested that the anorexic's conformity to social demands for high achievement coupled with her distrust of her abilities is a universal psychological characteristic of this group. She feels that whatever she does, it is never good enough.

Anorexia Nervosa - On a Continuum or a Separate Clinical Entity?

Traditionally, anorexia had been considered an uncommon and intriguing disorder of adolescent girls from wealthy families. More recently, studies have demonstrated an increase in the incidence of anorexia nervosa across all socioeconomic classes and among adult as well as adolescent females (Theander, 1970; Kalucy, et al., 1977). Garner & Garfinkel (1980) suggest that

cultural trends such as the conflicting role expectations which suggest that women be both competitive and passive may be a partial explanation for the increased frequency of anorexia nervosa. The conceptualization of anorexia as existing on a continuum of weight preoccupation that ranges from 'satisfied' to 'the occasional dieter' to the 'chronic dieter' to 'the bulimic' and finally 'the anorexic', has raised much controversy between feminist and non-feminist writers. Lawrence (1984) sees anorexia "at the end of a continuum of confused and conflicted responses which we as women have towards ourselves" (p. 12). Orbach (1986) states that there exists "a painful continuity between most women's daily experience and that of the anorexic woman . . . (N)early all women feel the necessity to restrain their appetites and diminish their size" (p. 97). Those who regard anorexia nervosa as a distinct syndrome that differentiates from excessive dieting or weight preoccupation suggest several strong arguments. Bruch (1973) argues that anorexia nervosa is preceded by important psychological events including ego deficits resulting from the failure of early parent-child interactions to effectively discriminate or reinforce the child's identity. She also identifies a constellation of ego and personality deficits that include: inaccurate perception and cognitive labeling of visceral and affective states, faulty perception of the physical body

and its boundaries and a deep sense of ineffectiveness and lack of autonomy. Crisp (1977) emphasizes biological changes, specifically the reversal of the neuroendocrine mechanisms mobilized at puberty resulting in the anorexic's return to the prepubertal state as a clear distinguishing factor from other forms of weight and diet preoccupation. Garfinkel & Garner (1982) and Garfinkel & Kaplan (1986) state that evidence to date supports the position that anorexia nervosa is more than a case of obsessive dieting. They concur with Bruch (1973) in suggesting that psychological predisposing and perpetuating factors are interacting with the dieting behavior and pursuit of thinness of the anorexic. These factors are considered crucial in identifying anorexia nervosa as a distinct clinical entity from other dieting behavior. It is suggested by the author of this report that such polemical viewpoints are important to be aware of in that they do say something about our politics as writers, researchers and/or therapists. Lawrence (1984), a feminist writer and therapist, asserts that "it is only when we begin to approach the problem (anorexia) as an extension of the difficulties which all women have in our lives, that we can really begin to make sense of the experience itself, and of the issues which underlie it" (p. 15). Considering the act of self-starvation in a political realm sheds light on both the activity and the

plight of the anorexic woman. Anorexia nervosa can then be seen as an attempt at empowering and the refusal of food as the action of a woman whose cause has been dismissed or denied. Orbach (1986) asserts that there is an urgency and a strength in the anorexic's starvation. It requires extraordinary desperation and courage. The placement of anorexia nervosa on the extreme end of a continuum of weight preoccupation in women, accommodates focusing on strengths, issues of power and coping mechanisms as opposed to a deficits, pathology and problem orientation.

Contributing Factors

Orbach (1986) identifies three underlying factors that she believes are key in the occurrence of anorexia nervosa. She states the determinants are: the social climate of a period, the attempt by each generation to find its place in the world, and particular models of parenting. The first factor, the social climate that encourages weight preoccupation in women, was discussed in the body image section of this chapter. Given that psychological symptoms express the ideas a culture has at a given time about itself (Orbach, 1986), the increased incidence of anorexia nervosa is not difficult to comprehend. As explained in the previous section, the image industries' profits are sustained on the body

imperfections that they both identify and allege to ameliorate while simultaneously reinforcing and promoting this very insecurity. The second factor, the attempt by each generation to find its place in the world is addressed in Selvini-Palazzoli's (1985) discussion of major lifestyle changes in the last thirty years including the conflicts women experience over their contradictory roles in the modern world. She identifies the conflicts as due to such factors as the movement of women into traditionally male domains when previously they were confined to the home in the roles of wife, mother and homemaker. She suggests that concurrent with this conflict is the increase in female narcissism due to the constant pressure to keep up with the latest fashions. Women are expected to be beautiful and intelligent as they compete in the business and professional world; while continuing to devote copious amounts of time and energy to personal appearance. Barnett (1986) offers an explanation that addresses how women's attempt to find a place in the world could be influential in the increased incidence of anorexia nervosa. She hypothesizes that eating disorders are a "symptom of the sex-role strain young women experience when their career choice conflicts with their sex-role socialization into the feminine role" (p. 311). Feminist writers (Boskind-Lodahl, 1976; Chernin, 1981, 1985; Lawrence, 1984; Orbach, 1986) have made connections

between weight and body preoccupation and an over-identification with the feminine role. Barnett (1986) asserts that it is no coincidence that with the broadening of women's career options there is a concurrent increase in eating disorders. Chernin (1981) suggests that the weight and body obsession of the contemporary woman is related to her inability to resolve the contradiction between her desire to grow and develop as a person and her need for conformity, that is, to 'fit in'. She states that our treatment of our bodies expresses our loyalty to the conventional world in which we have been socialized.

The third factor identified by Orbach (1986) as key in anorexia nervosa is particular models of parenting. Garfinkel & Garner (1982) however, state that in their experience:

> . . . there is no one family constellation or a single type of mother-child relationship that will regularly be associated with anorexia nervosa . . . (R)ather there are a variety of difficulties in families that may predispose to anorexia nervosa.
>
> (p. 177)

They do concede that by the time the family presents for treatment, issues of hostility and dependency may be so magnified that the family relationship pre-anorexia is obscured. Selvini-Palazzoli (1985) analyzed the day to day communication between family members with an anorexic daughter and identified those patterns that she found characteristic of these families. She describes them as

tight-knit; the parents are outwardly respectable, hardworking, conventional people who do not have arguments. Excessive concern for the welfare of their children is particularly evident. Selvini-Palazzoli (1985) has found in therapy with these families that they are actually people who have repressed their resentment of one another and of their respective roles within the family. No family member is prepared to assume leadership and each member claims that all her/his actions are being performed for the good of other family members. Any form of alliance or coalition between any other members is seen as a betrayal of her/himself as well as of the whole family unit. Rules (including nonverbal or even unconscious) are firmly fixed and must never be challenged. She concludes that these families are highly resistant to change and to any expression of individuality which seems to present the threat of change. Minuchin (1978) and his colleagues consider the familial context of the eating disorder as more significant than the etiology of the adolescent's individual issues. In fact, they seem to have discarded the intrapsychic approach along with any consideration of the wider social and political context. They see the family as particularly prone to 'conflict avoidance'. On the surface they appear civil and loving but underneath there is anger, resentment, possessiveness and secrets amongst

family members. They found these families to be enmeshed and rigid. Individuals tend to speak for one another, to presume to know what the others are thinking and feeling and to act accordingly. They identified a lack of privacy (e.g. bedroom and bathroom doors left open) and any individual who sought it would be resented by the other family members. Minuchin et al. (1978) concluded that the anorexic is best treated as a member of a family because her symptoms and her behavior refer to that of the entire family network in which she is enmeshed. Through her eating disorder, the anorexic has taken the focus off the family conflict and has become the 'problem'; she has taken responsibility for a family pattern of emotional difficulty. Yager (1982) combined the various family descriptions of many theorists and therapists and presents a profile of a "typical" anorexic family. Features include: high achievement orientation, mother and often other members vigilant about weight control and place high value on slimness and exercise; superficially they appear to be a healthy family, however, overly concerned with outer appearance and social status - the family "is diligent about putting up a congenial facade" (p. 44). Conflicts between the parents are hidden - lack of fulfillment as a couple leads to mother becoming overly-involved with the children and father with his work. Yager (1982) states that parental limitations can lead to

fear of their adolescent daughter's psychosexual development and eventual separation. Parental over-involvement is considered to lead to the daughter becoming more concerned with parental approval than with her own internal needs. The daughter's individuality is negated resulting in a fragile self image and a feeling of having no control in her life. Parental approval is sought as opposed to autonomy so as to fill the void. Anorexia nervosa is said to begin when the family 'order' is disrupted often by such precipitating events as relocation, illness or concerns of the anorexic daughter regarding parental friction. Garfinkel & Garner (1982) caution that "(W)hile the familial characteristics that predispose to the disorder may be common in a population, it is their interaction with an individual's constitutional and psychological make-up and the cultural milieu that determine whether this predisposition will result in disease" (p. 167). It is important to note that family therapists (Minuchin, 1978; Selvini-Palazzoli, 1985) focus on adolescent onset of anorexia nervosa as a symptom of family dysfunction. Studies on anorexia nervosa in mothers and how to deal with it in a family therapy context were not found when reviewing the literature.

Finding a Place in the World

Schwartz et al. (1986) state:

> Elements in the culture determine in part both the coping value and the signaling value of a given symptom. It does this in two ways: by defining what is desirable, and by defining what is obscene or taboo. The "relentless pursuit of thinness" that we find in anorexics - - which has so often been called a "caricature" of what society considers beautiful is an example of the former. Anorexic girls do believe that what they are doing does in fact make them more desirable and more attractive.
>
> (p. 28)

The desirability and attractiveness that anorexic women strive to achieve is not simply in the cosmetic sense. Lawrence (1984) states: "it is rarely as simple as that . . . the origins lie in a longstanding sense of dissatisfaction with life - which seems as though it may be solved by losing weight" (p. 32). This sense of dissatisfaction is suggested by feminist writers and therapists (Greenspan, 1983; Chernin, 1985; Orbach, 1986) as rooted in the psychology of femininity. Orbach (1986) asserts that for a woman to successfully achieve femininity, she must meet three basic demands: "she must defer to others, she must anticipate and meet the needs of others and she must seek self-definition through connection with another" (p. 43). Gilligan's (1982) studies demonstrated that as women we tend to see ourselves as connected and affiliated to others in a complex set of bonds; whereas men tend to see themselves

as separate individuals, independent and even cut off in their relationships with others. While Gilligan (1982) and Saulnier (McCannell) (1982) assert that we should celebrate our connectedness and affiliation needs, traditional psychoanalytic theory has argued that one of women's deficiencies is an insufficient sense of separation. Sanford & Donovan (1984) state that for many women, an insufficient sense of their own individuality and separateness results in low self-esteem. Chodorow (1978) points out that this differential socialization begins in the way we are raised as girls and boys to have different senses of ourselves in relation to others. According to Chodorow (1978), girls do not develop a true sense of their separateness and individuation because they are the same gender as the primary parent. Boys develop a strong sense of themselves as separate because they are the opposite sex to the mother. Eichenbaum & Orbach (1983) state that it is within the family structure, particularly the mother-daughter relationship that a girl learns her social role and develops her sense of self. Orbach (1986) asserts that this relationship is an ambivalent one:

> . . . for the Mother who herself lives a circumscribed life in patriarchy, has the unenviable task of directing her daughter to take up the very same position that she has occupied. Explicitly as well as unconsciously she psychologically prepares her daughter to accept the strictures that await her in womanhood. She

needs to do this so that her daughter is not cast as a misfit.

(p. 43)

The consequences of an adolescent female being socialized to defer to others, anticipate the needs of others and seek self-definition through the approval of, and connection with others, can result in her being "unable to develop an authentic sense of her needs or a feeling of entitlement for her desires" (p. 84). Many aspects of the self may be underdeveloped resulting in insecurities.

Chernin (1985) argues that it is in our desire to surpass the traditional idea of what it means to be a woman in this world, in effect to reject the position our mothers were placed in, that results in the mother/daughter separation struggle that is frequently associated with anorexia nervosa. The core of the problem is identified by MacLeod (1981), Chernin (1982, 1985) and Orbach (1986) as identity. Chernin's (1985) thesis is that:

> . . . as the Victorian culture did not permit women to accept or gratify their basic sexual needs, our culture does not permit women to accept or gratify their basic need to grow and fulfill their potentialities as human beings, a need which is not solely defined by their sexual role.
>
> (p. 17)

Chernin (1985) asserts that anorexia nervosa becomes a way to stop movement into a world that gives women contradictory and confusing messages about their role.

Finding our place in the adult world begins during adolescence. It is a time in life when young people are encountering the possibilities of their own independence for the first time. It is also a time of questioning one's identity. Lawrence (1984) states that "identity is best understood as a sense of self which involves both an acknowledgement and acceptance of individuality, of the uniqueness of ourselves, together with the feeling of being part of and accepted by a wider group" (p. 49). We all experience this kind of crisis at various points in our lives. It is when the conflict seems impossible to resolve that women might deal with it through anorexia nervosa. Anorexia may be seen as the only strategy open to the adolescent female in her attempt to define her identity as an individual. The eating disorder expresses both an uncertainty about who she is and what she may become and a yearning for freedom and liberation. Chernin (1985) identifies the sad irony in this situation. Weight and body preoccupation keep the starving woman from achieving her full potential in the adult world. Like her mother, whose role in the home often centered on food purchase and preparation, the anorexic becomes obsessed with food through her constant denial of it for consumption. The anorexic falters in her attempt to transcend her mother's existence because although food may take on a different meaning, it is central in her life.

BULIMIA

Historical Background

The term bulimia is derived from the Greek word bous limos meaning ox hunger. This is a misnomer as true hunger has little to do with bulimia. Recorded history of bulimia is scarce, unlike anorexia nervosa where case studies date back hundreds of years. Boskind-White & White (1986) offer a historical-sociocultural perspective that provides some insight into this recently recognized eating disorder. Gluttony in response to a period of famine or during magical and religious rites was not uncommon in primitive societies. Feasts were anticipated with the opportunity to eat with abandon as days or months of hunger would most likely occur again. Scenes of gluttony from the Renaissance era depict joy and vitality and women seemed to enjoy consuming food as much as their male counterparts. The Romans frowned upon obesity and thus invented the vomitorium which allowed them to relieve themselves after gorging. As cultures developed and became more sophisticated, ideal traits were introduced. In the 1700's fat continued to be emphasized among peasant women but small waists were considered attractive and desirable for upper class women. Fatness became increasingly viewed as bourgeois; a trait of the lower class. Women's identity was beginning to be less bound to her role as mother and therefore the necessity for her

body to reflect fertility, health and the ability to survive was diminished (Boskind-White & White, 1986). Seductiveness was emphasized for the upper class woman; a cinched waist and a petticoat to create an hourglass shape and a plunging neckline and a suffocating bodice to exaggerate the breasts.

The sociocultural climate that gave rise to bulimia is that which also influenced anorexia nervosa. Unrealistic societal expectations leading to confusion and conflict for women has been a major influence since the 1900's (Garfinkel & Garner, 1982, Boskind-White & White, 1986). Bulimia was viewed as a symptom of anorexia nervosa by psychoanalysts and binging was interpreted as the pregnancy wishes of the anorexic. Food was identified as symbolic of mother's milk, oral masturbation, or oral insemination. A commitment to a psychosexual interpretation with no mention of purging practices continued until 1976 (Boskind-Lodahl, 1976). Traditional psychoanalytic interpretations persisted with the publication of Linder's (1955) The Fifty Minute Hour in which he describes the "Case of Laura". Purging was minimized with Linder interpreting Laura's binging as a substitute for sexual hunger for her father and a desire to be impregnated by him. Linder interpreted Laura's behavior as a hatred of femininity and his therapy was to help her learn to accept and adopt her feminine role. He

surmised that she really wanted to become pregnant and that a healthy outcome would be for her to find a man and fulfill this desire.

Definition and Characteristics

Controversy over defining bulimia as a separate binging/purging disorder continued until 1980 when a clinical definition and diagnostic criteria was adopted. Five principal specifications were identified:

A. Recurrent episodes of binge eating (rapid consumption of a large amount of food in a discrete period of time, usually less than two hours).

B. At least three of the following:

   (1) Consumption of high caloric, easily digested food during a binge.

   (2) Inconspicuous eating during a binge.

   (3) Termination of such eating episodes by abdominal pain, sleep, social interruption, self-induced vomiting.

   (4) Repeated attempts to lose weight by severely restricted diets, self-induced vomiting, or use of cathartics or diuretics.

   (5) Frequent weight fluctuations greater than 10 pounds due to alternating binges and fasts.

C. Awareness that the eating pattern is abnormal and fear of not being able to stop eating voluntarily.

D. Depressed mood and self-deprecating thoughts following binges.

E. The bulimic episodes are not due to anorexia nervosa or any known physical disorder.

(DSM III, 1980:72)

Bulimia emerged as a separate syndrome because binge eating was found to occur in individuals who ranged from anorexic to obese (Stunkard, 1972). To describe binge eating and purging behaviors, Boskind-Lodahl & White (1978) suggested the term bulimarexia. The terms seem to be used interchangeably, although, Boskind-White & White (1986) argue a preference for 'bulimarexia' as they distinguish it from the disease model definition of bulimia. The binging and purging practices are asserted as representing a tenacious habit as opposed to a disease process; "(B)inging and purging are learned behaviors that can be unlearned utilizing the principles of social learning theory" (p. 354). The most recent revised edition of the DSM III has replaced the term bulimia with bulimia nervosa.

Bulimia and Anorexia Nervosa - A Comparison

Studies comparing and contrasting bulimics and anorexics reveal significant differences (Russell, 1979; Fairburn, 1981; Halmi, Falk & Schwartz, 1981). Bulimics tend to be normal or slightly overweight while anorexics suffer severe weight loss. Both exhibit a morbid fear of becoming fat but the bulimic does not relentlessly pursue the thin body ideal that the anorexic strives for. Lack of self-esteem, profound sense of ineffectiveness, a distorted body image and an obsessive concern with food is

common in both groups. The obsessive concern with food, however, is manifest in very different ways. While bulimics turn to food, anorexics turn away from it. A binge is an exception and occurs infrequently for the anorexic. She is in a starvation state most of the time. In contrast, binging and purging is often an everyday, sometimes several times per day ritual for the bulimic. Boskind-White & White (1983) observed that anorexic women are generally younger, less socially competent and more dependent upon their families. They suggest that the more a young woman is isolated and enmeshed in her family, the greater the chance that she would 'choose' anorexia as opposed to bulimia. They offer an interesting perspective:

> Women who veer towards bulimarexia are more tenacious (than anorexics). They do not have to "show" their pain to the extreme evidenced in anorexia. However, their passivity and desperation and their attempts to maintain control are a matter of degree; they are, in effect, stronger carbon copies of their younger, anorexic sisters.
>
> (p. 35)

Bulimia "is a closet illness - a shameful secret from family and friends - and most of its victims become expert at hiding it" (Cauwels, 1983). Unlike the anorexic who shows the physical signs of her disorder, the bulimic can and often does carry on for years keeping the secret. Her weight is usually within an average range and eating in social situations is controlled and appropriate (Fairburn

& Cooper, 1982). The woman with bulimia, however, will more readily acknowledge her abnormal eating patterns while the anorexic denies food related problems. Outwardly, the anorexic exhibits more self-control; bulimics are more impulsive; alcohol and drug abuse and kleptomania are noted in this group (Garfinkel, et al., 1980; Crisp, 1982; Hatsukami, et al., 1984). Family histories of substance abuse are more common in the bulimic population (Root, et al., 1986) as is a history of weight problems (Garfinkel, et al., 1980). Bulimics are known to more frequently initiate treatment, whereas family and friends of anorexics tend to seek out and initiate help. Anorexics are identified as having a very low tolerance for intimacy while bulimics are often in relationships albeit experiencing problems. A history of victimization is less common with anorexics; women with bulimia have more frequently been physically and sexually abused (Root, et al., 1986). Studies examining sexual abuse as antecedent to eating disorders are recent and few have been published (Leichner & Sloan, 1986; Goldfarb, 1987; Schecter, et al., 1987). In view of the traditional psychoanalytic interpretations of bulimia as noted previously in this section; the 'fears' of these women regarding 'age appropriate sexuality' and 'femininity' may have had a lot more to do with their bodies being violated. With regard to the interpretation of binging as

their desire for impregnation by their fathers, one wonders how many women's experience as children and adolescents was not 'desire' but in reality 'fear' that they would and very well could become pregnant. Interpreting body violation as desire can lead the victim to taking responsibility for the actions of others. The implications for practice are as significant and profound as the prospect of misinterpretation would be damaging and tragic.

Studies demonstrating the incidence of bulimia have focused predominately on the university population. Halmi, et al., (1981) demonstrated that 13% of a normal college population experienced the symptoms of bulimia as described in the DSM-III (1980). Eighty-seven percent of this bulimic population was women. A Canadian study by Piccinini & Mitic (1987) revealed that 14.8% of female university students were exhibiting bulimic behavior. Binge eating most often begins in the late teens and the onset of vomiting has been identified as generally one year after the binge eating began (Fairburn & Cooper, 1982). Studies reveal contradictory findings regarding socio-economic, cultural and racial factors. While Maceyko & Nagelberg (1985) found the syndrome to be oblivious to these factors, other researchers drew different conclusions. Hart & Ollendick (1985) found binge eating in 47% of working women and 69% of university

women. Bulimia was found in 1% of the working women and 5% of university women. They speculated that the stresses of academia and having moved from the parental home might be contributing factors. Herzog (1982) concluded from his case studies that bulimics tend to be white, married, upper class, well-educated women.

The Phases of Bulimia

Swift (1984) identifies five phases in the bulimic sequence. The dieting phase is characterized by restricted eating and mastery over food and appetite desires. Dieting provides the bulimic woman with the hope that she will reach and maintain an ideal body weight. Ironically, the severe calorie restriction heightens the urge to binge. The binge phase is motivated by the wish to relieve internal tension via the calming effect of food. An ecstasy accompanies the relinquishing of control and surrendering to food. Vomiting allows her to be rid of the forbidden food; to feel 'clean' and 'pure'; a 'purification rite'. In relaxation, inner harmony is achieved after the rigors of the binge/purge; a state of euphoria is experienced and sleep often ensues. In the final phase - repudiation - tremendous guilt and shame about the entire process takes over as promises are made to have control around food. For a woman with bulimia control means restrict, therefore, leading to dieting and

the repeating of the cycle. Her day revolves around food and the next opportunity to eat. Thoughts of food, eating and purging impair her everyday activities. Planning a binge, deciding what to buy and where (bulimic women often select a variety of stores for fear of being recognized) and declining offers for socializing so she can be alone, keep her constantly ruminating over food. Food is a way to stuff down and cover up feelings that might otherwise burst out. Orbach (1981) states "uncomfortable feelings become transformed . . . so that whatever unpleasant emotions are experienced take the form of berating yourself for having overeaten" (p. 80). Women with bulimia know intellectually that binging to 'cover up' feelings and purging as a way to rid the body of them will not truly fill their emptiness inside. However, the feeling of numb euphoria following a binge/purge is a panacea for that fleeting period of time. Bulimic women can often identify the circumstances that led to their first experiments with binging and vomiting. Many had struggled with their weight as children and as adolescents. Many tried their first fad diet as an adolescent, learning about it from family, friends or popular teen magazines. Reinforced by compliments they often continued on strict diets until the urge to binge becomes overwhelming. Cultural pressures to be thin increase the drive to try desperate weight loss measures.

The discovery of purging (through vomiting, laxative and/or diuretics) is seen as a 'magical' method of weight control. Media and jokingly unintentional comments from friends and family are cited as ways purging is learned about or encouraged (Greene, 1984). Cauwels (1983) reports that trauma (e.g. loss of or separation from a significant person) can cause an existing conflict to interact with women's already troublesome connection with food. Rejection, confrontation, disappointments and anxiety often lead to binge eating. Anger is a rare emotion . . . "(T)heir immediate response to disappointment and pain is to feel hopeless and helpless rather than angry" (Boskind-White & White, 1983:50).

Contributing Factors

Depressive symptoms were identified by Herzog (1982) in 75% of bulimic women in his study sample. Hatsukami, et al., (1984) found that 56% of the bulimic women in their study scored within the moderate to severe range on the Beck Depression Inventory. Root, et al. (1986) state that "(D)epression is the most common feeling experienced and expressed by the bulimic" (p. 10). They state the "smiling" depressions are common; talking about experienced pain and loss while smiling. Bulimics often come from families where displays of sad emotions are not permitted. This inability to display felt emotion is

congruent with feelings of powerlessness. Lack of power is a central issue for women with bulimia. The experience of all women, so tragically expressed in women with anorexia and bulimia, is one of being raised on false illusions about power; that our power lies in our kindness and our beauty. Root, et al. (1986) assert that "the lack of power in society and in the family . . . underlies the bulimic's intense anger, which is suppressed and emerges as depression" (p. 23). Binging and purging establishes a fleeting sense of control. Bulimia is an attempt to establish control; it is expressed through the body as this area of control is socialized in women and socially reinforced in the culture.

As explained in the section describing anorexia nervosa, feminist theorists see all eating disorders as linked to changing, confusing and contradictory role expectations for women and the cultural values attributed to thinness. Wooley & Wooley (1986) assert:

> For the first time in memory, young women are expected to grow up to be more like their fathers than like their mothers. Those new expectations can make the transition from adolescence to adulthood excruciating, and bulimia can become a way of dealing with the pain.
>
> (p. 71)

The current expectations for women are diametrically opposed to the traditional feminine role many of us were socialized to fulfill. Current expectations for women not only include the traditional ones of being passive, good

listeners who are kind, nurturant, considerate and understanding but also to be successful, intelligent, assertive, achievement-oriented and independent. 'Superwoman' has been sensationalized and glamorized by the media and she is set up as our role model. The bulimic woman is a sad example of someone who has "learned the cultural lesson well, often being socialized to an extreme degree to demonstrate characteristics of the traditional female" (Root, et al., 1986:26) while being aware that to be truly successful in the modern world she must also incorporate the current expectations into her being. Wooley & Wooley (1986) state that many women with bulimia rage inside at their mothers for not offering an adequate example. Mother's problems get transposed onto her body by her daughter and therefore, bodily changes during puberty are not welcome by the adolescent. To have a female body is to be like mother - powerless. Greenspan (1983) asserts:

> Women who say they do not want to be like their mothers most often consciously mean that they do not wish to be housewives, or that they do not wish to be emotionally and economically subservient to husbands . . . The "boomerang" effect, by which mothers who have become the kind of persons required by society end up with children who hate them for it, is one of the most poignant aspects of the cultural double-binds of femininity.
>
> (p. 107)

Wooley & Wooley (1986) found in a sampling of female bulimics in their clinic that there were three common features:

> Less than 9% of the bulimic women they treated had mothers who had jobs that required a college education - and could provide role models their daughters wanted.
>
> 66% of their clients, though in their twenties, had not yet chosen careers.
>
> Almost 50% had suffered sexual abuse.

The shame that accompanies sexual abuse makes women with bulimia hate their bodies to the point that they set out to demolish them. Avoiding food and strenuously exercising are seen as a form of self-purification. Wooley & Wooley (1986) express shock and surprise that almost half of the clients presented with sexual abuse. Given the well documented Canadian statistics that one in four women have been sexually abused by age eighteen (Badgeley Report, 1984), it is imperative that the connections between eating disorders and sexual abuse be examined in research and practice.

Finding a Place in the World

Adolescence is a time when we are expected to make decisions and set off on our own, however, Friedman (1985) suggests that the adolescent female often finds her relationship to her 'self' inadequate in providing her with a sense of identity. She suggests that bulimia is

"symptomatic of a young woman's inability to negotiate the developmental passage; separation from mother, which is the necessary precursor to individuation" (p. 63). Wooley & Kearney-Cooke (1986) concur in their explanation of bulimia as a disorder of maturation; a breakdown in the final stages of movement from adolescent to adulthood. They provide an interesting perspective in their belief that "while anorexia nervosa represents severe problems surrounding the passage <u>into</u> adolescence, bulimia reflects problems in a passage <u>out of</u> adolescence, and into independent adulthood" (p. 478). They suggest that while the anorexic does not develop sexually and falters in transferring her focus from the family to her peer group, the bulimic becomes sexually and socially active but fails to establish intimacy, authentic peer relationships and separation from her family. Root, et al. (1986) state that "(L)eaving home is more than the physical process of moving out; it is a psychological process enabling the individual to be emotionally separate" (p. 33). Families with a bulimic member are characterized by the same enmeshment described earlier as common in anorexic families. Boundaries are loosely defined: members listen to each other's telephone conversations, clothes are borrowed without permission and bedroom and bathroom doors remain open. Physical violation of boundaries including physical abuse and incest were reported in 66% of 172

bulimic women interviewed by Root & Fallon (1985). Intrusions on one's physical and psychological space leaves the individual powerless and robs them of self-esteem. Families of bulimics tend to be either rigidly organized (like the anorexic's family) or very disorganized. Dysfunctional loyalties are created by such rules as: problems are not discussed outside the family, do not do things that reflect 'negatively' on the family and think of parents' feelings first. The young woman with bulimia learns well how to keep secrets.

Women with bulimia are often heard saying "my mother is my closest friend". Friedman (1985) states "relationships with their mothers (are) characterized by over-identification, a sense shared by mother and daughter of similarity and enmeshment, and a style of relating based not on genuine recognition of the child as a separate person, but rather on the sense that mother and daughter are in some way the same person" (p. 63). Separation from her mother would then feel like a loss of self since the only sense of identity came from the enmeshed relationship. Symptoms of bulimia usually occur when the daughter attempts to separate from her mother. To leave home is "to abandon her mother, both literally, because she is no longer present as friend and confidante, and symbolically, in the sense that she has chose to be like her father and to reject her mother's values" (Wooley

& Kearney-Cooke, 1986:480). Leaving home, she takes with her the socialization of a confusing and contradictory role learned within the family and the culture - be strong and be weak; be aggressive and be passive; be independent and be dependent; be intelligent and pretend you are not when in the presence of men! Chernin (1985) urges us to embrace and take with us into the world with pride that which our mothers have given us:

> There is something within us - and it is loyal, devoted, and striving, moreover, for wholeness and completion - that will not allow us simply to turn and cast away these mother-lives that haunt us at this moment of developmental urgency and transformation, when we are so eager to leave our mother behind and enter this culture that has always excluded us. Our mothers may not be able to model for us the new women we need to become, but there is in their lives much of value we need to take with us over that great divide that separates us from culture.
>
> (p. 202)

CHAPTER 2

STRENGTH-ORIENTED APPROACHES

Introduction

Helping professionals have access to a wide variety of therapeutic approaches for assisting people to deal with their life problems. There are commonalities in all of these approaches but the one that should be of concern to therapists is the tendency to focus on the individual's problems apart from the context within which she lives. This individualized problem orientation has a significant effect both on the therapist's way of thinking and behaving and on the client's way of thinking about herself or her life situation. If alleviation of 'the problem' is a therapeutic goal, then it follows that the client sees the solution to 'the problem' as somehow, at least partly, in the hands of her therapist. When the therapist is seen as the expert, there is a tendency for the client to appear deficit, at least in regard to the area of her life with which she is seeking help. Although this is an oversimplification, it is meant to illustrate the kind of therapeutic relationship that can develop when our initial focus is on problems, deficits and inadequacies. It is suggested by the author that the too frequent recurrence of 'the problem' in client's lives may be partly explained by the lack of therapeutic time given to clients' strengths, their coping mechanisms and the

reality that their 'presenting problem' may be a coping tool for them at that time in their lives and in the environment in which they live. Building on existing and potential strengths and power for change assists the client in recognizing and acknowledging her own abilities. Clients are better equipped to deal with problems should they recur if they know that their personal strengths and coping abilities played an active role in the past and can continue to in the present and in the future.

The ecological approach is a strength oriented alternative to problem focused therapies. By emphasizing strengths, the ecological approach allows clients to recognize a potential for growth and change and forward movement in their lives. Maluccio (1981) and Brown (1981) suggest that this orientation promotes feelings of competence in people's lives. This shift in focus also suggests to the client that she has the ability to deal with her life but that she needs to be provided with choices, options and support in how to go about doing the work. Knowledge about the situation is shared and the belief is that the client is the expert on her own life.

In an attempt to work with women with anorexia nervosa and bulimia and, specifically, to work with them on their body image concerns, the author was frustrated with the paucity of literature that both addressed women's body

image and offered a perspective that fit with her commitment to strength-oriented approaches. Well known authors writing from many perspectives about anorexia nervosa and bulimia provided a wealth of knowledge about women's body image. Social work writers provided a refreshing perspective in the ecological approach while enticing the author to ask many questions about the goal of improving the person-environment fit given an environment that is hostile in its narrow definition of women's role in society. Personal experiences as a woman provided the author with an insight and at the same time a passion for the issues. It was from a commitment to feminist principles and from knowledge through social work experience that the author chose to analyze the ecological perspective and raise some questions.

This report reflects a knowledge about women and our body image concerns and the author's belief that as a social worker she could contribute to our profession's understanding of women's body image as a crucial issue in promoting women's health.

An overview of ecological social work practice will be presented followed by a discussion of a feminist approach to practice. Integrating a feminist approach with an ecological perspective provided the author with an exciting way of working with women who have anorexia nervosa or bulimia. The synthesis of the two perspectives

presented in Chapter 3 raises many questions about what our society views as 'competent' and what women are striving to 'adapt' to.

Women's body image, as the author has come to understand it, is a complex issue in a contradictory world. Whatever circumstances bring a women to seek our help, it is asserted in this report that body image will have a part to play in how that woman feels about herself. By present an understanding of women's body image concerns in the context of a feminist and ecological approach, it is hoped that some clarity is provided in how we can incorporate body image work into the helping process.

THE ECOLOGICAL PERSPECTIVE

An Overview

The science of ecology studies "the delicate balance that exists between living things and their environments and the ways in which this mutuality may be enhanced and maintained" (Hartman, 1978:467). Ecologists have developed a systemic view of the relations between organisms within a given environment. This ecological viewpoint has provided a useful metaphor for considering the relationships between human beings and their social and physical environments. "The metaphor assumes that neither people nor environments can be truly understood except in the context of their reciprocal relations"

(Germain, 1983:113). The ecological perspective (Bronfenbrenner, 1977; Germain & Gitterman, 1980; Maluccio, 1981; Garbarino, 1982) suggests that in social work practice the emphasis should be on changing the environment as opposed to changing the people. Conceptually, the perspective implies that there are "neither inadequate persons, nor inadequate environment, but rather the fit between persons and environment may be in relative accord or discord" (Balgopal & Vassil, 1983:20). Environments are dynamic and complex and Germain (1983) suggests that this may be why the concept of environment is relatively underdeveloped in social work theory. Bronfenbrenner (1977) proposed one of the first ecological frameworks that focused on the ongoing accommodation and reciprocal relations between individuals and their changing environments. Garbarino (1982) in his work with children and families, asserts that "we cannot account for or understand the intimate relationships between the child and the parents without understanding how conditions surrounding the family affect interaction between child and parent and define each family's particular experience" (p. 18). Hartman (1978) asserts that an ecological metaphor can lead social workers to see the client as a part of the complex eco system as opposed to an isolated entity. She notes that the emphasis on identifying the roots of problematic

conditions in complex situations has resulted in social workers supporting and providing simplistic cause and effect explanations. Causation is conceptualized in a reductionistic way as reality is arranged in chains of simple cause and effect reactions. Hartman (1978) suggests that "(S)uch linear views reflect limitations of thought and language rather than the nature of the real work, where human events are the result of transactions among multiple variables" (p. 466). A strength oriented perspective is based on a complex view of causality. Once the notion of specific causal factors in disease is discarded, then the idea of disease and its manifestations is amenable to a more expanded interpretation. Multiple individual and environmental factors can then be considered. Jenson (1985) asserts that with a strength orientation the obsession with the need to cure is eliminated as the object is to promote growth. The ecological orientation enables helping professionals to gain a comprehensive perspective which includes a dynamic understanding of people and their sociocultural-physical environment (Balgopal & Vassil, 1983).

Attributes of the Ecological Perspective

Germain (1983) states that ecological approaches are distinguished from other practice orientations by two main attributes. First, because problems are defined in

transactional terms, the responsibility for change does not rest completely on the client. The perspective recognizes the power of people to affect their health but also acknowledges the responsibility of society to provide the resources necessary for people's wellbeing. Focusing only on individual capacity without regard for collective responsibility is inconsistent with a strength orientation. Secondly, the issues expand beyond the therapeutic dyad to include the client's life space and entire field of relevant systems. Intervention focuses on changing maladaptive transactional processes to adaptive ones that enhance forward movement in the client's life. Ecological theorists assert that a base requirement in a commitment to an ecological perspective is a view of human beings as striving, active organisms who are capable of organizing their lives and developing their potentialities providing they have appropriate environmental supports (Maluccio, 1983; Germain, 1983). Maluccio (1983) suggests that implementing this perspective in practice necessitates, for many clinicians, a shift in attitudes toward human beings in general and clients in particular. He points out that social workers have been trained "only too well to focus on pathology and overlook or de-emphasize human strengths and possibilities for change" (p. 137). An ecological perspective, by virtue of its emphasis on growth and

adaptation, takes the focus off pathology. Jenson (1985) points out that the ecological approach provides a framework that identifies all behavior as an adaptational response to a social situation. She asserts that while problem oriented approaches concentrate on 'disease' as 'entity', the ecological model focuses on 'person' as 'entity'. A problem orientation assumes a prior knowledge of what is appropriate behavior thus impairing an appreciation for the range of responses that can occur as a natural product of the illness experience. Weick (1986) asserts that the ecological approach "has contributed significantly to a view of practice that moves away from static, linear relationship to a more fluid field of interaction between people and their multiple environments" (p. 552). The strength or health orientation of the ecological perspective allows for a fundamentally different way of viewing health and illness than that of the problem or biomedical models. Health implies a dynamic system of interaction and, in this sense, it corresponds with the ecological perspective for it focuses on the complex set of factors that contribute to or adversely impact on the health of people, both individually and collectively (Weick, 1986). In the ecological perspective, the capacity for individual change and growth throughout the life cycle is believed in, reinforced and encouraged. The overall purpose of

intervention is seen as "improvement of the person-environment transaction rather than treatment of the person" (Maluccio, 1981:11). The general notion in traditional treatment models is of behavior as symptomatic and the assumption that if one gets at the cause one will then be able to move toward the cure or know the cure. In an ecological approach, human interactional phenomena are not viewed or explained in the context of pathology. The therapeutic stance is that the reason for a given behavior can be seen not just by tracing its etiology, but by considering its function for another system. Germain (1979) points out that social workers have always asserted the importance of the environment but have often had difficulty developing its application to practice. She emphasizes that "we ought to avoid at least one source of difficulty and that is a tendency to act as if the social environment were self-evident, as if recognizing its existence were equivalent to understanding it, taking it into account and making use of it in practice" (p. 87).

Transactional Thought and Processes

Therapists working within an ecological framework realize that the terminology of a problem focused disease model is incompatible with a strength oriented approach. Although few would argue that they are 'just words', our

use of the language in therapy and the political statement we make is often underestimated. Just as "language reflects the prejudices of the society in which it evolved" (Miller & Swift, 1980:3) it seems obvious that the same would apply to the language of therapy. Our beliefs about personal power, individual choice and client dignity are reflected in our language and our therapeutic orientation. An ecological perspective necessitates thinking and therefore, speaking, in a transactional as opposed to linear fashion. The sequence of events (past-present-future) that is important in linear thinking is replaced with concentrating on how individuals and environments relate to and impact on others. The context of the life space at any given time is the focus of attention. A strength-oriented approach is reflected in a therapeutic language that speaks of the natural life processes of transactions, physical and social environments, growth and adaptation and competence. Germain (1983) defines <u>transactions</u> as the reciprocal relations between persons and the environment. Transactions are the "processes by which people continually shape their environments and are shaped by them, over time" (p. 115). An ecological perspective is concerned with the transactions between people and environments that promote or inhibit growth, development, and the release of human potential and promote or inhibit

the capacity of environments to support the diversity of human potential.

The Environment

The environment is both objective and subjective. The objective environment exists independently of the individual's perception of it; and the subjective environment is that which is perceived. Jenson (1985) explains that part of each individual's sense of identity, autonomy and social competence is influenced by the dynamic and continuous transactions with the perceived and actual environments. Social, cultural and personal factors affect individual's perceptions (subjective) of their environment and these may differ from the actual (objective) environment. A conceptualization of the environment for social work practice must take into consideration physical and social aspects and the interplay between them and the culture. The physical environment consists of the natural and the built world. Germain (1981) states that security and shelter is a main characteristic of the physical environment needed to enhance growth and survival. For optimal functioning, the physical environment needs to be structured in a manner which provides protection from harmful environmental elements. Increasing the nutritive properties of the physical environment is a goal in the ecological

perspective. Physical environments can also have a profound effect on social contact. Space that is designated as public influences how much and what type of sharing occurs. Hospital wards are most often designed without attention to space for discussion of intimate matters pertaining to the health care of those who are hospitalized. The exchange of information often occurs in close proximity to other patients and staff (Jenson, 1985). The social environment consists of the network of human relations at various levels of organization. The levels include social networks, organizations and institutions and the societal component. Social networks include those interconnections that have developed between people as part of the process of their daily lives. These connections include family, friends, the neighborhood and the workplace. Social networks may also be constructed out of circumstances such as prolonged hospitalization. Strong connections can develop out of commonalities regarding health issues. These connections often remain after members of the network leave the hospital setting. Organizations and institutions are those components of the social environment that are formalized in their human relationships. These include the organizations and institutions that employ the helping professions. An ecological perspective necessitates that the helping professional be sensitive to how the setting's

philosophical stance, its policies and its mandates affect her or his or the organization's ability to meet the needs of clients. The societal level of the social environment includes the cultural values, political frameworks and laws of any given community, country or continent. Both the physical and social environments are "affected by the cultural values, norms, knowledge, and beliefs that pattern social interaction and determine how we use and respond to the physical environment" (Germain, 1979:13). The physical and social environments have a reciprocal influence on each other. Germain (1979) states that the social environment, interacting with the physical environment and the culture "affects the development of identity, competence, autonomy and relatedness . . . families, networks and formal organizations may provide or withhold resources and opportunities for the development of competence and autonomy; they may contribute positive and/or negative components to the sense of identity. . ." (p. 14). Identity, according to Erikson (1968), is the most important developmental task of adolescence. It means the individual's sense of self and their way of thinking about the rest of the world. Identity formation is a process of self-definition. Competence is defined by Maluccio (1983) as the skills, knowledge and talents that enable individuals to interact with their environment. Autonomy is described by Germain (1984) as the ability to

be self-directed that comes with identity formation. It is the ability to separate from family and peers and to engage independently in the environment. Relatedness, in ecological terms, refers to the individual's ability to maintain ongoing relationships with the environment in an attempt to achieve equilibrium and reciprocity. Jenson (1985) points out that the environment can either discourage or support personal growth, initiative and coping behavior through the 'climate' it provides.

Adaptation

Adaptation is a central concept in the ecological perspective. It is a transactional process whereby people shape their physical and social environments and, in turn, are shaped by them. The biological concept of adaptation refers to the "active efforts of species over evolutionary time and/or individuals over their life spans to reach a goodness-of-fit with their environments so they may survive, develop, and achieve reproductive success" (Germain, 1979:8). Gitterman & Germain (1980) assert that human beings change their physical and social environments and are changed by them through continuous reciprocal adaptation. This process results in a goodness-of-fit for both individuals and the environment when they work, and, undermine the fit of either the individual or the environment or both when they falter. Maluccio (1983)

asserts that adaptation does not suggest passive submission or adjustment by the individual to the environment. The person is an active, as opposed to reactive, participant in interaction with the environment. Emphasis on the life processes of adaptation and reciprocal interaction between people and their social and physical environments contributes to an orientation that focuses on strengthening the adaptive capacities of people and influencing their environments so that transactions are more adaptive. One of the goals of this orientation is to help individuals and their environments overcome obstacles that inhibit growth, development, and adaptive functioning. There is an emphasis on understanding all of the transacting forces in a person's life and on intervening in ways that promote growth.

Competence

Competence is a key concept of the ecological perspective. Maluccio (1983) defines competence as "the network of skills, knowledge, and talents that enable the person to interact effectively with the environment" (p. 140). Competence is an attribute of the transaction between the person and the environment. The essence of competence-oriented social work practice consists of changing the person-environment transactions so as to support and/or enhance the competence of individuals,

families and groups to deal effectively with the environment. The perspective suggests that it is more useful to view competence as a function of the individual's transaction with the environment rather than as an innate ability (Brown, 1981). The perspective of ecological competence suggests sensitivity to the importance of what is happening between people and their environments and the interplay between (a) the person's needs, qualities, and coping patterns and (b) the properties of the impinging environment (Maluccio, 1981). Brown (1981) asserts that the environment is a constant source of negative reinforcement for competence among women. Because women are afforded less opportunity, respect, resources and power than men, they often perceive themselves as incompetent despite a high level of ability. Competence in women is often negatively reinforced when it becomes too visible or threatening.

Maluccio (1981) suggests several themes that are the essence of competence-oriented social work practice:

> The view of human organisms as engaging in ongoing, dynamic transactions with their environment and in a continuous process of growth and adaptation.
>
> The conception of people as 'open systems' that are spontaneously active and essentially motivated to achieve competence in their coping with life demands and environmental challenges.
>
> The premise that varied environmental opportunities and social supports are necessary to sustain and promote a human being's efforts to

> grow, to achieve self-fulfillment, and to contribute to others.
>
> The conviction that appropriate supports should be matched to the human being's changing qualities and needs in order to maximize the development of his or her competence, identity, autonomy, and self-fulfillment.
>
> (p. 10).

Problems or needs are not seen as specific weaknesses; "behavior is not viewed as sick or well but is defined as transactional - an outcome of reciprocal interactions between specific social situations and the individual" (Kelly, 1973:538). The competence perspective suggests that there should be more emphasis on changing the environment than on changing people (Maluccio, 1979).

In competence-oriented social work practice assessment is reformulated as competence clarification. The process is one of identifying and understanding the person's or persons' competence in dealing with the environment at a particular point in time. The overall goal is to understand the complexity of the person-environment transaction, since this interface is the focal point of intervention. Maluccio (1981) presents three main areas essential to this orientation:

> <u>Clarifying the competence of the client system</u>. What are the unique capabilities, skills, attitudes, motivations and potentialities of the client(s)? What are the particular areas of coping strengths? Which areas of competence need to be reinforced or supported?
>
> <u>Clarifying the characteristics of the impinging environment that influence or could influence the</u>

> clients coping and adaptive patterns positively or negatively . . . What are the critical environmental demands and challenges currently confronting the client system? What are the actual or potential supports available in the environment in such areas as social networks? . . . . What are the blocks, obstacles, and deficits in the environment that interfere with the person's life processes and adaptive strivings?
>
> Clarifying the goodness-of-fit between the client system and its impinging environment. How nutritive is the environment in relation to the person's needs and qualities? That is, does it contain the ingredients necessary to support, nourish, and challenge the person? What should be added or removed?. . . What is interfering with the person's efforts to use existing resources?
>
> (p. 13)

Maluccio (1981) also suggests a redefinition of client and practitioner roles and relationships. The client plays an active role in the helping process including assessment, goal formulation and selection of interventive strategies. The client's active role enhances her/his autonomy and competence. The relationship is viewed as two people working on a shared project. Each individual brings a special expertise to the task. Maluccio (1979) found in studying client perception of treatment that the human qualities of the practitioner were valued more that technical skills. Germain (1979) asserts that there is a need to demystify the phenomenon of 'treatment' in general, and the client-practitioner relationship in particular.

Our Assumptive World

The concepts and processes discussed thus far focus on change at the interface between individual and environmental transactions so as to improve the person-environment fit. Parkes (1971) asserts that "(W)henever a major change in state takes place the need arises for the individual to restructure his (sic) way of looking at the world and his (sic) plans for living in it." (p. 102). He states that the way in which an individual copes with the process of change is a crucial factor. Changes in an individual's life are deemed significant or insignificant depending upon their influence on the assumptions which the individual has made about the world. Assumptions are based on past experiences and our assumptive world includes everything we know or think we know (Parkes, 1971). Changes in our relationship with the environment may impact on our expectations for the future and our interpretation of the past. Resistance to change is to be expected whenever that change required us to give up a part of our assumptive world to which we have become accustomed. Whenever a particular aspect of our assumptive world is recognized as inhibiting growth and we are encouraged to give it up, a painful loss can occur that needs to be grieved. Restructuring our assumptive world can be both a frightening and a growth-enhancing

experience. The struggle that accompanies this process is evident in the Intervention chapter of this report.

A FEMINIST APPROACH

Feminism and Social Work

One of the author's observations during her graduate work was that certain approaches are considered more credible, more sophisticated and apparently carry more prestige than others. A second observation was that, generally speaking, when talking to many helping professionals one hears a lot about their theories and treatment modalities but little about how their training experience, whether in a university setting or a mountainous retreat, has helped them to close the gap between 'them' and 'us'. The author's conclusion is that maybe many of these helping professionals have made personal connections between their experiences and those of the individuals and groups they work with but feel that to share them might make them appear vulnerable or 'not quite together enough' to be doing therapy! If that is the case, social work as a profession has much to learn from a feminist approach. It also has much to learn from a feminist analysis of women's oppression in a patriarchal society. It is suggested here that, comparatively, social work as a profession has found itself in an oppressive position in a professional

hierarchy of medicine, psychiatry, psychology, nursing and social work. It is important that in attempts to compete in this hierarchy the vision is not lost. Rather than suggest that women take on masculine defined roles so as to be more powerful in society, feminists encourage women to value themselves as individuals who have personal and collective strength. Similarly, as social workers, valuing our knowledge and skill in looking beyond the individual to societal causes and issues should remain our domain. This perspective not only helps in closing the gap between 'them and us' but demonstrates that the gap is often artificially created so we can feel healthy. Feminist therapy and social work ethics recognize the impact society has in creating and maintaining many of the issues that are brought to counselling situations (Canadian Association of Social Workers Code of Ethics, 1983; Feminist Therapy Institute Feminist Therapy Ethical Code, 1987). Feminist pride and conviction to feminist principles has much to offer social work as a profession. Thunder (1983) asserts:

> Pride is the sine qua non of feminism - pride in ourselves, individually and collectively, and the strength to act and resist which grows out of that pride.
>
> (p. 214)

Feminist Beliefs

Feminism is not simply an alternative value system but a profoundly different perspective on experience itself (Greenspan, 1983). Feminism is a common belief that "women suffer systematic social injustice because of their sex", and therefore, it is essentially concerned with "a type of injustice it wants to eliminate rather than with a group of people it wishes to benefit" (Radcliffe-Richards, 1980:17). Society has always been characterized by domination of certain groups of people by others. The domination of women by men has been a common theme throughout history. This domination is reflected in the social conditioning of men and women along gender lines and the creation of masculine and feminine traits that are considered gender appropriate. Feminist researchers have shown that differences in sex roles are socialized, not innate and, therefore, can be changed (Greenspan, 1983). Feminists aim to "equalize the opportunities of males and females to gain personal, political, institutional and economic power" (Pilalis & Anderton, 1986:101). Social conditioning on the basis of sex-role stereotypes has led to the differential treatment of women and men in society in general and in the mental health system in particular (Sturdivant, 1980). This socialization has been detrimental and oppressive for women. Levine (1983) suggests that a form of

bilingualism and bi-culturalism exists between women and men. Women are treated as a minority and, therefore, are expected to adopt the values, observe the rules, and share the assumptions built into the ideology of the dominant sex. The damaging effects of women's imposed minority-group status and the function of sex-role expectations in the etiology of women's mental illness are major concerns for feminist counsellors (Sturdivant, 1980). Because women are expected to abide by the rules of the dominant sex they often experience the frustration of remaining silent or censoring their statements or withholding their ideas or their anger. Levine (1983) connects this women's experience with the common survival stance of oppressed groups. Feminists assert that "women need to speak up to break some of the silence and isolation which reinforce the personlessness of women" (Loewenstein, 1983:535).

The feminist approach grew out of a critical analysis of the sexism inherent in the theory and practice of helping professions (Levine, 1983). Women were dissatisfied with sexist assumptions and measures of therapeutic outcomes that stressed adjustment rather than change. Feminist writers (Chesler, 1972; Penfold & Walker, 1986) assert that the mental health system functions to locate and contain within the individual and the family unit the distress and dysfunction of our

society. As workers in the mental health system, we exercise considerable power to either define women's experiences in terms consistent with the current societal explanations or to allow women the power to define and interpret their own situations. Greenspan (1983) states that therapists are in a unique position to alter a woman's experience, awareness and understanding of herself and her world. If we choose to "ignore or minimize problems arising from our social structures including the difficulties, tensions, and stresses emanating from women's role in society" (Penfold & Walker, 1986:11) then we need to seriously look at the quality of the service we are providing. Many of the systems which we work in discourage people from participating in social change and train people to focus on themselves as the source of their life problems. This experience is particularly harmful to women whose problems are a mixed result of social oppression and individual reaction (Mander & Rush, 1974).

A Growth/Development Model

Feminist therapists believe that psychological problems are rooted in the conditions under which we live and in the experiences we have while growing up. Feminists assert that we must shift our attention from the individual person to the role played by the environment and the social/economic system in producing life's

problems. In her model for feminist therapy, Sturdivant (1980) gives priority to environmental interpretations of etiology of psychological distress over intrapsychic explanations. This shift in perspective has resulted in what Sturdivant calls a growth/development model of therapy rather than the illness/remediation model of traditional therapies. Social and personal change, rather than adjustment, are a primary goal of the helping process. The social conformity goals, adopted by 'adjustment' models of mental health are rejected in favour of goals representing personal self-definition and self-determination. Feminists believe that individuals need to shape their identity by choosing roles and adapting them to fit personal needs rather than by accepting roles and role definitions as they are prescribed. Levine (1983) writes:

> By and large, women have found that helpers stress adjustment rather than change; individual not collective or political solutions; personal pathology; weakness rather than strength; the psyche unrelated to economic and social hazards in women's lives; and the authority of male experts, male management, and male decision makers in and beyond the home.
>
> (p. 77)

Levine (1983) asserts that "(T)he mandate for feminist counselling includes a healing process, an educational process and a political process" (p. 79). Loewenstein (1983) suggests that all therapy is political and the question is merely whose politics! The feminist

definition of politics is one's relationship to power. Every therapist offers a world view; the terms by which one understands themselves and the world.

> The therapist's very choice of words, (his) choice of what to go after in therapy, what to analyze, what to stress and what to ignore; these are all political acts laden with meaning.
>
> (Greenspan, 1983:27)

From this viewpoint, every therapy, directly or indirectly, teaches the client something about the politics of power. The focus on the political context of personal experience is a critical aspect of feminism. Feminists believe it is crucial to make these attitudes apparent. Other therapeutic philosophies make these connections but usually in practice the politics are lost (Mander & Rush, 1974).

Loewenstein (1983) presents a concise set of feminist principles that are an excellent starting point when beginning to work with women. Feminist therapists encourage their clients to shop around; to take a consumer approach to their counselling. Clients are encouraged to take an active part in setting goals and evaluating the helping process. The values of the therapist must be made explicit allowing the client to accept or reject them (Sturdivant, 1980). This not only gives a message of belief in one's competence to choose what is right for her but also shows respect for the individual and allows

her the right to say "no" to one's orientation.

Loewenstein's principles (p. 532) are as follows:

1. Problems are interpreted in a sociopolitical framework without denying the individual situation of a particular woman.

2. No particular sex-role expectations are held up, but automatic submission to traditional sex roles is questioned. There is support and permission for both traditional and nontraditional life choices.

3. Emphasis is on strength rather than pathology.

4. Potential sources of strength and power, available lifestyles, and ways of having an impact on one's own life are identified.

5. Traditional feminine assets of sensitivity and interpersonal skills are acknowledged, while the learning of assertiveness and an analytic-rational approach to problems is also encouraged.

6. Encouragement is given to the development of an independent identity that is not defined in relation to others.

7. Friendships with women are held to be as important and life-enriching as relationships with men.

8. Immediate action as well as long-term planning is recommended.

9. Open and honest confrontation both with the counsellor and the woman's significant others is encouraged. It is to take the place of martyrdom and psychological sabotage. The expression of rage and fury within the counselling session is permitted and expected.

10. Work is considered a natural aspect of living and the woman is helped to find some balance between work and interpersonal relationships.

11. New ways of filling traditional familial roles can be suggested with the goal of avoiding subordinate positions in love relationships.

Gilbert (1980) explains that the two most important principles of a feminist approach are that the "personal is political' and that the therapist-client relationship is viewed as egalitarian. The separation of the internal from the external is considered essential in feminist therapy. In this process, the client learns to differentiate between what she has been taught is socially acceptable from what might be actually appropriate for her. The feminist therapist facilitates this process by encouraging clients to evaluate the influence of social roles and norms on their personal experiences and to consider the relationship between sociological and psychological factors. The client comes to understand the role of society in shaping all individuals. This validation of her experience as a woman is empowering. Many women, when they make this connection, realize that the source of their self-esteem has been largely external and dependent upon the judgement of others. A desirable outcome in the helping process is a shift from reliance on external sources of self-esteem for validation to a personal self-definition based on strengths and capabilities.

The Role of the Feminist Therapist

Effective feminist therapists explore their values and attitudes concerning women and make an ongoing commitment

to confront tendencies to maintain the status quo. Gilbert (1980) states that given the way women have been socialized, societal changes are necessary before significant improvements will occur in women's lives. An emphasis on change rather than adjustment is a common theme. Feminist approaches respect and believe in women's ability to forge a better life for themselves. The therapeutic orientation is toward affirmation, empathy and validation of the female experience. A feminist therapist will guide women toward experiences that will enhance a sense of autonomy, mastery and control over their lives (Loewenstein, 1983).

Personal Power and Empowerment

A feeling of personal power is often foreign to women or it is obtained through such fragile external means as physical attractiveness and the ability to make others feel good. A feminist approach encourages women to nurture themselves by first beginning to value themselves and other women as women. Encouragement to accept support and nurturance from other women is given. Assuming power in one's life may bring up feelings of anger. Expression of that anger is essential to the positive outcome of the helping relationship (Gilbert, 1980). Allowing women clients to express their anger is a process that requires the counsellor to feel comfortable facilitating an

experience that may be at once infuriating and exhilarating for women. The expression of anger is a sign of increasing strength (Greenspan, 1983). Anger is often expressed about expected societal roles, existing relationships that feel oppressive and rage at living a legacy of inferiority because she was born a woman.

Using a feminist approach necessitates a symmetrical relationship between ourselves and our clients. A model of equality rather than subordination provides a positive model for the client's other important relationships (Loewenstein, 1983). Greenspan (1983) asserts that when inequality exists in the therapeutic relationship women are positively reinforced to accept social domination in the rest of their lives. Feminist therapists feel free to make the connections between their personal experiences and those of the women who seek their help. The commonality between the two women makes understanding and working together a natural part of the helping process (Levine, 1983). It is however, important to acknowledge that therapy cannot be a totally equal relationship. The focus is always on the client. Greenspan (1983) makes the point that because only the client's transference, and not the therapist's, is examined, there exists an inherently unequal power relationship.

Self-disclosure of the therapist's experience as a woman in our society helps the client to validate her

experiences (Gilbert, 1980). Greenspan (1983) suggests that there is nothing more inherently neutral or professional about emotional distance than there is about emotional connection. She explains that "(E)motional give-and-take is a distinctively female style in our culture . . . " (p. 28). She asserts that "(T)raditional therapists seem unable to distinguish between sharing oneself as a person and exploiting . . . " (p. 28). Self-disclosure is a powerful tool when used appropriately. The client can learn about herself through the therapists's feelings and responses to her. The skill lies in revealing oneself without taking the focus away from the client. Loewenstein (1983) cautions that feminist therapists be aware of the danger of the "Yes, I know how it is" syndrome which can block purposeful work. She affirms that "overidentification might also lead to premature reassurance (indirect reassurance of self) and fear of exploring some of the more frightening aspects of certain experiences such as rape or incest" (p. 541). Mander and Rush (1974) emphasize that "while it is important to share oneself with others it is equally important not to usurp the other person's experience with one's own" (p. 16). It is crucial that the therapist know who she is. Greenspan (1983) declares that "(T)he therapist who is not willing or able to face her own ghosts, to know her own strengths and weaknesses and to

understand what in a client's story triggers her own feelings, is a therapist severely hampered in her work" (p. 243).

Modeling the ability to recognize and articulate one's feelings encourages the client to do the same. This can occur through self-disclosure, empathy and compassion. When a therapist expresses empathy where a client's pain touches her own it lets the client know that the therapist has learned from a similar experience (Greenspan, 1983). Feminist therapists appreciate the crucial importance of compassion. Compassion "grows out of a deep experience of connection to others, an experience of what binds us together as persons in a similar social - and human-condition" (Greenspan, 1983:337). Compassion is a respectful opening to the other person and a knowledge about the sources of suffering. A feminist therapist assumes that the client is the 'expert' on her feelings and experiences. The therapist and client work toward increased client autonomy through validating experiences and perceptions. An expectation of competence and personal power reverses the usual socialization process in which women are taught to be passive, dependent and incompetent. Trusting her own decision-making and problem-solving skills and refusing to allow others to make decisions for her is one of the most significant gains women can make in the helping process (Sturdivant,

1980). Women can feel comfortable asserting "What's right for me is what I determine is right for me". Loewenstein (1983) asserts that women need a sense of mastery and competence so that the view of women as passive, defective, powerless and helpless can be rejected with confidence. The belief in a feminist approach is that clients know more about their problems and the effects than do the therapists whose help they seek. This makes the feminist approach a consumer product whereby the client's goals are served, not the therapist's. Feminist therapists share their skills with their clients, rather than impress with them.

Levine (1983) notes that "contemporary professionalism places the emphasis on personal weakness, faulty communication, defective personality, family relationships and, ultimately, on change at the personal level alone" (p. 81). She suggests that a feminist approach lifts the burden of blame, guilt and individual responsibility from women. She perceives women as scapegoats in our society and a feminist approach as a way to change this injustice in their lives both individually and collectively. The symptoms that women bring to therapy are the individual manifestations of women's collective problems. Feeling powerful for women must be connected to social reality (Greenspan, 1983). Feeling powerful as a psychological state of mind but not as a social fact is fleeting at

best. Helping our clients to understand themselves in relation to the world makes feminist therapy an empowering experience. Women in feminist therapy develop a strong consciousness of the social roots of their emotional pain. Feminist therapists assert that without such an awareness it is impossible for women to gain a full sense of their individual and collective power.

FEMINIST GROUP THERAPY

Feminist principles strongly influenced the movement in the 1970's to consciousness-raising (CR) groups that fostered a sense of women's commonalities and encouraged collective support and strength. It was in these groups that women began to share "feelings of powerlessness and rage, of frustration and underdevelopment and a sense of themselves as less than whole people" (Eichenbaum & Orbach, 1983:3). Sharing with other women and recognizing the commonalities of their experiences in a sexist society allowed women to challenge harmful sex role socialization. Feminists were concerned that in traditional group settings, women continued to be encouraged to focus on intrapsychic or interpersonal interpretation of their problems rather than a social, political or economic interpretation (Burden & Gottlieb, 1987). By the 1980's there was "a shift from groups

focusing primarily on interpersonal issues to groups organized around specific problem areas" (Johnson, 1987:15). The feminist influence on traditional therapeutic approaches led to the growth of groups for rape victims, incest survivors and battered women and legitimized the therapeutic value of sharing the psychological trauma of these experiences.

Feminist oriented groups are distinctly different from traditional therapy groups in terms of "group development, goals and structure, leadership dimensions, interpersonal relations and communication patterns" (Walker, 1987:4).

Group Development

In feminist oriented groups there are no covert agendas. The facilitator makes the process explicit from the beginning by discussing the objectives and motivations of the group and sharing with members what they can expect. The group is encouraged to determine the structure and content of the sessions and to provide ongoing feedback throughout the duration of the group (Gottlieb et al., 1983). Feminist groups strive "to combine subjective feeling and thinking with objective analysis thus directing women to investigate the role position of women in society" (Walker, 1987:4). A feminist approach to group work empowers women by providing a resocialization process that gives us the

right to be nurtured as well as to nurture and helps us distinguish between the personal and political sources of our difficulties (Burden & Gottlieb, 1987).

Goals and Structure

Feminist groups are "not viewed as a corrective experience but rather as a process of personal growth" (Kravetz, 1987:56). Emotional support is valued as much as personal problem-solving or change. Exploration of the social determinants of personal problems is encouraged rather than emphasizing solely interpersonal issues. Traditional therapy groups focus on the individual and are adjustment-oriented. Kravetz (1987) explains that the "goals of traditional psychotherapy include changing individual attitudes, behaviors and emotional states that are assumed to be deviant, sick, or maladaptive" (p. 55). Treatment is focused on recovery from illness, modifying problematic behavior, gaining insight and discovering the underlying causes of symptoms. By contrast, feminist groups find their framework for analysis in institutional structures and social norms as well as individual attitudes and behaviors. Feminist groups help us to understand and deal with personal problems in the context of living in a patriarchial society.

Leadership Dimensions

An important attribute of feminist groups is the priority placed on reducing the power differential between the group facilitator and the group members. The facilitator encourages an awareness of the impact of women's place in a sexist society and facilitates the development of skills to counteract the negative impact of our socialization. Because the facilitator shares the same sex-role socialization as the group members, self-disclosure and role modelling are important strategies for empowering the women in the group. The leader is a resource person and a consultant but she is also a woman who shares many commonalities with each of the group members.

Interpersonal Relations

Feminist groups emphasize the development of trusting, caring, close female relationships (Walker, 1987). An atmosphere of co-operation and affiliation is encouraged and valued. Improved relationships and a sense of solidarity with other women is often an outcome of feminist oriented groups. Altruism consisting of support, suggestions and empathy is reinforced in feminist groups. Hotelling (1987) states "altruism allows members to care for and to be connected to others". (p. 246). Gilligan (1982) asserts that altruism, connectedness and

affiliation are important dimensions of our identities which need to be valued.

Communication Patterns

Studies reveal that women's groups appear to be more conducive to the expression of anger as members are not uncomfortable or threatened by verbal and emotional outbursts (Halas, 1973; Kirsh, 1974; Wolman, 1976). Kravetz (1987) states that anger and dissatisfaction are viewed as symptoms in traditional therapy but as desirable and encouraged outcomes in feminist oriented groups. Women are encouraged to focus on their unique identities separate from their primary roles and relationships.

In this group atmosphere women can come to know and trust other women and understand how our stereotyped socialization can lead to doubts about our competencies and abilities. A larger societal view can change the notion of individual inadequacy and failure (Gottlieb et al., 1983). Each time a woman encourages and supports another group member she is reinforcing her own determination.

CHAPTER 3 - INTERVENTION

INTEGRATING A FEMINIST APPROACH WITH AN ECOLOGICAL PERSPECTIVE - A CRITICAL ANALYSIS

Introduction

In a search to find a therapeutic group work approach for working with women with body image concerns, specifically women with anorexia nervosa and/or bulimia, the author discovered that existing approaches did not fit with her beliefs about group work and her understanding of body image concerns. The literature suggested, for the most part, highly structured groups with an emphasis on alleviating body image distortion. While this is a desirable outcome, it also was clear to the author that distorted women's bodies are presented to us daily as role models and as a small, but significant piece of success in this world. Addressing body image concerns with a group of women with eating disorders therefore, became a challenge. While the ecological perspective provided a fresh approach to assessment with its focus on strengths and competence, it also lead the author to ask many questions. How do we as women achieve reciprocity with an environment that is hostile towards us by narrowly defining how we should look, what we should strive for and what we should realistically expect to achieve? How can we achieve competence and <u>feel</u> competent in an environment that limits our opportunities for power and respect? The

author's perspective as a feminist provided a knowledge base with which to begin to consider and critically analyze eating disorders and women's body image concerns as an attempt at equilibrium with an environment replete with contradictory messages. The difference between the fashionably thin woman, her thinking and her actions and the eating disordered 'mentally ill' woman, her thinking and her actions is not always as evident as we like to believe. It was a feminist analysis of competence-oriented social work practice that helped the author gain a deeper understanding of the struggle of women with eating disorders. For a woman to fit with today's physical and social environment and to be perceived as competent is to be a woman who is preoccupied with diet, fitness and fashion. She may achieve a 'good fit' by society's standards but not in a way that is reciprocal. She will be disillusioned that the environment did not yield what it promised should she achieve the thin ideal. What she has given to the environment in the way of a stereotypical ideal is not reciprocated with the promised successes. The question we must ask is, can women ever achieve goodness-of-fit given environmental demands that far exceed what is healthy for us? Goodness-of-fit might, in reality, be the achievement of those women who are able to disregard many of the environmental demands we are confronted with on a daily basis!

In this analysis the main concepts of the ecological perspective, as presented in the review of the literature, will be critiqued from a feminist approach and in the context of eating disorders and women's body image concerns. This analysis provided the author with a framework for intervention. The concept of reciprocity in transactions with the physical and social environments, the concept of reciprocity in adaptation to achieve goodness-of-fit with the environment and the concept of reciprocity in the achievement of competence will be questioned because of the very assumption that reciprocity exists or that the environment necessarily strives for that equilibrium.

Transactions Between The Person and The Physical and Social Environment - Reciprocity or Recognition of Reality?

Germain (1983), as noted in the review of the ecological perspective, asserts that throughout their lives people continually shape their environments and are shaped by them. She suggests a reciprocal quality to this person-environment relationship, "(W)hen the transactions go well, the fit is good - that is, people's growth, health, and social functioning bring personal and social satisfaction within the given cultural group, and the environment's capacity to support growth, health, and social functioning is protected and promoted" (Germain,

1983:116). Although Germain (1979, 1983) concedes that goodness-of-fit is never fully achieved because of continual internal and external changes, she implies that reciprocity from the environment is forthcoming without adequately addressing whether what the environment gives back or offers is healthy. She explains that poor fit causes stress and that unmitigated stress reduces the fit. Coping responses to stress are thought of as efforts to restore a previous level of fit or to improve upon it. It is suggested in this report that if the degree of fit with the environment is the issue then we must critically look at the environment with which we are attempting a 'good fit'. Gaining a more realistic understanding and assessment of our environment can permit, encourage and foster the ability to reject some of the powerful environmental forces we are confronted with on a daily basis. Klein (1976) states that "(W)hat is good for society must be good for the women is unhealthy from the feminist viewpoint" (Sturdivant, 1980:164).

It is suggested in this report that more therapeutic time should be put into recognition of the reality of unrealistic environmental demands that are placed on women. The question then becomes one of whether the improved transaction between person (woman) and environment should be a confident rejection of what we receive from the environment in the guise of reciprocity?

Our physical and social environments bombard us with the message that thinness will be rewarded with personal and professional success and that adaptation to society's demands will reward us with being perceived as competent. As women we will not likely be free of the stress that comes out of the ideals for women that we are presented with, but we can reach a place of being confident that we do not need to buy the message - or the product! By re-examining sex role stereotypes and defining for ourselves what <u>our</u> ideal self might look and feel like, we can begin to see ourselves as attractive regardless of whether we measure up to societal standards of beauty. A feminist approach can provide an opportunity for women to define 'beauty' and 'success' in ways that fit with our experience and knowledge. Feminist ideology is reflected in the assumption that the female sex role itself will generate emotional conflict (Sturdivant, 1980). Conflict occurs on two levels; the internal (psychological) and the external (sociocultural). Traditional therapy has always felt most comfortable intervening at the first level - the psychological. Feminists argue for the necessity to also consider the second level - the political or sociocultural. Earnhart (1976) suggests, "(I)t is this process of sorting out the personal from the political and most importantly encouraging the realization of the political implications of the personal problems of women

that is a major hallmark of feminist therapy" (Sturdivant, 1980:78). Greenspan (1983) convincingly argues that women's emotional problems could be viewed as unconscious attempts both to adapt to and rebel against the unhealthy psychosocial situation of being female in a male dominated environment. The author suggests that women with anorexia nervosa and/or bulimia express both an adaptation to fit with the physical and social environment as it is presented to us, as well as a rebellion in the realization that they are living representations of the paradox of the environmental message. Thinness is applauded, however, if a woman takes the environmental message to an extreme she is labelled deviant. The nebulous point along the continuum where a woman is no longer highly valued, but rather, 'mentally ill' is very unclear. Feminists have argued that women create symptoms that manifest our rebellions without openly declaring them (Chesler, 1972; Greenspan, 1983). It is suggested that women have converted their anger at the narrowly defined role of femininity into symptoms that allow us to be feminine and to rebel against femininity at the same time. It is argued here that the anorexic woman openly declares her rebellion - her body carries the message. If we look around the environment and do not see ourselves reflected in it we learn to feel marginal and unimportant and recognize our powerlessness. The anorexic or bulimic

woman in her desire to have some power attempts to be reflected in and a reflection of the environment by internalizing the environment's message to women about how to be powerful and noticed - be thin = attractive = success. The self, at least, appears to be under our control, the social world certainly does not. The message we receive, however, is that if we respond to environmental demands we will be graciously rewarded. The woman with an eating disorder needs to know, if she does not already, that she has been duped. In her relentless quest for the rewards of thinness she may be labelled, even punished, with a mental illness label. Removal from her social environment to the social environment of an institution is often the outcome of her desperate attempt to 'fit'. Hospitalization not only puts her assumptive world into question but also requires transaction with a totally new set of environmental demands. As discussed in the review of the ecological perspective, giving up beliefs and assumptions about how women can achieve competence in this society is difficult when we are socialized that thinness will give us power in our lives.

Adaptation to Achieve Goodness-of-Fit - Reciprocity or Conformity

If as women we attempt to respond to environmental demands to achieve a 'good fit' and thereby reduce stress

we may be fooled as ultimate conformity to the environmental messages leads to stress more serious than that which results from disregarding the demands of the environment. In an attempt to respond and achieve the ultimate fit, women risk 'mental illness' (anorexia nervosa, bulimia). Loewenstein (1983) states that the expectations on women make us feel "deficient, inadequate, and uniquely responsible for not measuring up to the various unrealistic cultural ideals . . . Learning to love herself becomes a woman's lifelong struggle" (p. 531). The woman with anorexia nervosa and/or bulimia is proof of that very struggle. Attempting to adapt to cultural ideals and environmental expectations can lead to serious health problems, even death. It is ironic that the goodness-of-fit is within our grasp, but once held, we are no longer healthy.

Dally and Gomez (1980) suggest that perhaps bright and tenacious women are those who are best at dieting and are most likely to accurately perceive potential cultural rewards for an attractive appearance. Smead (1983) suggests that it may actually be the strengths and capabilites of these women that are causal factors in them becoming anorexic or bulimic. When these same women are labelled as eating disordered by the mental health system, the suggestion is that something about these individuals has to be changed. Ryan (1971) explains that when this

happens, blame for difficulties and responsibility for change shifts from the larger society to the victims of that society. The author asserts that the woman with anorexia nervosa or bulimia is representative of an individual's attempt at adapting to a thin crazed, body pre-occupied society. The irony is in her achieving the ultimate adaptation to society's message she is labelled mentally ill. A social problem is defined as individual pathology.

Competence - Reciprocity and 'Mental Illness'

A society's definition of competence or effective interaction with an environment reflects the predominant values of that culture (Brown, 1981). Brown suggests that a society which tends to "place a high value on the things men do and the roles they play and to devalue female roles and skills can expect to produce more men than women who are or perceive themselves as competent" (p. 214). It is important that as therapists we are sensitive to the connection between a woman's perceived lack of competence in relating to the environment and the limited opportunities that are available for power, respect and control over our lives and the choices we make. In our society being perceived as competent and deserving of a reciprocal relationship with the environment suggests the following equation: competent woman = thin = attractive =

successful = environment reciprocates (rewards) with competent man = fit = attractive = successful = happiness. Women with eating disorders are testimony to the fact that this equation is false - they reciprocated with what the environment demanded of them but they were not/are not rewarded; on the contrary, they are punished; they are sick. The few women who do prove the equation true are held up as role models for the rest of us. They often have careers that require them to maintain the thin ideal lest they jeopardize their livelihood. They also spend countless hours maintaining their body shape and when we see them photographed they are air-brushed and made up.

The literature on competence-oriented social work practice suggests that a sense of competence emerges from the transaction between the person and their environment. Women often perceive themselves as incompetent despite a high level of ability and input into the environment. The unrealistic and damaging expectations of the environment promote feelings of insecurity and incompetence in women. Maluccio (1983) suggests that in our transactions with the environment we struggle to maintain a dynamic equilibrium while facing challenges to be competent, striving human beings. We must ask ourselves if women can or should achieve this equilibrium in view of the environmental demands - women's input into the environment far exceeds the returns - personally and professionally.

Can we achieve competence or goodness-of-fit when environmental demands exceed what is healthy for us? Is goodness-of-fit achieved by those women with the confidence and social supports to disregard or at least question environmental demands? Is the anorexic or bulimic woman maladaptive or the ultimate in adapting; incompetent or highly competent; deviant or the ultimate conformist?

The body image group described in this chapter answered many questions raised in this analysis. What to this point has been an academic discussion became a very personal exploration into the lives of the women in the group. The author's (facilitator's) comments in the latter part of this chapter will refer to this analysis in highlighting the understanding of the group members of their 'fit' with the environment.

THE SETTING

The site of the practicum experience was the Eating Disorders Clinic at the Health Sciences Centre in Winnipeg, Manitoba. A six month placement from July 1985 to December 1985 was negotiated with Dr. Pierre Leichner, the psychiatrist at the clinic at that time and Daryl Johnston, a nurse therapist at the clinic. The clinic offers both outpatient and inpatient services and continues to have a waiting list of up to four months.

The program is the only one of its kind in Manitoba and out-of-province referral is not uncommon. Dr. Leichner and Daryl Johnston were both founding members of The Anorexia Nervosa and Bulimia Foundation of Canada (ANAB) in 1983. The Foundation was formed "to provide interim assistance in the form of education and self-help and support groups for both sufferers and their families, who are at times equally confused about the behaviours exhibited in an eating disorder such as anorexia or bulimia" (The Development of the Anorexia Nervosa and Bulimia Foundation of Canada, 1983:2). Lengthy waiting lists at the clinic and long periods of recovery as well as the need for community awareness of eating disorders were also cited as reasons for the development of ANAB.

Individuals referred to the Eating Disorders Clinic are initially interviewed through the outpatient program. The DSM III criteria as outlined in the literature review is used as a diagnostic tool. Standardized measures (Eating Attitude Test - EAT and the Eating Disorders Inventory - EDI) are administered as part of the assessment procedures. A decision is made regarding whether the individual's physical and mental health necessitates hospitalization and the philosophy of the program is shared with the individual and her/his family. The average length of stay in the inpatient program is three to four months.

The Eating Disorders Clinic Manual (1984) for the inpatient program describes the services it offers as follows:*

*NOTE: The description of the inpatient program is taken verbatim from The Eating Disorders Clinic Manual (1984). The therapeutic language and approach, therefore, does not reflect that which is presented in this practicum report.

Goals

To accomplish thorough and accurate evaluation, diagnostic formulation and therapeutic intervention for patients with anorexia nervosa and bulimia, utilizing an inpatient setting.

Objectives

1. to assess physical, psychological and functional status of patients referred to the unit;

2. to set up appropriate treatment programs tailored to individual needs.

3. to utilize individual, group and family therapy techniques in the treatment of these patients;

4. to utilize appropriate behaviour-cognitive therapy techniques to help patients correct maladaptive eating behaviours and concerns about food and body image;

5. to educate patients regarding nutrition and exercise and communication patterns;

6. to provide appropriate discharge planning;

7. to gather information regarding these disorders for research purposes.

The format of the program includes:

- two group therapy sessions per day.

- assignment of a primary therapist for individual psychotherapy and co-ordination of care.

- immediate attention to any outstanding medical problems and to nutrition by providing meal trays.

- weekly contract meetings with the psychiatrist co-ordinating the program and other members of the treatment team. Contract meetings include a discussion of progress, the program, problems, goal weight and reinforce the need for an individualized approach.

- a required weight gain of 1.0 kilograms per week until goal weight is achieved.

The purpose of daily group psychotherapy is to provide an opportunity for patients to practice and improve their interpersonal skills and to gain insight into individual and group psychodynamics. The objectives are:

1. To help members achieve a clearer recognition of their maladaptive social behaviors and begin to alter these behaviors.

2. to help members achieve an awareness of conflicts or motives underlying maladaptive social behaviours.

3. to help members achieve readiness for outpatient therapy by gaining an enhanced ability to enter into a therapeutic alliance.

Task-oriented groups are also offered twice per week for one hour. The objective of these groups is to facilitate the learning of effective coping skills. Self-awareness exercises, assertiveness training and transactional analysis concepts are utilized as ways to explore alternative ways of approaching real-life situations.

(Eating Disorders Clinic Manual, 1984)

The Eating Disorders Clinic utilizes a team approach to treatment. Staff from dietetics, occupational therapy, physiotherapy and pharmacy work with psychiatry and nursing as part of the treatment team. A social worker was available to the ward for consultation but appeared to

be minimally involved during the author's six month duration at the clinic. Social workers from outpatient psychiatry were available for family therapy consultation.

Pre-Group Preparation

The body image group was offered in the third month of the author's (group facilitator) six month placement at the Eating Disorders Clinic. An 'open' format was used as the potential for discharge and admission to the ward was a reality during the ten week duration of the group. Six women were on the inpatient ward at the time that the group was initiated; a seventh woman joined the group following admission during the week of the fourth session and one group member was discharged after attendance at the seventh session. The group facilitator met with each of the women prior to the first group session to define the purpose, the feminist philosophy of the group and the themes to be explored, and, to request that each woman come to the group having done some preliminary thinking about her personal goals. Common concerns about women's body image were also discussed at that time. All six women knew the group facilitator from previous contact through her periodic co-facilitation of psychotherapy groups, attendance at contract meetings, some individual counselling and overall visibility on the ward as a team member of the Eating Disorders Clinic for the duration of

the practicum experience. The woman who was admitted to the hospital during the fourth week of the group, came as a result of encouragement from other group members. The facilitator had not previously met her. The group ran for ten weeks with two hour evening sessions once per week. Feedback from group members regarding format and process was ongoing and encouraged throughout the duration of the group. An evaluation questionnaire was handed out following the tenth session.

The Clients*

*Names and some of the circumstances have been altered for reasons of confidentiality. Limited information is provided to protect identity.

Maluccio's (1981) assessment format based on competence clarification, as outlined in the literature review, was used to help the group facilitator understand the competence and strength of each of the seven women who participated in the body image group. The information provided on each of the women was gathered during the pre-group interviews.

Francis

Francis was a fifteen year old who was admitted to the inpatient ward with anorexia nervosa and periodic episodes of binging and purging through vomiting. This was

Francis's first admission to the unit and first time in treatment for an eating disorder. The onset of anorexia nervosa had been recent; within the previous six months. She was an athletic young woman who excelled in school sports. She would rigorously exercise by briskly walking in the hospital corridors and tunnels whenever she had the opportunity. Francis identified herself as fat and wanting to achieve a toned, well-shaped muscular body. She was hospitalized throughout the summer and attended school from the hospital in the fall. One of the environmental demands confronting Francis was a feeling of competition with her mother. She stated that her mother was always dieting and wanting to fit into her clothes. Francis was determined to stay smaller than her mother. Francis came from a young, wealthy family that was adequately able to support and nourish her. During the pre-group interview, she shared with the group facilitator that she would feel 'odd' being the only adolescent in the group, but that she would attend.

Monica

Monica was a twenty-three year old woman admitted to the Eating Disorders Clinic with anorexia nervosa and periodic episodes of binging and purging through vomiting. She had been treated on an outpatient basis in another province prior to this admission. Monica identified the

onset of her anorexia nervosa as the result of having been a chronic dieter who was never satisfied with her body shape and size. Monica's identified coping strength was in many ways a challenge now. She had taken pride in being on her own and supporting herself since she was nineteen, but was now feeling she could use some support when she returned home. She was also concerned that her work environment, a large impersonal setting, would not be helpful to her in dealing with questions about her lengthy absence. During the pre-group interview, she shared feeling 'terror' at the thought of some of the planned group exercises, especially body tracing and video tape reviewing, but that she was willing to give it a try as she knew her body perception was a major issue.

Rhonda

Rhonda was being seen on an outpatient basis at the Eating Disorders Clinic for anorexia nervosa prior to her admission to the hospital. She was an eighteen year old who had several hospital admissions from the time that she was fifteen years old. Rhonda was at a time of transition in her life. The environmental demands and challenges that Rhonda was confronted with were her questioning of her strict family upbringing and the values that she had adopted. Her home environment was no longer nutritive in relation to her needs. It no longer challenged her,

although it could support her basic requirements. She was seen by the hospital staff as rebelling in a way that was healthy for her. She was beginning to recognize her right to basic needs, for example, food and clothing, and was realizing that she did not need to deny herself the right to feel good. She welcomed the body image group as another way to 'treat herself good' and learn to appreciate her body.

Nancy

Nancy was a twenty-four year old woman who was admitted to the hospital with bulimia. This was Nancy's first time in treatment. She identified herself as always having been unhappy with her appearance. Nancy worked full time and felt guilty that she did not have more time to spend with her daughter. Nancy was a single parent who had coped through some difficult financial periods with her daughter. She had very supportive parents who were often available to her for child care. Her employer was also part of her support network. He was aware of Nancy's hospitalization and was respectful of her need for confidentiality. She was very keen on attending the body image group as she identified her perception of her body as the main preoccupation in her life. She shared that

food was a comfort when she was lonely but an enemy the rest of the time.

Barb

Barb was a twenty-four year old woman who had been previously hospitalized with anorexia nervosa, depression and self-mutilating behaviors. She kept to herself on the ward, often choosing to express her thoughts and feelings through poetry. While a sense of kinship seemed to evolve with the women who were hospitalized for eating disorders, Barb choose to remain isolated. Barb shared her book of poetry with the group facilitator. Her coping abilities were poignantly expressed on paper. The characteristics of her environment that negatively impacted on her were also recorded. She expressed 'never feeling a fit' with her home environment and never feeling that it could meet her needs. During the pre-group interview, she shared apprehension and anxiety about attending the group. She stated that she was reticent because talking in front of others 'paralyzed' her.

Bonnie

Bonnie was a thirty-nine year old woman admitted with bulimia. This was her first time being treated for an eating disorder and acceptance of this fact was very difficult for her. She choose to refer to her 'intestinal

and stomach problems' which lead to some alienation from the other women on the ward with anorexia nervosa and bulimia. She was a single, divorced woman who described herself as very alone and lonely. Bonnie shared that she no longer felt a challenge in her environment. At work she felt stifled and bored and in her home environment she was lonely. She had lost a very close woman friend through a tragic death that continued to have a profound effect on her, even though the loss had occurred two years previously. She expressed interest in the group stating her body image had always been an issue for her.

Michelle

Michelle was a thirty-five year old woman admitted to the hospital with bulimia. She stated that she had been anorexic four years previous to this admission, however, she had not been treated. Michelle had been married twice and had one teenage son. She felt like she had wasted life to this point and was determined to make positive changes for the future. She stated she became bulimic following her bout with anorexia nervosa because "life wasn't any better when I was skinny, so I had to get fat to build a wall; I was so vulnerable". Michelle shared in the pre-group interview that she had a deep hatred for her body and that overcoming this was her main challenge. She often had visions of cutting off pieces of

flesh. Michelle was a highly motivated woman who also demonstrated genuine caring and concern for the other women on the ward. She stated that an environmental obstacle for her at that time was a partner that was not as supportive as she had hoped he would be. She also had financial demands that often burdened her thoughts. She welcomed the philosophy and purpose of the group and was eager to attend.

BODY IMAGE GROUP

Introduction

The format for each of the body image group sessions was planned by the group facilitator with enough flexibility to allow group members to introduce issues or exercises that they felt would be helpful. An explanation of the process, as it transpired, will be provided through the group facilitator's perspective and through quotations from, and the summarized comments of, the women in the group. The group sessions were recorded on video tape so the group members could review the sessions as part of the body image group experience. The video tapes were also reviewed extensively by the facilitator in the preparation for, and writing of, this report.

The integration of a feminist approach and an ecological perspective is evident in what was considered pertinent for each of the ten sessions, how the group was

organized and how it evolved. A feminist approach to working with the women in the body image group allowed the facilitator the opportunity to participate and contribute as a woman who could relate to the shared feelings of the group. The ecological perspective, with its commitment to environmental factors that impact on individual's lives, was valuable in providing a framework around which to organize the sessions. The first three sessions focused on our personal experiences and awareness of our bodies and ourselves. The third and fourth sessions moved to a focus on family influences and our socialization as women. The sixth and seventh sessions allowed for a return to dealing with the personal issues of how we express power. Learning to appreciate and enjoy our bodies through the experience of massage was the focus of the seventh session. The eighth session dealt with socio-cultural influences and the pressures on us to conform to the 'thin ideal' stereotype. The final two sessions focused on anger and control, caring for ourselves/our bodies and finding 'safe' places to continue with the kind of openness and sharing that had occurred in the group. While the ecological perspective's commitment to environmental factors helped in the formulation of the group format, the feminist approach provided the group facilitator with a critical analysis of the environment and issues of competence. The analysis allowed for a

group that was organized around ecological principles but that was also able to question some of those principles, specifically, the achievement of equilibrium with the environment and the sacrifices made by women in our attempts to conform to environmental messages.

Format and Process

Session 1

The group opened with a summary of information that had been discussed by the group facilitator with each of the women during the individual pre-group meetings. The discussion included:

1. a feminist approach to groups with women in the context of ecological social work practice;
2. the role of the group facilitator;
3. open format of group - trust and termination;
4. the use of relaxation and visualization techniques (Appendix 1 & 2) as a way of accessing and addressing buried feelings related to body image development;
5. the use of group video tape reviewing as a way to 'see themselves as they are' and to receive feedback from others;
6. fears they may have about becoming a member of the group;
7. topics and themes to be explored; and
8. confidentiality.

The group facilitator shared her goals in establishing the group:

1. to provide group members with a safe place to explore feelings about our bodies;

2. to facilitate discussion and exercises that encourage respect and appreciation for our bodies;

3. to explore new ways of identifying, experiencing and expressing ourselves in a supportive and challenging environment;

4. to facilitate a sense of self-worth that is independent of body image;

5. to create a more positive body image by exploring ways to accept our bodies as sources of feelings and physical needs;

6. to encourage members to share family patterns and influences that may have, or presently are, contributing to a negative body image and to explore alternative healthy responses;

7. to heighten awareness of the unrealistic societal expectations for thinness and how these demands can affect women;

8. to explore the limited ways in which our culture teaches women to see and use our bodies and to encourage experiencing our bodies in new ways through greater sensory awareness; and

9. to convey to women in the group a sense of our power in controlling our own imagery including body imagery.

The group members were asked to share their hopes and expectations for the group. These included:

> "I want to know more about how our bodies become the most important thing in life."
>
> "I want to learn to express my feelings . . . I've been punishing my body for so long."
>
> "My life is ruled by numbers . . . I hope to learn how to not judge myself by the scale."
>
> "I hope to learn how 'not to hear' the messages from 'out there' . . . how come they are so important to me?"
>
> "I like the idea of respecting my body . . . I don't have a clue on how to do that, it's so ugly

and out of shape . . . but I guess that is why I came."

The Everyperson's Bill of Rights (Appendix 3) was distributed, read and accepted as the rules for the group. The right to say no without feeling guilty, the right to ask for what one wants and the right to make mistakes were identified as the most difficult to accept. It was agreed that the group would be a place where trying out new and different ways of communicating would feel safe. A lengthy discussion ensued on the two main issues planned for the first session: <u>self-esteem and self-awareness</u>. The Declaration of Self-Esteem (Appendix 4) was distributed and read in the group with each member and the facilitator reading a section. Responses from the group following the exercise were revealing in their sadness, for example:

Nancy: "I am me, but 'me' has been the bulimic for so long, that is me, there has been nothing else."

Monica: "What does owning me mean, when I read I own everything about me - my body, including everything it does, well, all it does is make me angry . . . I don't want it."

Rhonda: "I like how this affirms us . . . I really need to do that."

The group discussed the reality that many women often do not have anything positive to say about themselves and that negative comments so readily come to mind. The negative comments for the women in the group included

negative body messages as foremost in their thoughts. While they acknowledged that they were often recipients of compliments regarding their thinness, they interpreted these remarks as lies. They stated that they never believed a compliment and that they knew they perceived themselves very differently from how others saw them. The group discussed the extreme preoccupation with the thin ideal for women in the context of the positive messages they received even when at very low body weights. Women's self-worth being contingent upon the current ideal for physical attractiveness was discussed, with the facilitator posing questions to the group to consider: What do you think looking good means? When and where were you first given the message that you are somehow lacking? When did the word 'fat' begin to have negative connotations for you? All group members responded with looking good means being thin; that their teenage years were when they first felt lacking; and that being fat was something to avoid - at all costs! These women could not recall a time when fat did not have a negative connotation. A relaxation (Appendix 1) and a visualization exercise (Appendix 5) - "Visualizing Feeling Good" - were introduced at this time so that the group members could learn a technique that would enable them in their struggle to feel good about themselves. In the visualization exercise, the women were asked to think of a

time when they felt good about themselves. The exercise included identifying the setting, the people present, the sights, the sounds and all other specifics of that particular time. It was suggested that would be a place 'to go' whenever they were feeling critical of themselves, bored, or lacking in strength and energy. The feedback following the relaxation and visualization exercises helped the group to understand the chaos they all felt inside:

Nancy: "I couldn't find a place, a time, or anything . . . everything was dark."

Rhonda: "There wasn't a place, I was jumping all over, everywhere in my mind."

Michelle: "It's hard to relax . . . I can't remember a whole lot of good times."

The group members shared that the visualization was difficult because they had not been able to reach a state of relaxation during the relaxation exercise. They requested that the group facilitator bring in music to accompany the relaxation exercise and that lamps could be brought in for future sessions as the fluorescent lighting was very harsh. They also agreed that the notion of relaxing was a foreign concept to them, and had been for as long as they had eating-related problems. The group acknowledged that one's imagination can be a powerful resource in heightening awareness and exploring the past. A Self-Awareness worksheet (Appendix 6) was handed out for

group members to complete on their own after the group session.

The group video tape reviewing was met with apprehension and ambivalence. Nancy envied Monica's slim body, commenting, "you look like a model in that jumpsuit". Complimentary remarks were made to each other by the group members, however, they were either not well received or not acknowledged. The facilitator suggested that they might consider the observation that no one was able to comment on herself.

Summary of Observations

The pre-group interviews were valuable. Group members came to the first session well prepared. They had done some preliminary thinking about their hopes, fears and expectations for the group. Some brought pillows for comfort because they knew from pre-group discussions that relaxation exercises were part of the format. The idea of a group that focused on women's issues, and specifically, women's body image, was appealing. They acknowledged that they came to the group with their eating disorder but liked the opportunity for it not to be the issue. They appreciated that anorexia nervosa and bulimia were not mentioned in the group format. They expressed that the inpatient program gave them sufficient opportunity to deal with their eating disorder per se.

Session 2

The focus of the session was body image and what it means, and body awareness and distorted perceptions. The group discussed how a negative body image affects all areas of one's life. Relationships and the capacity for intimacy were identified as severely hampered by our dislike of our bodies. Bulimia and anorexia nervosa resulting in hospitalization were identified as the most severe end result of a negative body image. The amount of time and energy spent hating our body size, shape, or a particular body part was talked about in the context of lost friendships, social isolation, self-contempt and loneliness. As the women were challenged to focus on their personal body image concerns, they shared that specific areas of their bodies tended to be despised more than others. The group discussed how this could lead to distorted perception of that area of our bodies. Orbach's (1982) "Part of the Body" exercise (Appendix 7) was introduced following the relaxation exercise (Appendix 1). This visualization technique was used to help them "explore the meaning of (their) distress about various body parts and to work through the barriers to feeling at ease in (their) bodies" (Orbach, 1982:103). Group members were asked to focus on the part of their body that they currently felt most unhappy about and then try to get in touch with when that unhappiness first occurred. Included

in the visualization were reviewing their feelings about this part of their bodies, imagining what they perceived to be their ideal size and experiencing the feelings that accompanied this image. Visualizing whether they handled situations or approached the world differently when at their perceived ideal size was also suggested and proved to be a very valuable part of the exercise. When the exercise was completed, the facilitator asked the group members to reflect on their experience in the exercise by considering the following questions:

1. What kind of associations did you come up with regarding that part of your body that you are most uncomfortable with?
2. Why do you dislike this part of your body?
3. Can you get in touch with any emotional issues this dislike might be masking?
4. Does preoccupation with this body part help you in any way?
5. What is the actual bodily function of this body part? How well does it perform its function for you? How do you feel about its function?

(Adapted from Orbach, 1982:155)

The women in the group shared openly and honestly their discoveries during the exercise and their feelings following it as demonstrated in this excerpt from the discussion:

Francis: "I couldn't choose one body part . . ."

Barb: "Me neither, I had too many, I kept switching to different parts of my body."

Rhonda: "All my negative thoughts went to my stomach, but then they would go to my whole body and I was really uncomfortable . . ."

Nancy: "Hate, strong hate, disgusting, were the first thought that popped into my head, and it was for my stomach."

Monica: "This will sound weird but for me it is my tailbone. Feeling my tailbone always felt good, it was my indication . . . now that I had to put this weight on, I can't feel it! I hate it, I can't feel it, so therefore, I'm fat!"

Michelle: "For me it was specific to my stomach, it's soft and mushy, not taut and firm. When it is firm it represents my self-confidence, I can walk erect. Now I sit with my hands in front of my stomach to hide it. I couldn't even walk from point A to point B at work- I would have to walk by others, I couldn't do it. It's so ugly I can't touch it, if my boyfriend does, I freak out . . ."

Nancy: "Pretty shitty way to live . . ."

Michelle: "It's stupid; not rational at all."

Rhonda: "When you asked us to imagine our ideal size my stomach was flat and hollowed out, but I handled situations just the same, nothing changed or got easier."

Michelle: "Yeah, when I was thin, then my breasts were too small!"

Rhonda: "My stomach was flat but something else was wrong!"

The group talked about never being thin enough, flat enough, small enough and never being satisfied. The group members could vividly recall when they first felt a sense of unhappiness about their bodies; it was not specific to a particular body part, but rather an overall disgust. Francis, Rhonda and Nancy shared that it was during junior

high that they began to diet. They talked about the "fat tests" at school:

Francis: "We had to do that last year and this year- those fat calipers, others had more fat so I felt more confident but I still wasn't satisfied. I want to be a lot less than I am now - parts of me that I look at seem just as big - they never change - even though I lose weight."

Michelle shared that prior to becoming bulimic she had anorexia nervosa. She shared that it was a "power trip" and that it was "making me high". She stated that she still wasn't happy, even at a low weight and that her unhappiness about her body seemed to have always been a part of her. Barb, who had shared earlier that talking in the group would be very anxiety producing for her, agreed with Michelle stating that she couldn't recall a time of feeling satisfied with herself.

An emotional discussion arose when the group shared their responses to the questions asking them if they got in touch with any emotional issues their body dislike might be masking and if their preoccupation with their bodies might be helping them in any way. Comments included:

Nancy: "I don't know what I'm feeling so I don't know what I'm covering up."

Michelle: "Well, the preoccupation with my body and the binging and purging keep me from feeling. It's my coping mechanism. Binging stops everything - it turns the feelings off - I focus on disgust with myself - by the end of the cycle I hate myself and my body

more than when I started - it's a constant fight."

Michelle's comment led to a discussion that explored the binge/purge cycle and "that glorious feeling of being empty". She received acknowledgement that she was expressing a feeling they all could relate to. The group facilitator asked members: "What does empty feel like?" Responses included: 'numb', 'nowhere', 'a moment of tranquility', 'still' and 'an end result'. Michelle stated that "the purging is purifying, yes, you are empty, but never clean." When encouraged to say more she explained that she felt dirty, guilty and disgusting. Other group members agreed with Michelle. They talked about coming into the hospital feeling empty and Michelle shared that she had her 'final' binge/purge just before being admitted.

The group video tape reviewing was once again met with nervousness and anxiety. Francis and Barb left stating they were unable to look at themselves that evening. Other group members let them know that they would be in their rooms and around the ward after the group should either of them want to talk.

Summary of Observations

The honesty and openness of group members regarding their body discomfort resulted in an atmosphere that was emotionally charged. The literature on body image

distortion discusses how women with eating disorders exaggerate the actual size of their bodies, however, the group process focused on the painful feelings 'located' in the body. The physical size was not the issue; but rather, the amount of feelings that are stored in that area of the body. Three of the women diagnosed with anorexia nervosa, specifically, Barb, Rhonda and Francis had a difficult time locating any feelings and found during the "Part of the Body" exercise that they felt an overall discomfort with all of their body. Two of these three women were the group members who chose not to see themselves on video tape following the session. The women with bulimia, Nancy and Michelle, found that their stomachs were automatically visualized during the exercise. The different body perceptions seem to suggest that the feelings of the woman with bulimia seem to find a 'place' of 'expression' in the body and the starving woman's feelings do not find a 'place'; they are diminished along with her body.

Session 3

The session began with relaxation (Appendix 1) and the "Visualizing Feeling Good" (Appendix 5) exercise that had been used in the first session. The group members shared that the relaxation and visualization exercises were getting easier to do. Rhonda stated, "it's a nice way to

learn more about us as women." The focus of the third session was body tracing (Appendix 8). The group facilitator shared her understanding of how much emotional discomfort and pain women experience because their bodies are not perfect. She acknowledged the group's uneasiness with the exercise and encouraged a discussion about fears and ambivalence. Francis shared, "I can't do it, I would get all depressed". Michelle agreed stating, "I can't do it at this time, I feel very uncomfortable". Barb stated, "I can't do it at this time". Nancy and Rhonda shared their desire to do the exercise and gently encouraged the others to join them. When they were unsuccessful in their efforts, the facilitator suggested that the group needed to make a decision about whether to do the exercise in the session at that time. Francis, Michelle and Barb expressed that although they felt unable to do body tracing, they did not want their fears to hinder Nancy and Rhonda from doing the exercise. The group agreed to do the exercise and decided it could be done again if and when the others felt ready. Rhonda readily volunteered to go first while Nancy and the group facilitator offered to do the tracing. The group had a moment of comic relief when it was realized that two people tracing each side of one person's body does not work. The group laughed at the comment, "if you don't have a distorted body image you'll have one when those two finish with you!" Interestingly

enough, Michelle offered to trace Rhonda again and the exercise proved revealing for both women:

Rhonda: "My head looks so tiny, I look emaciated!"

Michelle: "I felt uncomfortable tracing you, I'm fat compared to you and the others here, I'd give anything to look like you, I don't see you as too skinny, I have this fantasy of cutting off pieces of my body . . . "

This dialogue lead to a discussion of how as women we compare ourselves at some point in our lives, to other women who we see as slimmer, prettier, smarter, happier and more successful because of it! While the group shared, Rhonda went over to the paper and drew a smile with one of the coloured markers. She held up the tracing and chose to keep it. Rhonda then offered to trace Nancy. Nancy's initial response to her tracing was a long silence. She then stated, "it's not what I expected, looking at it this way doesn't seem so bad". She looked for a while longer and added, "I've got short legs, if you could do this sideways it would be bad," as her hands moved to her stomach. Nancy also took the markers and drew in her face and stated that she would like to keep the tracing. The facilitator pointed out to Nancy how she responded to her initial positive reaction with a critical comment. The group then discussed their difficulties in accepting positive feedback and how hard it is to believe positive messages. They agreed that how others

perceive us is probably always much less critical than the way we see ourselves.

The group closed with relaxation (Appendix 1) and a visualization exercise to get them in touch with their inner selves ("Old Woman" - Appendix 9). The group members meet an old, wise woman in this visualization and are instructed to ask her for whatever it is they need from her at that time. Following the exercise group members shared how hard it was to ask for something. Acceptance of their bodies and freedom from food preoccupation and self-criticism were asked for, albeit with great difficulty.

A shortage of time did not allow for video tape reviewing following this session. The tape was made available to the group members to view on their own time, however, no one took up the offer.

Summary of Observations

The group atmosphere was tense during the discussion prior to the body tracing exercise. It was interesting that the three of the five members attending this session who chose not to do the body tracing still chose to attend. Barb was actually in the room fifteen minutes prior to the start of the group. In reviewing the tape, the facilitator noticed that although Francis, Barb and Michelle did not do the exercise, they were very involved

through their attentive body language, their laughter, their caring comments and their expressions of what appeared to be envy as they watched Rhonda and Nancy doing the exercise.

Session 4

The session focused on 'our families, our food and our bodies', in effect, an opportunity for group members to explore and reflect on family influences. The movement from personal body perceptions and experiences to family issues was in keeping with ecological social work practice. Considering factors such as our family environments kept us focusing on the transactions and interactions in their lives and helped us to identify how family patterns can influence our adult behavior.

The group members shared, as they did in the second session, that their negative perception of their bodies began to surface in their early teens. However, it soon became apparent in this session that criticism, a lack of positive reinforcement and negative messages specific to food, were common experiences for these women prior to their teenage years. The hoarding of food and secrecy about the consumption of it, was learned by the group members when they were children. We shared how patterns learned in childhood can affect us as adults. The following excerpts demonstrate the trust of the women in

discussing painful childhood experiences that were now being relived in 'embarrassing' adult behavior:

Bonnie: "I remember I was supposed to give my teacher these Oh Henry bars for Christmas, I forgot them in my desk and I knew I'd get a 'licking' for not giving them to her so I hid them in my closet at home. On parent-teacher day my mom and dad found out that she never received them . . . they searched my bedroom and when they found them I got a beating . . . so many things like that . . . now if I snack I feel guilty, it's wrong, it pisses me off, I'M NOT DOING ANYTHING WRONG!"

Monica: "My mom always hid food and would only share it with one of us at a time, my Halloween candy - she locked it in her suitcase, I had to sneak it . . . maybe that is why I can't eat in front of others."

Michelle: "Yeah, this sneaking thing, I experienced that today eating a bran muffin by my bed, I was getting it down so fast so that no one would know. I didn't enjoy it, I was afraid of getting caught. It's a healthy piece of food that I'm supposed to be eating!"

Bonnie: "All guilty because we are eating . . . a nurse came in my room the other day and I was having a snack, I turned red with embarrassment and she didn't give a damn, she was looking for an ashtray! She was probably glad that I was eating."

Francis: "Before I came into the hospital, when I was at home, I'd offer to clean the table, grabbing food off the plates once I got them into the kitchen, then I'd run in the livingroom with it to stuff it in - sometimes Mom would catch me - I'd feel so STUPID!"

The facilitator suggested exploring in more depth the issue of feeling guilty for feeding themselves and if they felt guilty for being alive. The discussion that ensued was a very positive part of the group process:

Rhonda: "I wore my mother's fortrel pants to school because I didn't want my parents to spend money on me. I had already cost my parents thousands of dollars on piano and private school so it was "don't buy me clothes, don't buy me anything". Because I went to private school the other two did, so it was my fault because I wanted it."

Michelle: (to Rhonda) "That explains why you can't spend any money on yourself."

Rhonda: "Yeah, I wanted so bad to fit in but I wouldn't let them spend money on me - in private school it was okay because we had uniforms but in Grade 8 I went to public school - my mom did my hair in rollers - I didn't fit in, I felt very different, I changed so much that year."

Francis: "I don't want money or gifts from my parents so staying here I'm out of the way."

Rhonda: "For me it's, you guys when you adopted me if you only knew how much money and grief I was going to cost you wouldn't have taken me."

Monica: "After my dad died, my mom would say things like "I really needed new glasses but I HAD to buy this for you."

Francis: "I get sick [vomit] in the shower at home so I use it a lot and then I hear my dad saying to mom that the water bill is so high and I feel guilty."

Michelle: "What I see happening is we feel unworthy and our eating disorder confirms that we are. This 'deviant' behavior is our coping mechanism."

Bonnie: "Well it wasn't normal to feel like a normal kid - I always wished I lived at Janet's house because they could eat chocolate!"

Sharing these experiences and reflections was very moving and empowering. Hating themselves for their hunger and ashamed of their need to feed themselves had resulted in

starvation amidst food preoccupation and binging when it all became too overwhelming. The metaphor of 'food is comfort' was made real in the group when Monica stated, "I binged then, and I do now, because there is no one to get a hug from, and when I don't eat I don't deserve hugs." This comment got unanimous agreement from the group. The group facilitator asked the members if they could further explain. Francis, the adolescent in the group, shared that she feels sorry for herself "even though I shouldn't; I'm a big suck". She stated that starving herself made her feel "stronger and not like such a baby" and then she did not need hugs from anyone. The facilitator asked the women if starving partially served the purpose of justifying why they were not comforted as adults and had not been as children. A discussion followed that explored how as children it had to be them that there was something wrong with; that if they were being criticized or punished in overt or subtle ways it had to be something they were doing to make their parents unhappy with them. For Francis and Monica, refusing food gave them a tangible reason for their parents' unhappiness. Prior to that they had no reason that they could grasp for their parents' high demands and expectations and lack of ability to comfort them. For Rhonda, starving was another way of denying her needs, not unlike her denial of her need to have clothes. Her expressed guilt around basic needs was

responded to by the group as her rights as a child and as an adult. The facilitator suggested that the group members consider their response to Rhonda within the context of their own life situations. Michelle stated, "(G)ee, we're not totally to blame for all of this, it wasn't something I created all on my own . . . it helps that we can laugh here too."

The session ended with relaxation (Appendix 1) and the "Old Woman" (Appendix 9) exercise. The facilitator instructed the group members to give the old woman something that they had been carrying with them from their family homes that they no longer needed to be burdened with. It was suggested it could be something they got in touch with and shared during the session or it could be a private matter.

Rhonda, Francis and Monica reviewed the video tape following the session. Bonnie and Michelle returned to the ward stating they would not be comfortable seeing themselves at that time. The three who watched got into a discussion about their hair, prompted by Monica's comment that she needed to 'do something' to it once she got out of the hospital. The conversation was light and observations were made with a sense of humour, for example, they noted that they all came to the body image group in either their housecoats or sweats and brought their pillows.

Summary of Observations

Group members spoke of and heard with sensitivity the painful and unresolved past experiences of each of the women. Their recollections were so vivid and seemed to be so clear in their minds. This may have been due to having done some thinking about family influences prior to the group because they knew the plan for the session, or because they were encouraged to discuss these issues in other therapeutic situations (individual and group psychotherapy) outside the body image group.

Session 5

The facilitator's objective in this session was to move from individual and family issues to cultural influences and stereotypes and how they impact on our lives. An exercise was introduced in which group members were asked to portray with words the 'ideal' man and the 'ideal' woman and then state in descending order those characteristics or qualities that were most important to them. The facilitator recorded responses on a blackboard. The characteristics or qualities suggested are listed below in the order that the majority of members thought was their ideal:

The Ideal Man

sensitive
responsible and hard working
open-minded
intelligent
independent
active and enjoys life
sense of humour
attractive
proud
good income

The Ideal Woman

attractive - in shape, toned muscles, conscious of her body, feminine
sensitive
responsible and hard working
proud
creative
classy, dresses well
good listener

The discussion that accompanied this exercise was interesting and insightful. Priorizing what was important to them in the 'ideal' male was a relatively easy task. Comments like "enjoying life is far more important than looks", "sensitivity is primary, number one", "lots of good looking guys are complete assholes!", were stated emphatically. While all agreed that attractiveness was the most important for them in the 'ideal' woman, they disagreed whole-heartedly on what that meant. The discussion served to highlight the contradictory messages that we receive and how they can become internalized in our lives:

Rhonda: "Attractive to me means soft and feminine."

Nancy: "I don't agree with soft . . . "

Rhonda: "Soft can mean nurturing . . . like my mom, I can hug her but my dad, I don't know what to do with my arms."

Francis: "Attractive to me is being in shape, toned muscles, not soft!"

Nancy: "Yeah, attractiveness equals being in shape."

Rhonda: "I know a lot of attractive women but they are not in shape. Models aren't necessarily in shape. You can look very pretty if you are a woman but not be in shape - with men it seems to go together; if he's good looking he is assumed to be in shape."

Nancy: "A woman cannot get away with as much as a man."

The facilitator encouraged the group members to think about where their interpretations of attractiveness came from. They were asked to consider how attractiveness could mean soft and nurturing for someone and a hard, firm body for someone else. The discussion also included exploring how an enormous amount of their time and energy goes into trying to achieve all of these traits and how contradictory they are. They shared that despite the contradictions, striving for these ideals continued to be their goal because "that is how you make it in the world". It was interesting that Francis, the adolescent in the group added, "you don't have to have all of those traits to be a neat person!".

The group talked about the trait of sensitivity in the 'ideal' male and how men are socialized to be quite the opposite. The facilitator pointed out that while we are

socialized to be good listeners that they as a group made that their lowest priority. The women stated that they were 'tired' of that expectation.

The group discussed at length how cultural influences and stereotypes regarding being a woman can lead to false hopes and dreams that with the perfect body she will have access to 'all the finer things in life'. They felt that they had been ill-prepared for what was ahead of them.

Video tape reviewing had a different dimension added to it in this session. Each woman had the camera focused on her individually for a period of time. Francis was the most uncomfortable during the taping, often turning her head to the side. In reviewing the tape, she was more relaxed and laughed about always wearing her black sweats. Rhonda's body posture changed dramatically when 'classy' was offered by a group member as an 'ideal' woman trait. Rhonda remarked, "for me it would be dresses well because I'm not classy . . . a class all of my own, yeah". As she made this comment she pulled her legs up in front of her chest and rested her chin on her knees. Her comment was challenged during the review in light of the previous sharing regarding not fitting in and feeling different.

Summary of Observations

The group was relaxed during this session, possibly because the topic was not as personal as in the previous

four sessions. Members were however, comfortable in challenging the opinions of others and were able to agree to disagree. Given that the literature (Wooley & Kearney-Cooke, 1986; Hall, 1985) suggests that women with eating disorders have a tendency to avoid conflict and please others, this assertiveness was a significant forward movement.

Session 6

The session was designed to deal with the issues of women, weight, and power. It was the facilitator's understanding from the literature, from observations and learning at the Eating Disorder Clinic and from being a woman, that the issue of power needed to be addressed as an element in the struggle with food, eating and body image concerns. Providing opportunities to increase the group members' awareness of their personal power was inherent in the philosophy and goals of the group. The discussion focused on how our bodies become our primary source of power. The family, the media and the larger society were cited as 'arenas' where messages are given to us that in order to have some power and control over the future, discipline of the body is essential and being attractive makes everything 'easier'. These women felt that their bodies did not have the power society implies that a woman has through her body for they felt

unattractive. Group members stated that since they did not have any power as a result of 'natural' beauty that at least they could strive for the ideal as best they could by meeting the 'thin' criteria. However, one group member offered the following:

Michelle: "I was anorexic, I was so skinny a few years back, sure it was a power trip but I didn't attract men like I thought I would, I didn't get any dates - so I got fat so that I had a reason - I put a shell around myself."

Nancy: "Well, all I know is, when I'm thin, I'm confident - I can go out and have a good time - but like this I stay at home- nothing looks or feels good. . ."

Francis: "It seems everyone around me is dieting. My mom's always on a diet - everyone seems obsessed."

Group members reflected back to the "Part of the Body" exercise and how even when they visualized their perceived 'ideal' size, they still handled situations in the same way and they still found something amiss or lacking. The facilitator asked group members if they saw themselves as giving a lot of power to the 'thin image' that they were striving for at the time of hospitalization and if that was still continuing. Michelle and Nancy shared that their lives had been stagnating because everything had to be on hold until the magic number showed on the scale. Monica shared that although she had learned a lot about herself while in the hospital, the thin ideal was still

important and she was afraid to be discharged to her home because:

Monica: "I have this fear of returning to my closet full of clothes that fit before I was admitted here - I'm afraid I'll be tempted to lose to fit into them again . . ."

The group offered suggestions and support to Monica on how to cope with this anticipated fear once she returned home. They commented that if she had any friends with young daughters who could wear the sizes four to six in her closet it might also help her to see the stark reality of how thin she had become!

The facilitator asked group members to share what 'power' meant in their lives. Generally, it was perceived as a negative and destructive trait as they shared that it had been used in a punishing or withholding manner in their lives as children. The power they were exercising in their attempts to control their body size was discovered to have similar qualities. While the power to endure strenuous exercise over extended periods of time and the power to withhold food from their bodies gave them a sense of control, they shared feeling like it was never enough and that it was fleeting because their bodies would eventually betray them, that is, the urge to feed themselves became overwhelming. Surrendering to their body needs was seen as failure and a return to ultimate powerlessness. It became clear that the power invested in the drive for thinness could not be relinquished until the

group members sincerely believed that there were other ways of coping and being in the world. It was suggested by the facilitator that the energy put into controlling their bodies might be channelled into appreciating and enjoying the bodies they had. When the facilitator asked the group members to attempt to share what made giving up their expression of power through body punishment so difficult, the responses were similar, for example:

Michelle: "It's what I know, it's familiar - I don't know another way to be, to live . . . "

Nancy: "I don't know what would be <u>me</u>; the thing I've best developed is my bulimia."

The facilitator pointed out the observation that their responses were almost identical to how they responded to the "Declaration of Self Esteem" that they read out in the first group session. The facilitator asked the group if fear of the unknown, that is, "(W)hat would life be like without anorexia nervosa or bulimia?" was part of what kept them from giving it up. They responded with comments like, "it's predictable", "it calms me", and "it's safe". The facilitator suggested that giving up their body punishment and their eating disorder would then mean grieving the loss of a way of life that had become so familiar. Group members were asked to take time outside the group to think about the losses and gains that would

occur and were occurring as they were beginning to feel differently about their bodies.

Group video tape reviewing did not follow this session as the group decided to spend the remainder of the time continuing the discussion as presented.

Summary of Observations

Relinquishing the belief that thinness is power was the most difficult notion that we contemplated throughout the entire ten sessions. The fact that the group members all felt more powerful when they were thin and could give countless examples of thinness being linked to success for women, served to further complicate the issue. To accept that thinness results in a kind of power that is fleeting and superficial was like accepting that they had been duped; that their struggle was for nothing. To relinquish this belief would be, as they perceived it, to accept that they would have to look inside themselves for power and 'inside themselves', as they shared in the session, was a dark, unknown place. These women successfully avoided their inner power; the anorexic by literally starving it and the bulimic by covering it up and throwing it up before it could surface. It seemed from what group members shared, that power was seen as destructive and needed to be kept under strict control. Only bodily expression of power (thinness) were permitted.

The contradiction is that it was their inner strength that permitted them to persevere in their pursuit of the thin ideal. The ninth session which focused on body punishment and anger shed light on these issues in a way that completed a process that at this point felt incomplete and confusing.

Session 7

One of the goals in establishing the body image group was to encourage the women to respect, appreciate and enjoy their bodies. This was facilitated through various discussions and exercises and was exemplified in this session through the demonstration and experience of body massage. Joan Turner, M.S.W., a massage therapist, attended the session and shared her knowledge and expertise with the group. Joan discussed the different types of massage and explained her philosophy that the technique used needs to come from a place of caring. She shared that fears about massage often come from past experience of touch that had been used in a hurtful, destructive way. She explained that touch can re-awaken memories and, therefore, must be done with sensitivity. Trust was stated as crucial in order to facilitate 'a letting go and freeing up from' memories that are stored in the body. Massage was explained as a giving and receiving process; a gift that can be given through the

hands coming from an awareness of what might be helpful to the person receiving it.

Group members shared what their hopes were for the session:

Rhonda: "I hope it will make me more comfortable with my body, I need to get out of my head."

Bonnie: "I want to learn how to do this for myself- some techniques I can use on my own . . . I walk around with my shoulder tensed up."

Nancy: "I have tension headaches all the time . ."

Michelle: "My shoulder actually goes numb, I've become aware of how tight everything has become- my entire body - I didn't realize until we did the relaxation exercises here that it's even in my toes! I hope to learn ways to massage myself."

Joan explained the importance of getting in touch with one's breathing before giving or receiving a massage. She stated that although breathing is taken for granted, there are a host of ways to do it depending on how one feels, for example, if the body is tight or tense the individual will breathe in a restricted manner. Michelle related when she commented, "(I)'m always holding in my stomach and I know it inhibits my breathing - I won't allow my stomach to expand". Joan led a relaxation exercise that had us focusing on our breathing and then moved to self-massage. Following this exercise, we paired off and Joan guided the group through massage techniques. She emphasized the reciprocity of giving and receiving and encouraged us to relax, notice our breathing and to

comment on what felt good when we were receiving the massage. In giving massage, we were reminded that the strength in massage comes from our 'centre' and, therefore, to use our body strength as well as the strength in our hands.

The atmosphere during this session was very relaxed and comfortable. Feedback following the massage was encouraging:

Michelle: "It's a total feeling - it's like getting in touch with when you were an infant and touch felt so good . . . now that you've shown me I can do that for myself."

Bonnie: "Yes, I've experienced bad touch so I've protected myself - but I trusted that you weren't going to hurt me."

Rhonda: "It felt really good . . . it did get me out of my head."

The group ended the evening with wine and cheese, as had been planned, because Nancy was being discharged from the hospital the following morning.

Summary of Observations

Group members were relaxed and willing to give and receive touch through massage. It was a memorable experience to be part of these women enjoying and appreciating themselves given the knowledge that their bodies were sources of great anxiety and discomfort. Questions about how to alleviate the pain in their bodies through touch were a positive sign of forward movement.

Group members were able to share that the pain was usually an emotional 'kind of hurt' and that ignoring, depriving, blocking or denying the feeling of it in their bodies had been their survival. The facilitator pointed out that this knowledge related to what was discussed in the previous session. The drive for thinness could not be relinquished until they believed that there were other ways of coping and being in the world. It was suggested that they consider giving and receiving massage as one way of accessing their own inner strength and power. Coping and being in the world was suggested as more manageable when our body awareness comes from a place of appreciation and caring as opposed to deprivation and punishment.

The sharing of wine and cheese to mark our 'ending' with Nancy and as a way to celebrate a very enjoyable group session was significant. We were nourishing ourselves without any apparent tension or anxiety. Food was not the enemy but rather a welcome part of good conversation and relaxation.

Session 8

The facilitator's goal in this session was to heighten group member's awareness of the unrealistic societal expectations for thinness and how these demands impact on our lives. The film, "Killing Us Softly", was

arranged for viewing and discussion in the session. The depiction of women by the advertising industry is presented in the film through the use of slides and dialogue. The group discussed how the images of women, such as those presented in the film, encourage the notion that women's power is in her body, whether to 'lure' a man or get a successful job. It was agreed that any woman who strived for the ideals that we are bombarded with on a daily basis would feel inadequate and frustrated. The group members shared that they were testimony to that fact! Cultural norms which define 'beauty' were challenged. They were seen as restrictive and limiting in their depiction of women. The unrealistic image of 'superwoman' was laughed at, however, it was agreed that the pressure 'to be like her' is everywhere. Francis shared that "even at fifteen, I feel the pressure to be like that - with my friends, in school, from magazines, t.v. shows . . . ". The facilitator suggested a discussion of the advantages and disadvantages of living up to the 'superwoman' image. Advantages were:

Michelle: "I get more attention . . . I think I do anyway."

Francis: "I feel more confident."

Barb: "Others admire you."

Bonnie: "I feel competent - like I can take on anything."

Rhonda: "I feel more worthwhile."

The disadvantages were stated as:

Michelle: "Thin didn't work anyway and I was so preoccupied with running and dieting that I had no time for fun anyway."

Francis: "It got me sick, I'm here."

Barb: "Ruined my health . . . "

Bonnie: "Mine too - my system's all screwed up- my stomach looks pregnant now after all this . . ."

Rhonda: "There's more to life . . ."

The group discussed how self-defeating it was to attempt to conform to an impossible image. They also discussed how not conforming would be very difficult and how real their fears of rejection were. Michelle shared her resentment at having to spend time in the morning putting on make-up and yet how it would be impossible to go to work without it. She offered her experience to the group:

Michelle: "Everyone dresses for success - clothes are very powerful - we're competing in a man's world where women compete with each other - fashion is a big thing downtown- I used to work at (clothing store) where they paid me peanuts yet I was expected to dress in their expensive clothes. My entire salary used to be on my back . . . Why do we put these expectations on ourselves? Why are we doing this to ourselves? Where does it start and where does it stop? Here?"

Rhonda stated that she wore make-up to enhance her looks; that she wore it for herself, not for anyone else. She then added, "it's my hair more than my make-up - if I don't like my hair then I don't like myself." The group discussed how it all came down to the same point: women

aren't acceptable as they are. The facilitator pointed out that in the sixth session they all felt that they lacked 'natural' beauty and so they had to do their best by meeting the thin ideal criteria. They were challenged to consider what 'natural' beauty really meant in view of the sharing that was going on at that time.

Barb was asked for her perspective as she worked as a manager in a clothing store. She shared that she felt the pressure of expectations for women to be thin on a daily basis and that when working in an environment that promotes and markets fashion it was impossible not to conform. Group members shared that even in the hospital they felt pressure to wear make-up; that it made them look healthier. They noted that the hospital should be a place where they did not have to worry about looks but that for them it indicated getting better - taking care of themselves.

The facilitator, in responding to Michelle's question, "(W)here does it start and where does it stop?" asked the group for their ideas. The media portrayal of women was mentioned and Michelle offered family influences with the following statement:

Michelle: "I was raised that I can't go out the door without make-up on . . . my grandmother for fifty married years got up ahead of my grandfather - took the curlers out of her hair and put on her make-up before my grandfather woke up . . . it got me going . . . I feel less of a person if I don't put on make-up . .

> . it takes a lot of guts to go out of the house without it and yet we set ourselves up by always wearing make-up - this is how I really look - the other is a mask."

Others related watching their mothers put on make-up and curl their hair and then hearing the compliments from their fathers.

The sharing of ways that they could help in changing some of the attitudes that cause women to dislike their bodies was encouraged. Empowering group members to take political action toward changing the environmental messages women receive fit with the group goals and the facilitator's orientation to practice. The facilitator offered information from the Manitoba Action Committee on the Status of Women Media Watch campaign and encouraged members to contact them should they see advertising that depicted unrealistic, demeaning and limiting stereotypes of women.

Summary of Observations

Group members were able to share their own stories of how the societal expectations for thinness had impacted on their lives. Michelle seemed the most able to challenge the stereotypes in her personal life and make some healthy changes for herself. It became very clear in the session how deeply entrenched the cultural stereotypes had become in these women's lives. Even though taking on society's challenge to us to be 'superwoman' was part of their

reason for their body punishment, the thought of totally abandoning the elusive dream continued to be very threatening.

Session 9

The focus of this session was anger and control. It seemed that an opportunity to get in touch with and express their anger would be a positive experience for the group members. Previous sessions had addressed individual, family and cultural influences and, although anger was expressed, it was assumed by the facilitator that 'stuffing down' or 'swallowing' their anger was probably the more typical response. It was important to check out this assumption and this session was the opportunity.

The session began with relaxation (Appendix 1) followed by instruction to the group members to get in touch with a recent situation that had aroused feelings of anger in them. They were asked to recall how they handled the situation and if they felt satisfied with how they chose to handle the angry feelings associated with it. Francis, Michelle and Monica shared the situations they got in touch with:

Francis: "I though of how I've left the ward to walk for exercise to burn off the food and then I get angry at myself - but I don't stop."

Michelle: "I made a chocolate cake when I was out on the weekend and my boyfriend was over, I

made it for us for dessert and then he said "Are you allowed to have that? - as if I can't have any - I was so angry but I said nothing. He's so fit and it wouldn't have bothered me so much if I hadn't been 110 pounds when I met him."

Monica: "I thought about my binging, I feel like a mad woman during a binge - when I'm binging I'm another person - especially after it's like Holy God, this is ridiculous - I'd rotate stores because I was getting paranoid - he's going to start to suspect- all this junk food - and then driving in my car, I got stopped once for a spot check, I panicked, I needed to get home. I was frantic and when I get home and it's over I have to get rid of the garbage, I run to the garbage chute to get rid of the evidence, but fast so that no one will see. And now here, I go to the washroom so fast so that the nurses don't think I'm puking!"

When asked what it was about the situation that she shared that made her angry, Monica stated the craziness of it all and the fact that she could not stop herself. The facilitator suggested group members discuss whether binging and purging, strenuous exercise, strict dieting and whatever forms of body punishment they were familiar with, were ways to remove the focus from troublesome feelings. The attention would no longer be on the angry situation, for example, but rather, on the food they would be consuming and the self-loathing they experienced for not stopping themselves. All group members stated that being hospitalized helped them to realize this and that they needed to face the feelings. They agreed that the fleeting satisfaction that came from binging and purging or weight loss did not make the feelings go away.

The group discussed how preoccupation with food and dieting and their bodies distracted them from their life problems and the intense feelings associated with them. It was as though it was one way of coping in a world that otherwise felt beyond their control. This brought the group back to issues discussed in previous sessions. Feeling powerless over their worlds could be circumvented by pursuing the myth that being thin is synonymous with being perfect and powerful. Achievement of the thin ideal occurred but the group members shared that they still did not feel in charge of their lives, in fact, it was worse, because they now had a stressful relationship with food. At this point in the discussion, the women began to share the feelings they were experiencing at that time:

Michelle: "I know what happened - I'm not going to let it stop me from getting better or stop me from changing things . . . I'm telling myself to hell with the dieting and binging and purging, I don't want it anymore; it screwed me up long enough."

Monica: "Why do we put ourselves through this anxiety (looking at the group), you're smarter than this - why the hell are you being like this - we're smart, but look at us here, on a psych ward."

Bonnie: "I want to be me - but I'm afraid I'll look like my grandma (then turning to Francis and crying), you're young and I know what you are doing, you're fighting tooth and nail but it doesn't work, just look at the rest of us!"

Bonnie shared that her grandmother was a fat woman and that she had similar facial and body features. Francis

responded to Bonnie's comment with "(M)y mom seems to want to look like me, always dieting, trying on my sweats- it's kind of the reverse of your fear - it bugs me. Why does she want to look like me?" The group allowed Francis to share her frustrations regarding her mother 'competing' with her. Francis was determined not to let her mother get smaller than her.

Group members shared that all they really were striving for was to fit in and that they were trying to achieve this from the time they were children. A feeling of 'never quite making it' was shared by the women in the group. The idea of 'making it' through thinness was tempting because they knew they could muster up the willpower to diet and it was a tangible, attainable goal. The anger surfaced when the body changes did not make the difference that they had anticipated. They were back to the feeling of 'never being good enough' and were angry at and blamed themselves.

To challenge the unrealistic and damaging effects of the 'thin is perfection' myth would have taken away the one tangible goal that they had. The anger was kept inside, swallowed, vomited up and numbed because they were inadequate in the first place and so the only person to be angry at was themselves. The group reflected back on discussions in previous sessions where they had tried to locate when they first felt somehow inadequate or lacking.

They shared, once again, personal stories of abusive touch, and of ridicule and how they tried to counter that treatment by being perfect.

The group ended the session with relaxation (Appendix 1) and the "Visualizing Feeling Good" exercise (Appendix 5). None of the group members wanted to see themselves on the video tape. This session ended with silence and a sense of exhaustion. Group members wanted to return to the ward and to their rooms.

Summary of Observations

Intense anger and profound sadness were shared in the session with members offering support and encouragement to each other both in expressing their feelings and resolving their issues. The session brought issues explored in the past together in a way that made a strong and lasting impression on the group facilitator and hopefully with group members. This was the first session that it seemed that the group members did not feel the need for defenses; trust was firmly established and very evident. It seemed as though reviewing the video tape would have meant a complete acceptance of their feelings of anger and sadness. By visually seeing themselves expressing these feelings they would have to truly acknowledge their existence. While they verbalized these feelings in the

group they were not prepared, at this time, to see their physical expression of them on video tape.

Session 10

The final session was entitled finding safe places. One of the goals in establishing the body image group was to provide members with a safe place to explore their feelings about their bodies. The goal of this session was to explore how they could continue to find safe places to carry on with the body awareness work they had begun. Group members shared some of their insights:

Michelle: "There's not a lot of safe places in the hospital and the group was a safe place . . . it feels strange to be ending it."

Bonnie: "Well, it's [the ward] safe from food, more or less, but it's an artificial environment, in here, it's [in this group] like it's real . . . I don't care what I say here - I just say it."

Monica: "You've seen us in so many different ways . . . like we must look so different when we come to morning group as opposed to what we are like on Wednesday nights here with you . . . I'm relaxed here, I'm myself but in the morning it's PSYCHO therapy group."

The facilitator shared that different groups serve different purposes and that it was important that they try to create safe places for themselves. Group members shared that the biggest hurdle for them was trusting others to accept them as they are and that fear of rejection kept them 'keeping the secret'. Loneliness and

isolation were cited as the results of their fears of trusting and rejection. Monica, Bonnie and Michelle shared that their 'safe place' had been their food; it had been their comfort and their companion. Rhonda shared that her 'safe place' had been inside her head. It was a place of privacy where she did not have to explain her thoughts. Francis could not think of a safe place.

The facilitator asked if the acceptance they experienced from each other as they struggled to overcome their common problem provided them with a sense of collective empowerment. The group stated that it had and they shared how, in a sad way, being hospitalized had provided them with a social network. Some of the women had already made plans to keep in contact after hospital discharge. They stated that they could provide 'safe places' for each other. Group members were also encouraged to attend local self-help groups as a positive alternative.

The session closed with a 'Candle' exercise (Appendix 10) and group members went for coffee as a way of terminating.

Summary of Observations

The final session was very subdued. The group had become a 'safe place' and creating their own after the group ended was a frightening prospect. Group members

acknowledged that they could count on each other but that they had separate lives outside the hospital. The women realized that their food and body preoccupation had led to isolation and loneliness and that they would have to mend some old friendships and seek out some new ones once they left the hospital. Trusting others and the fear of rejection remained a concern, however, they now seemed more prepared to take the risk.

FACILITATOR'S COMMENTS

The opportunity to establish, facilitate and participate as a woman in a group focusing on body image allowed for the facilitator's personal and professional growth. On a personal level, the experience confirmed the commonalities that women share as a result of our socialization and the variety of responses we have to pressures from the environment. The group process allowed 'first hand' learning that answered many questions that were, until that point, hunches and academic learning. Questions raised by the facilitator in the section of this chapter on Integrating A Feminist Approach with an Ecological Perspective require further attention here as the group process provided some answers.

1. How do we as women achieve reciprocity with an environment that is hostile towards us by narrowly defining how we should look, what we should strive for and what we should realistically expect to achieve?

- We agreed as a group that although the environment is hostile its message is very enticing. Group members had internalized the message that 'to make it in this world' you have to be thin or even more oppressive, 'to be fat is to be a failure'. Unrealistic and damaging expectations of the environment are glorified by the media in thin models and 'superwomen'. The group concluded that the environment does not strive for equilibrium with women but rather, has a vested interest in keeping us dissatisfied and continually striving. The group also concluded that reciprocity does not exist because women put much more into the environment than they receive back in terms of motherwork, career and investment in the fashion, fitness and diet industries.

2. How can we achieve competence and <u>feel</u> competent in an environment that limits our opportunities for power and respect to our bodies?

   - The dilemma for women expressed in the group was that the competence assigned to women in society who are thin is false resulting in them feeling like a fraud; an imposter. They appeared to have mastered the environment by achieving the ideal but they knew inside that 'they didn't deserve it'. Competence was perceived by others but not by themselves as they knew the truth. These women knew that competence based on a power derived from the thin ideal would not be permanent. The group acknowledged that competence based on our achievements and feelings towards ourselves is a healthy alternative to portrayal of it through the thin body ideal.

3. Can women ever achieve goodness-of-fit given environmental demands that far exceed what is healthy for us?

   - Although group members had severely hampered their well-being attempting to achieve a 'goodness-of-fit', the consensus seemed to be that we can 'fit' if we lower our expectations of the environment. Alternatively, a response was to reclaim some of the power the environment has over defining what women should look like.

4. Is the anorexic or bulimic woman maladaptive or the ultimate in adapting; incompetent or highly competent; deviant or the ultimate conformist?

- Group members saw themselves as women struggling 'to fit in', 'to make it in the world' and in this way they were conforming. Adaptive behavior - dieting and exercise - both highly valued in our society, became maladaptive when it began to control their lives. For many, that turning point was not identifiable. When the group facilitator pointed out their strengths and competencies they had difficulty accepting the comments as they were in hospital, and therefore, saw themselves, for the most part, as incompetent in handling their lives.

An issue that arose periodically throughout the ten sessions and that demands some attention here and in the Evaluation chapter of this report is that of the hospital environment. The organization of the hospital, its treatment orientation and the social processes and activities in the hospital constituted a very important reality for the women. There were freedoms that they did not have because of this reality. Hospital structures and rules about coming and going, mealtimes and choices, visiting hours and shared accommodations were some of these realities. The facilitator's knowledge of the ward was important because it was the primary group for these women during their hospital stay. The perception, understanding and endorsement of the body image group by the ward was also important to the facilitator. Ward staff were very supportive in promoting the group and encouraging attendance.

COMMON THEMES

The ten session body image group highlighted some common themes that are present in the lives of most women. Discussing these themes as the experience of most women who live in a society that is obsessed with the thin ideal served to illustrate the point made by the author in promoting an approach that moves away from the disease model to a strength and competence orientation. The experiences shared by the women in the body image group echo those shared by many women in daily conversations. While not losing sight of the expressed pain of the women in the group, it is important to make the connections with the experiences of women who may not be struggling with an eating disorder but do have a body and dieting obsession that consumes much of their day to day lives.

The underlying message or common thread in all the themes was "we are not acceptable <u>just</u> as we are". The themes are presented here individually but it is crucial that the reader keep this persistent, underlying message in mind.

"If I were thin I would be perfect" or "Being thin will get me the finer things in life" was a theme that arose throughout the body image group sessions. Body transformation as a cure-all for the complex issues in our lives (Orbach, 1982, 1986) is a course of action taken by many women today. Women put their lives on hold every

time they refuse to purchase an article of clothing because of their size or refuse activities; social and physical because of their size. The belief that nothing will change until they lose pounds of flesh and that everything will fall into place once they do, is pervasive in many women's lives. The enormous amounts of time, energy and money that is put into the thinness ideal robs women from time for activities and pursuits that can be life-enriching. Body punishment that takes energy away from the pursuit of healthy alternatives is promoted in the guise of health by the fitness and diet industries. Many women see themselves as unlovable or certainly, less loveable, until they have achieved body perfection. Given a socialization process that designates women's place of power as their bodies (Greenspan, 1983; Orbach, 1986), it is not surprising that the struggle for power is then contained within the body.

It became clear in the body image group that the body as a 'legitimatized' place of power for women leads to assumptions about power that are misleading and damaging. Relegating our place of power to our bodies as opposed to a combination of personality, intelligence, creativity and body pride, leads to elusive dreams and false hopes. The image industries, in their glorification of youth and the thin ideal, lead us to believe that we can halt the aging process and transform our bodies with self-control and

discipline. The result is an ongoing uneasiness and dissatisfaction with our bodies because in reality we cannot control our bodies natural change processes.

"I am never at peace with my body" or "A woman's body is her life's work" was another common theme in the group. These statements are often heard by women regardless of their age and their body size and shape. Living in a culture that gives the message that we must keep our bodies under constant scrutiny lest they betray us with 'excess' fat or insatiable appetites creates a level of tension and uneasiness about our bodies that is difficult to overcome. The terminology used by the diet and fitness industries suggests that as women we must wage a war against our bodies. "Battling the bulge', and 'winning the losing battle' are popular phrases coined by the industries that profit from breeding body insecurity in women. Our bodies, our appetites and food become the enemy. Our bodies are the enemy because they will betray us if we allow them the freedom to indulge in a hearty meal or to take a break from strenuous exercise. Our appetites will betray us through cravings for 'forbidden' food. Sweet and starchy foods have been assigned a mysterious power in our culture as though they can lure us away from the salad bar with their toppings and aromas and cause us to sin. Because of this power, many women feel guilty each time they choose to nourish themselves with a

buttered, egg salad sandwich rather than a salad and melba toast, or apple pie rather than a piece of fruit. This guilt is expressed in running an extra mile, 'skipping' dinner or chastising and belittling themselves for the rest of the day as a way of 'repenting' for the 'sin'.

The reality that women's natural hunger fills them with despair is tragic. For many women, the very act of consuming food is an anxiety-laden experience which can lead to eating only when alone so that they are not observed succumbing to their appetites. The personal experiences shared by the women in the body image group highlight the emotions that are so intimately connected to the feeding of our bodies. Feelings of loneliness, anger and self-loathing are denied expression along with the physical hunger. It is easy to understand how a variety of feelings find their place of expression or denial in women's stomachs. When food, a necessity for survival, becomes so divorced from its original intent with the message that we will lose control in its presence, it is little wonder that it becomes a powerful force in women's lives. Denial of food for our bodies becomes equated with increased power and control. The thin body that can be attained through prolonged food denial is also equated with power and control and society's admiration.

The third commonly expressed theme addresses the issue of fat oppression. "Being fat is a sign of weakness and

demonstrates a lack of willpower" or "Fat people are just lazy; if you want to lose weight you decrease the calories and up the exercise - it's simple" are frequently spoken phrases. Fat oppression is evident everywhere. Specialized clothing stores penalize women for their size by charging exorbitant prices. Advertising and television media generally ignore fat people unless they are portraying roles to be laughed at and ridiculed. It is immoral in this society to be fat. The moral values that are attached to the thin ideal become especially evident when considered in the context of the condemnation that is placed on fat people. Fat women are considered inferior and are assumed to have some personal problem that is keeping them from losing the weight or, even more insulting, the notion that her fat must be 'hiding' something. Nelson (1983) poignantly asserts:

> I laugh at people who tell me I need my fat for protection, implying that if I understood that, I would lose the fat; implying that I no longer should need protection. As if I didn't need protection from all the fat phobics who harangue me with tales of how I "just" need fat for protection.
>
> (p. 228)

Women who do not ignore their appetites and, therefore, may not fit society's thin ideal are often subjected to ridicule and discrimination. Dickenson (1983) a writer on fat oppression states:

> Fat is a problem, because it makes women miserable. But why? Not because it is intrinsically best to be thin, but because society hates fat. Women internalize that hatred. Hence our misery: It's horrible to be hated for what one is, horrible to hate oneself . . . The sickness is in a culture that values women (like cattle, only in reverse) according to their girth.
>
> (p. 42)

The women in the body image group shared that 'fat' always had negative connotations in their lives. Socialization for the thin ideal begins very early in life. Children learn in adult environments to call their peers on the playground 'chubby' or 'fatty'. They often observe their mother's dieting and rejection of her body size and shape. Designer jeans for seven year olds and thin dolls equipped with pink aerobic outfits assure that female children grow up with the message that being thin must be a goal in life. The women in the body image group were testimony to the belief that fat must be avoided - at all costs!

The fourth theme that was expressed in the group focused on the current obsession with being fashionable when one exercises. "I'm too out of shape to buy a gym membership" or "You have to be thin to work out there!" were comments heard in the body image group. These comments are also expressed by many women who may want to introduce a regular exercise routine into their lives but find few organized facilities that focus on <u>health</u> as opposed to <u>looks</u>. The fashion industry astutely saw a

place to market its wares in the fitness facilities. Shops carrying aerobic gear complete with matching sweat bands and socks exist in all popular gym locations. It has become very fashionable to 'work out' and to engage in the activity in fashionable attire. The environment created is one of competition that fosters body insecurity. The promotion of diet, fitness and fashion obsession make a 'neat package' for profiting from women who are desperately trying to achieve the thin ideal.

The four themes discussed were ongoing issues in the body image group and are common concerns for many women in society today. The result is a deep dissatisfaction with their bodies and a myriad of feelings that are hoped will subside when the thin ideal is achieved. A final theme that is the result of the subtle and obvious messages contained in the previously discussed themes is "If anyone gets close to me they will see that I'm really a 'fraud'". When a woman's value is relegated to her body size, accomplishments and achievements that she has attained are often negated or attributed to luck. It is as though she does not deserve recognition and praise because she really does not 'measure up'. In a society that bombards us with the message that our worthiness increases the closer we are to the thin ideal, it is not surprising that women who perceive themselves as falling short of the ideal might also perceive themselves as less worthy individuals.

Demanding perfection of ourselves means measuring most everything we have done by what has not been accomplished rather than what has been accomplished. These tendencies to self-blame and to refuse self-credit further exacerbate a sense of powerlessness to affect the world around us.

CHAPTER 4 - EVALUATION

The Body Image Group Members' Evaluation

The women in the body image group provided feedback throughout the ten sessions and through a questionnaire that was handed out in the final session (Appendix 11). Group members were asked to complete the questionnaire outside group time as it was the group facilitator's belief that time for reflection on the previous ten weeks would allow for more constructive feedback. All responses to the questionnaire were compiled and are presented verbatim.

1. Did you find the group helpful to you during your hospital stay? If so, in what way; if not, what would have been helpful?

> "It was very helpful and relaxing, informal and honest - guards were let down and real true feelings were talked about."
>
> "Yes, I found the group very helpful because I didn't feel I was being analyzed or a human guinea pig. In the group, people were really opened up and most important we could laugh with each other not at each other. A lot of focus was on body image and that is really a big part of someone with an eating disorder. The low lighting and pillows made it a comfortable, safe place to open up."
>
> "Yes, it was helpful - it helped me to relax - the relaxation exercises were excellent. It gave me a more wholesome outlook on myself as a woman. It helped me form a healthier outlook."
>
> "Your voice was soothing when you did the relaxation. The film on advertising really challenged my thinking and I am still consciously pulling apart ads and T.V. shows that exploit women's bodies."

"It gave variation to the hospital format- having someone to come in to give massage, the wine and cheese celebration - it gave a certain type of freedom associated with being well and the outside world. I found the massage session very good. It helped me realize how beautiful touch can be. It is not to be feared. As well, it showed me how much loving can be given by a simple pressure of the hand. Thus, it made me appreciate my body more (excellent)!"

"Not being observed was very important. I was much freer to voice myself (absence of fear). Nothing was condemned about any one person. Having the video run helped me in that I discovered how I appear to other people. I found I like myself better - my voice, articulation, how I present myself, my laugh. It helped reshape my body image, along with the massage and talking."

"We didn't just talk about us, we talked about women. This differentiation was beneficial for we touched on many subjects that needed to be discussed, but otherwise wouldn't have been."

"It was helpful that as a group we made our own decisions - we had the input in making it our group."

"The group was helpful to me because it met during the evening - the time between supper and bedtime feels particularly long and lonely when visitors don't come by. The group was informal - it did not conform to psychotherapy - topics discussed were varied (not just eating disorder problems)."

2. Did you find the two hour duration too long? too short? just right?

"Two hour duration was just right."

"I found the two hour duration great, time just flew by."

"No - not too long, even too short at times- loved every minute!"

"Time was not important. We took what we needed, for me two hours was just right with time included to review the video tapes."

3. Can you provide me with some feedback on the room that was used for the body image group? Lighting, carpet, windows, etc.

"Bringing in the lamp was a good idea, the chairs were alright, more comfortable ones would be a big plus."

"Room is not that important - just as long as there is comfortable seating and enough space to not feel cramped. It would have been nice to have an open window view and light coloring on the walls, but it would bear little influence on the group itself because the group carried itself so well regardless of the environment. The subdued lighting (non-fluorescent) was nice for the relaxation exercises. Even if we did something more active where we wanted more open space, it was always good to sit back down in "our cozy room" and discuss the activity afterwards."

"Low lighting was nice - soft bean bag chairs that you can really relax in would have been great and a nice thick soft carpet in a calm blue colour! The candles we used sometimes were very nice for lighting, they gave the room a more private and peaceful atmosphere."

"Room should have more comfortable chairs, colors should be warm, neutral shades (earth tones), there should be a window or something that helps us from feeling closed in, and no distracting noise like the hospital P.A. system!"

4. Do you have suggestions for change - new and different ideas - If you were organizing the group, what would you do?

"I think the way the group went was great, we were free to talk and laugh with each other, there wasn't the tension that there is in psychotherapy group."

"Nothing - superbly done!"

"I would run the group again after a few months - I can think of little to change - nothing in fact, except maybe give homework - more to work on during the week."

"No, I don't have any suggestions right now."

5. What did you like least about the group? the most?

"The least - the one way mirror even though there was no one on the other side, the videotaping and the body tracing exercise. The most - I had no difficulty feeling comfortable with the facilitator of the group (very empathetic), the relaxation methods used, the film on advertising and body image and having the woman come in to do massage. The very best part of being in the group was having the opportunity of meeting and getting to know Lucille (now, how are you going to report THAT in your thesis?)"

"The least - sometimes hurting others feelings by thinking differently - but remembering that we are all sensitive. The most - a great facilitator who was caring and really understanding. I learned a lot about myself and others. Thanks for everything! The best group of all!"

"What I like least about the group was that it ended. It had helped me so much. The body tracing was very difficult. The thing I like the most was the free and relaxing environment this group had as opposed to the usual hospital veneer. I liked that any suggestion on what to do went. It really was <u>our</u> group. We were all equal women in this group."

"What I like most about the group was the fact that you, Lucille cared enough to share your experiences in life. What I like least about the group was that sometimes people felt uncomfortable with certain subjects and that made it hard for them to actively participate."

6. Did the group experience help you to change your perception of your body/yourself?

"Yes, I learned to appreciate my body by physically caring for it, for example, massage and relaxation and visualization exercises."

"Yes, listening to the facilitator and massage therapist sharing their experiences - they are not caught up in weight and body image and I became aware of how comfortable they were with their bodies and this lessened the importance of mine for me."

"I learned that I can love myself and discovered that I am acceptable and I can lower my standards and expectations of myself and others."

"I learned that I can be expressive and creative and thus unleashed my emotions. I learned what emotions/feelings I do have. I learned about things that give me enjoyment. I learned that I can make decisions. It was neat having people look beyond the illness to see me and accept me the way I am, even if they didn't like it."

"The facilitator's sharing as another member of the group, as another woman, helped me a lot, listening to her experiences was a way of helping me get better - I'm here trying to find a way to let it all go."

"I still have a long way to go with my body - but it helped me with how I just see me - I was always sitting with all these depressed people on the ward - watching a funny T.V. show but nobody laughs - coming to the group one evening each week reminded me that I <u>can</u> laugh and have fun even with anorexia, we worked but we laughed sometimes too."

<u>The Facilitator's Evaluation of the Body Image Group</u>

The atmosphere that can be created in a small group setting with women who share similar issues and concerns can result in a level of sharing and intimacy that can have a lasting effect after the group has ended. Because the body image group was for a time limited, ten week duration it was hoped that the group would have some long-term impact on the participants. The feedback suggests that for some of the women a more positive body image was an outcome. In reviewing the facilitator's goals in establishing the group the following summation is offered.

The group succeeded in providing members with a safe place to explore feelings about our bodies and a respect and appreciation for our bodies was encouraged and fostered. New ways of experiencing and expressing ourselves were explored with the expression of angry feelings encouraged. Facilitating a sense of self-worth that was independent of body image was a difficult undertaking. Our socialization to equate our self-worth with our body size could not be effectively counteracted in ten weeks. However, believing that self-worth could exist as independent of one's body image suggested some forward movement. Creating a more positive body image was best facilitated through the body massage session and through the relaxation and visualization exercises. Body tracing and video tape reviews were not popular aspects of the group. While some participated in these exercises, others were very threatened. The sharing of family patterns and influences on our present body images was an excellent session that allowed women to share, some of them for the first time, family behaviours and attitudes that were affecting them as adults. Highlighting unrealistic societal expectations for women and how these demands can effect us was a useful session as was the focus on ideal female and male stereotypes. The women shared the realization that they were not aware of how much their attitudes had been shaped by the socialization

process and the media. A sense of power in controlling our imagery, and specifically our body imagery was fostered through relaxation and visualization exercises that the women were also encouraged to do on their own. Some group members shared that they used the learned techniques when they found themselves restless and unable to sleep. The facilitator also got requests to tape some relaxation/visualization exercises for them!

Listening to others share their experiences related to body loathing and self-punishment seemed to help the women shed feelings of shame and hopelessness. The fact that we did not focus on food or anorexia nervosa or bulimia was welcomed in the group by the women. They genuinely appreciated the opportunity to deal with the women's health issue of body image. Group members appreciated the focus on women's strengths and enjoyment of our bodies even though these concepts seemed initially foreign to them. They had not thought of themselves/their bodies in positive terms in recent months, for some of the women, it had been years.

It was the facilitator's conviction in establishing the body image group with bulimic and anorexic women that it is the insidious nature of the female socialization process as opposed to some innate characterological defect that makes women susceptible to eating disorders. Unrealistic societal expectations for beauty and thinness

and the fostering of body insecurity have a profoundly negative impact on many women's lives. Psychiatric labels such as anorexia nervosa and bulimia obscure the similarities between those who are labelled and those who are not. This 'diagnostic' process leads to focusing blame for difficulties on individuals rather than the community, our institutions, our culture and our socialization process. Smead (1983) asserts:

> If the problems suffered by all constrained eaters from the very obese (sic) to the slightly overweight (sic), to the very skinny are seen as quite different, or as due to the individual's own inadequacies, then the women, not the process become the problem.
>
> (p. 32)

The body image group did not focus on eating disorders, but rather, body image concerns that are common in the lives of many women. This focus was appreciated by the women in the group. The facilitator was identified by group members as a positive role model as she shared her own struggles with body image issues, self-worth, power and assertiveness.

The facilitator's learning in the group and conclusions drawn when reflecting on the process and the members' feedback, is somewhat different from findings reported by therapists who have run groups with this population. Wooley and Kearney-Cooke (1986) report that "women with eating disorders have difficulty discussing feelings about their bodies . . . they are comfortable

counting calories or discussing exercise programs . . . they resist expressing, describing and understanding bodily perceptions" (p. 491). Hall (1985) states that women with anorexia nervosa are "likely to be silent, or preoccupied so much with food that this may be the sole topic of discussion" (p. 214). Generally speaking, these observations were not part of the group experience described in this report. Calories, food and exercise preoccupation was not evident. On the contrary, group members shared that by coming to the group as <u>women</u> with body image concerns they were able to 'get away' from these very issues. It is suggested here that the preoccupation with food, calories and exercise may be the result of a group philosophy or orientation that focuses more on the eating disorder per se and not enough on the women and their lives. Food was a group topic on the two occasions that it was actually consumed; once to mark an ending of an evening of massage and as a celebration for the departure of one of the group members and again at the end of the final session to mark termination. Discussing feelings about their bodies was difficult, however, the relaxation and visualization exercises facilitated sharing.

Interestingly, the feedback from the body image group members and the facilitator's conclusions were consistent with reported findings in feminist therapy groups.

Kravetz (1978) states that feminist therapy groups facilitate sharing thoughts and feelings about being a woman, increase self-awareness and self-acceptance, examine problems inherent in women's socialization for traditional roles and changes in identity, including changes in body image and feelings about sexuality. These findings are consistent with the benefits reported by the women from the group experience. The development of supportive relationships with other women is a crucial dimension of feminist groups.

For many women, developing a positive body image is a painful struggle that requires exploring messages received from childhood through to adulthood. A ten session body image group can be a great place to begin! A philosophy and approach to working with women that emphasizes strengths and capabilites is infinitely more conducive to positive body image development than that which emphasizes deficits and weakness. The facilitator should be sensitive to the reality that she is as susceptible to oppressive and destructive cultural norms and ideals as anyone else, and therefore, needs to be in touch with her own attitudes regarding eating, fat, weight and sexism. The facilitator is most helpful if she is in touch with her own body image concerns and with her attitude toward the bodies of the women in the group.

The Body Image Group in the Hospital Environment

The focus of the body image group was distinctly different from the psychotherapy groups that the women attended each morning. The psychotherapy groups had no planned agenda but rather focused on 'here and now' issues. Group members were encouraged to share in the group issues they were being confronted with on a daily basis during their hospital stay. Because the author participated in the psychotherapy groups as well she was involved in two very different group experiences. It was evident that the women did not view the psychotherapy group as 'a safe place'. This could be partly attributed to the one-way mirror through which team members and other medical personnel on rotation in psychiatry could view the process. It could also be partly explained by the process itself. The psychotherapy groups were co-facilitated on a rotating week by week basis so the opportunity to develop trust with two ongoing facilitators was not present. Traditional psychotherapy necessitates that the facilitators remain objective and not partake in the process through self-disclosure, thereby maintaining a 'them and us' orientation. Kravetz (1987) states that the goals of traditional psychotherapy include "changing individual attitudes, behaviors, and emotional states that are assumed to be deviant, sick or maladaptive . . .it is adjustment-oriented and focuses on the individual" (p.

56). Facilitating both the psychotherapy groups and the body image group exemplified the profoundly different atmosphere that is created according to the orientation of the facilitator and the setting. Using an integrated feminist and ecological approach provided the facilitator with an interventive framework based on commonalities, strengths and competence. A movement away from pathology to competence allowed for behavior to be defined in transactional terms; an outcome of interactions between the individual and her environment. The intervention objective was improvement of the person-environment transaction rather than 'treatment' of the individual. This objective was realized in the body image group, even though improvement of the person-environment transaction meant questioning how realistic 'fitting' with the demands of the environment is in relation to women's health. This orientation to practice allowed for an "understanding of the social origins of people's emotional pain" (Greenspan, 1983:339).

Applying feminist and ecological principles in a hospital setting presented challenges given the disease orientation of the medical environment. In evaluating the role of social work in the hospital setting from an ecological perspective, a goodness-of-fit seemed to be difficult to achieve. Applying the interventive framework with women hospitalized in a medical environment also had

its shortcomings. Firstly, the body image group format and process did not fit with the overall treatment philosophy of the clinic. Learning about touch and appreciation of our bodies through massage and relaxation exercises was not part of the clinic's treatment plan. The facilitator attempted to always be clear about her philosophy and approach and to explain that for the duration of her practicum experience the body image group was an adjunct to the existing program format.

The facilitator often felt 'pulled in two directions' throughout the practicum experience. In ecological terms, her 'person-environment fit' was somewhat precarious. Because of a commitment to feminist principles, the facilitator did not present as an expert but rather as a woman who had struggled with body image concerns and felt she had something to offer. Identity with the group members as women was strong. The facilitator's role as a social work graduate student compelled her to want to feel connected with the clinic team and as a result an identity with that group also transpired. Both groups provided valuable learning experiences and the facilitator reciprocated. Reflecting back on the practicum experience, the facilitator's continued professional and personal growth since that time would compel her to attempt to improve the 'fit' between these two groups.

SUMMARY AND CONCLUSIONS

A feminist approach to the concepts of environment and competence in the ecological perspective has led the author of this report to draw some conclusions. It is suggested that these conclusions can have a significant impact on our perception of the helping process and our ability to assist our women clients in achieving their maximum potential.

Women's lives are profoundly affected by the poor fit that exists between what we expect from the environment and what we receive in reality. The environment gives little in return - it purports to yield a high return to women who put enormous amounts of energy into the thin ideal, but in reality, there is little or no reciprocity. Women who achieve the thin ideal are often recipients of encouraging remarks and positive reinforcement, however, these environmental responses only serve to underscore the message from our physical and social worlds that our power lies in our bodies. The message is that the closer we conform to the thin ideal stereotype, the more power we will have in our lives. Women who strive for, and achieve, the thin ideal believe that they have fulfilled their part of the bargain but feel betrayed because the environment does not reciprocate with the promised successes that apparently are supposed to magically appear in our lives once we fit the stereotyped ideal. The

effects of sex role socialization leave many women ill-equipped to deal with the reality that the power we are assigned by being thin in our society is fleeting at best. Thinness satisfies society's demands but often limits our ability to do our jobs (physically weak or food preoccupied from starvation dieting), increases social isolation (fear of being around food) and can affect child-bearing choices (sporadic menstrual cycle due to chronic dieting). The problem for many women today is that the constant media bombardment with the thin ideal has blurred the distinction between realistic and unattainable ideals. The implications of this process are important for social workers. Encouraging women to confidently disregard the environmental demands for thinness and to develop and nurture personal and collective power that is not relegated to body size should be an integral part of our therapeutic goals. The cultural identification of women with our bodies has made negative body image a core factor in women's mental health issues. Developing interventions, such as that which is offered in this report, to help women gain a more positive view of their bodies and to challenge sex role stereotyped body messages are suggested by the author as critical to women's physical and mental well-being.

The myth of thinness = power and success puts women in the precarious position of having to rely on external

definitions of who we are. Living in a culture that implies that women must be beautiful (thin) to be worthy, and that sets up unrealistic and damaging standards to achieve this goal, has resulted in many women feeling incompetent. 'Attractive' people are viewed as smarter, more competent and morally superior. Competence is a key concept of the ecological perspective discussed in this report. Given that the thrust of the proposed intervention was to promote more effective interaction with the environment, then our profession needs to consider re-defining and promoting competence based on the more personal dimensions of skills, qualities, strengths and capabilites as opposed to the notion of competence based on womens' ability to conform to the thin ideal.

The emphasis on thinness in our culture is a form of social control for all women. Sanford and Donovan (1984) assert that "it's a whole system of social control that keeps thin women absolutely terrified of being fat or thinking they are fat, and a whole lot of energy goes into dealing with fat" (p. 372). Writers on fat oppression remind us that "we can't escape the oppression of fat women just by becoming thin ourselves - or even by making peace with our own flesh . . . oppression will be around as long as one person has power over another, be it power to hire and fire, power to rape, or power to make someone think she's ugly" (Dickenson, 1983:50). It is important

that as helping professionals we are aware of our attitudes and beliefs lest we collude in this insidious form of oppression and social control. We need to keep all women in mind in promoting healthy alternatives to existing societal definitions of beauty and competence for women. It is suggested by the author that it is imperative in our work with individuals to include environmental factors and how they may enhance or adversely affect our well-being. When we choose not to, we choose to individualize and privitize social problems. It has been suggested in this report that women's body image concerns cannot be divorced from any other life issues that may present in our work with women. This report has addressed women's body image from an approach that focuses on women's strengths and capabilities. Working from a strength orientation of feminist and ecological principles allows for a therapeutic process that is exhilarating and rewarding.

APPENDICES

Appendix 1

RELAXATION EXERCISE

(*Note to the facilitator - Use relaxing music to accompany the exercise; use pauses with your suggestions. Be gentle.)

Make yourself as comfortable as you can. Close you eyes. Now stretch your legs as far as they can go and turn your toes under and tighten the muscles very tight and hold. Now, also tighten the muscles in your calves and those in your thighs. Make your entire leg as tight as you can and hold. And now relax all the muscles in your toes, all the muscles in your calves, all the muscles in your thighs. Let your legs go completely limp. Pay attention to how you are feeling, in this place at this time. Now, stretch out your hands and make a tight fist. Feel the tightness. And now make it tighter, tighter, tighter and hold it. And now also tighten the muscles in your wrists, in your forearms, in your upper arms. Hold it. Now let go and pay attention to how your are feeling in this place at this time. Let your arms go completely limp, and pay attention to how you are feeling and how you are breathing. Now, arch your back backwards, raise your chest, tighten your neck and shoulder muscles and your stomach, remembering to keep breathing. Make all those muscles as tight as you can, tighter, tighter, tighter, and hold it, hold it. All right, now let go, notice how you are feeling in this place at this time. Just feel the muscles relax from your back, from your shoulders, from your chest, from your stomach; all over your back. Notice your breathing.

Now I want you to tighten the muscles in your face. Make a funny face. Tighten the muscles around your mouth, the muscles in your chin, around your eyes and your forehead. Wrinkle your brow. Make them tighter, tighter, tighter, hold it, hold it. All right, now let go, just let go. Let go and notice how it feels, and notice your breathing. Now take a very deep breath and hold it. Hold it, hold it. Now slowly let it out and you are letting out all your tensions, your frustrations and your anxieties. Once again, take a very deep breath and hold it, hold it, hold it. Now slowly, slowly let it out and relax your tensions, your frustrations and your anxieties. Allow yourself time to get in touch with how you are feeling right now; stay relaxed as best you can and we will move into a visualization.

Appendix 2

VISUALIZATION

The North Island Women's Services Society in their Working Together for Change manual describe visualization as follows:

> Visualizations are tools that draw on and develop our intuition, will and imagination. Visualization is a technique of using the imagination to reshape our reality in a positive way. It involves creating images to effect inner changes. Visualizations are a form of energy, mental energy, and they can affect energy patterns . . . The body can be relaxed through using simple visualizations, such as visualizing breathing tension out of the different areas of the body, or visualizing a quiet place where you feel relaxed . . . The mind needs to be relaxed as much as the body. This involves clearing it of thoughts, worries and anxieties. You can visualize drifting away as you breathe out.
>
> (pp. 96-98)

Appendix 3

EVERYPERSON'S BILL OF RIGHTS

The kind of rights that we are going to talk about are personal ones; the right to self-expression, the right to seek fulfillment and to be treated with respect. These are not the kind of rights that can be legislated. Can you imagine picketing for the right to set your priorities or say no to someone without feeling guilty?

But these rights are easily overlooked - sometimes by ourselves and sometimes by those who want to get their way at our expense. When we act non-assertively we are likely to ignore our rights altogether. An important goal of assertive training is to learn to believe in our rights so that we will be more likely to assert ourselves and feel good about doing it. Here is a list of what are considered some of the basic rights of people.

1. THE RIGHT TO BE TREATED WITH RESPECT.

2. THE RIGHT TO HAVE AND EXPRESS YOUR OWN FEELINGS AND OPINIONS.

3. THE RIGHT TO BE LISTENED TO AND TAKEN SERIOUSLY.

4. THE RIGHT TO SET YOUR OWN PRIORITIES.

5. THE RIGHT TO SAY NO WITHOUT FEELING GUILTY.

6. THE RIGHT TO ASK FOR WHAT YOU WANT.

7. THE RIGHT TO MAKE MISTAKES.

8. THE RIGHT TO CHOOSE NOT TO ASSERT YOURSELF.

There are lots of other rights you might not want to think about: The right to change your mind, to say "I don't know the answer", to say "I need some time to think that over". You might want to add these to your own bill of rights.

Appendix 4

MY DECLARATION OF SELF ESTEEM

I am me.

In all the world, there is no one else exactly like me. There are persons who have some parts like me, but no one adds up exactly like me. Therefore, everything that comes out of me is authentically mine because I alone chose it.

I own everything about me - my body, including everything it does, including all its thought and ideas; my eyes, including the images of all they behold; my feelings, whatever they may be - anger, joy, frustration, love, disappointment, excitement; my mouth, and all the words that come out of it, polite, sweet or rough, correct or incorrect; my voice, loud or soft; and all my actions, whether they be to others or to myself.

I own my fantasies, my dreams, my hopes, my fears.

I own all my triumphs and successes, all my failures and mistakes.

Because I own all of me, I can become intimately acquainted with me. By so doing I can love me and be friendly with me in all parts. I can then make it possible for all of me to work in my best interests.

I know there are aspects about myself that puzzle me, and other aspects that I do not know. But as long as I am friendly and loving to myself, I can courageously and hopefully look for the solutions to the puzzles and for ways to find out more about me.

However I look and sound, whatever I say and do, and whatever I think and feel at a given moment in time is me. This is authentic and represents where I am at that moment in time.

When I review later how I looked and sounded, what I said and did, and how I thought and felt, some parts may turn out to be unfitting. I can discard that which is unfitting, and keep that which proved fitting, and invent something new for that which I discarded.

I can see, hear, feel, think, say, and do. I have the tools to survive, to be close to others, to be productive, and to make sense and order out of the world of people and things outside of me.

I own me, and therefore I can engineer me.

I am me and I am okay.

by Virginia Satir

Appendix 5

VISUALIZING FEELING GOOD

(*To be preceded by relaxation exercise - Appendix 1)

Purpose: to learn a relaxation technique that will enable us to feel good about ourselves.

Procedure: When you are relaxed, think of a time when you were feeling especially good about yourself. Identify the scenery, the persons present, the time of day, what the weather was like. See if you can see the colours, smell the smells, hear the sounds. Get fully into the mood of that time and place. Enjoy being there and watch your feelings of well-being rise as you experience that scene and time.

PAUSE AND SUGGEST THAT:

Whenever we are feeling tired, bored, lacking energy, depressed or in a mood of low self-esteem, we can go to that spot and enjoy it. We can draw strength and energy from it and return refreshed and renewed.

Now, when you are ready, come back slowly to the group.

Discuss in the group:

How would it feel to come back to the time and place you visualized?

At what times would you wish to go back?

What was difficult about doing this visualization?

What was easy about doing this visualization?

Appendix 6

SELF AWARENESS WORKSHEET

Respond to the following questions:

1. Many people don't agree with me about
2. The happiest day in my life was
3. When I'm alone at home, I
4. My bluest days are
5. My best friend can be counted on to
6. I am best at
7. People can hurt my feelings most by
8. In a group I am
9. People who seldom let me know where they stand
10. People who agree with me make me feel
11. Strong independent people
12. When people depend on me, I
13. I get angry when
14. I have accomplished
15. I get a real pleasure from being part of a group when
16. People who expect a lot from me make me feel
17. The things that amuse me most are
18. I feel warmest toward a person when
19. I feel I can't get across to another person
20. What I want most in life is
21. When someone hurts me, I
22. I often find myself
23. I am

You may wish to share your responses in your group, with family, friends, etc.

Appendix 7

"PART OF THE BODY" EXERCISE

(*To be preceded by relaxation exercise - Appendix 1)

I'd like you to lie down, get as comfortable as you can. Close your eyes and notice your breathing . . . Try to feel your body physically . . . Feel your breath as it travels through your body into your arms and legs, chest and diaphragm . . . Now I'd like you to focus on the part of your body that you currently feel most unhappy about - it could be your legs, your stomach, your thighs, your breasts . . . . Review your feelings about this part of your body and see if you can get back to when you first became aware of it as part of you that you were not comfortable with . . . Let whatever memories that come to mind emerge . . . Now I'd like you to pinpoint what exactly it is about this part of you that you feel so rejecting of . . . How would you describe that part of you? . . . What does that say about you? . . . . What emotions is this part of your body expressing? . . . . Now I'd like you to imagine what <u>you</u> perceive as your ideal size . . . What happens to this part of you? . . . . Can you actually visualize how you would be? Try to feel your body changing . . . . If you really feel that this part of you would be more acceptable smaller, try to imagine yourself smaller and see how that feels . . . What does this part now express about you? . . . How do you feel in your body? . . . Let yourself experience whatever feelings that are aroused whether they are positive, negative or confusing . . . Now I'd like you to go back to your body as it is in reality, including the part that gives you so much distress, and just feel it again . . . Do you get any further associations to this part and what you so dislike about it? . . . Really let yourself explore this part of your body rather than judge it . . . Try to experience it as part of you . . . . Integrate it into the rest of your body . . . Now imagine again that you are your perceived ideal size . . . What happens to this part of your body? . . . What does being 'your ideal size' allow you to do in your imagination? . . . Do you approach the world differently? . . . Now think of a difficult situation you experienced this past week. Let the details of the situation come to life, and put yourself back into the situation but at your ideal size . . . Would it be different? Think it through carefully . . . When you are ready, return to the group . . .

Discuss:

1. What kind of associations did you come up with regarding that part of your body that you are most uncomfortable with?

2. Why do you dislike this part of your body?

3. Can you get in touch with any emotional issues this dislike might be masking?

4. Does preoccupation with this body part help you in any way?

5. What is the actual bodily function of this body part? How well does it perform its function for you? How do you feel about its function?

(Revised and adapted from Orbach, 1982:153-155).

Appendix 8

BODY TRACING

Purpose: To increase our awareness of, and appreciation for, our bodies.

Using large sheets of paper and felt markers, each member lies on her back on the paper while another member traces the outline of her body.

Discuss:

Reactions to the tracing - does the outline relate to your perception of your body?

Does the outline help you to change your perception of your body shape and size?

Appendix 9

OLD WOMAN

(*To be preceded by relaxation exercise - Appendix 1)

Purpose: To get in touch with the inner self through visualizing a spirit guide.

Pay attention to your breathing in this place at this time. Now imagine that you are walking in the woods, notice the ground beneath your feet. Hear the sounds around you. See the trees - experience their colour and their smell. Pause. Approaching you slowly on the path is an old woman who quietly asks if she may join you. Be aware as you walk together of her size, her eyes, her hair, what she is wearing. What else do you notice about her? Pause. You come to a clearing together and sit down on a log. If it is cold, light a fire to warm yourselves. You are protected in this place. Ask the old woman for whatever you would like from her right now. Maybe you want more than one thing. She is here for you. Pause. Take time now to appreciate this time you have had together and what you have received. Pause. Say goodbye to her and slowly retrace your steps through the woods. Feel how relaxed and calm you are. Pause. When you are out of the woods, open your eyes, stretch your body and slowly return to the room.

Allow time for sharing experiences.

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Appendix 10

CANDLE EXERCISE

Purpose: To terminate the group with caring and respect.

Lights off - the candle is lit - it symbolizes the 'beginning' the group has experienced. Group members 'give to' and 'receive from' each other a positive statement to take with them from the group experience. The group takes whatever time it needs. The candle is blown out by the group to symbolize the 'ending'.

Appendix 11

BODY IMAGE GROUP EVALUATION

I've listed a few questions below that I would like you to respond to. I have appreciated the feedback I have received from you thus far; these questions are specific to the group. The feedback will be considered by me for future groups of this nature that I hope to organize. The feedback I receive from each of you will be compiled and reported in my practicum report as group evaluation.

If you have any questions/comments please call me at: _____.

Thank you.

Lucille.

1. Did you find the group helpful to you during your hospital stay? If so, in what way.

2. Did you find the 2 hour duration too long? too short? just right?

3. Can you provide some feedback on the kind of room you would prefer to see it run in. Lighting? Carpet? Windows, etc.?

4. Do you have suggestions for change - new and different ideas - If you were organizing the group, what would you do differently?

5. What did you like the least about the group? the most?

6. Did the group help you to change your perception of your body/yourself?

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