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Holly G. Light
“I Feel Fat!”: How Do
Therapists Help Recovering
Female Anorectic Clients
Overcome Body Image
Issues?

ABSTRACT

This study was undertaken to explore how therapists help their adult, female anorectic clients (who are post-medical stabilization and have committed to some therapeutic level of treatment and recovery) overcome body image issues related to the pursuit of thinness prescribed by Western culture and the media.

Through interviews with ten therapists who had extensive experience working with anorectic women in recovery, this exploratory study examined clinicians’ experiences with clients’ body image issues and chief complaints, their strategies for treating the body image disturbance in their clients, their perceptions of what factors help someone to fully recover and what the most powerful messages are that someone who is fully recovered takes away, and finally their experience with treatment issues regarding women of color.

The findings revealed that therapists reported being “blended” in their psychological orientations, using a variety of interventions simultaneously – thus approaching the complex construct of body image in anorexia from multiple angles. The study also unveiled a creative range of 22 different interventions and approaches that therapists found helpful in approaching body image healing in anorexia. Finally some therapists believed strongly that there are specific issues pertaining to race, ethnicity and

the legacy of racism that are unique to the treatment of body image in women of color with anorexia.

“I FEEL FAT!”:
HOW DO THERAPISTS HELP RECOVERING FEMALE ANORECTIC CLIENTS
OVERCOME BODY IMAGE ISSUES?

A project based upon an independent investigation,
submitted in partial fulfillment of the requirements
for the degree of Master of Social Work.

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2008

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This thesis is dedicated to women liberators throughout the ages (both those well-known and the everyday she-roes and he-roes) who have fought to liberate us from the educational, economic, political, and cultural barriers that have at times held women back. May this work continue on all fronts and in particular, may there come a day when Western society accepts and celebrates women of all shapes, sizes and colors.

This thesis could not have been accomplished without the assistance of many people whose contributions are gratefully acknowledged. First, I wish to thank the clinicians who shared their time and experiences with me – and reinforced that this was a topic worth researching. Next I want to thank the faculty and administration at Smith College School for Social Work. You have provided me with an excellent education from which I am taking away professional knowledge, clinical experience, and important life lessons. Special thanks to Susan Donner for taking the time to get to know me and for her support. Much appreciation to Laura Rauscher for her invaluable assistance and friendship. I am also grateful to Leah Slivkoh and David Burton for their stimulating classes and introducing me to new therapies and paradigms for helping clients.

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CHAPTER I

INTRODUCTION

The purpose of this study is to answer the following question: “How do therapists help their adult, female anorectic clients (who are post medical stabilization and have committed to some level of therapeutic treatment and recovery) overcome body image issues related to the pursuit of thinness prescribed by Western culture and the media?” For the purpose of this study *body image issues* refers to “dissatisfaction with physical appearance and excessive importance given to physical appearance in self-evaluation” (Rosen, 1995, p. 93). In anorexia, critical evaluation of the self (specifically fear of gaining weight and fat) is the most important body image variable to overcome; however, in the body image literature for other eating disorders (which is beyond the scope of this investigation), “perceived scrutiny and negative evaluation of appearance by others” (Rosen, 1995, p. 332), is a second important variable. This researcher is focusing on clients who are medically stabilized because when a client’s body mass index (BMI) and other vital signs drop below a certain level, she does not have enough energy and “brain power” to engage in therapy. This means that when a person’s body weight drops below a BMI of 18, the body begins to consume itself because there is not enough incoming nutrition from food. This causes severe changes in brain chemistry which usually leads to mood destabilization, cognitive impairment, anxiety, a drop in body temperature and gradually, without treatment the internal organs begin to systematically shut down (Garner & Garfinkel, 1997). Therefore, the goal at that point is medical stabilization.

“I feel fat!” is a concern often voiced by anorectic clients who are in recovery and beginning to restore weight as a necessary part of treatment. Often therapists will attend to the word “feel” by responding that “fat” is not a feeling, and then explore the underlying feelings connoted for the client by this word. However, this researcher believes it is equally important for therapists to attend to the other underlying issue in that statement, namely that their client is suffering from extreme body image disturbance, stemming, to a significant degree, from lifelong exposure to the media engineered by Western culture (Hesse-Biber, Leavy, Quinn, & Zoino, 2006; Kilbourne, 1994; Surrey, 1991).

For therapists, body image issues are perhaps the hardest part of recovery to address for several reasons. First, therapists are primarily trained to treat intrapsychic and interpersonal phenomena as opposed to sociocultural phenomena like the “culture of thinness,” which will be discussed further in the literature review. Second, Western culture and the media are so pervasive in upholding the thin ideal for women that by the time a client comes in for treatment, this message has been thoroughly engrained in her. Finally, even if a therapist is able to help her client challenge media images during a fifty-minute session, as soon as the client walks out the door, she is back in the world of television, magazines, and billboards that tell her she is not thin enough. This researcher’s study about what approaches and interventions have been found to be effective in helping anorectic clients overcome body image issues will help therapists and clients with this difficult aspect of treatment and recovery.

Research on treating body image disturbance in eating disordered clients is limited, especially when the search is narrowed to treating anorexia. Review of the

literature reveals that while a great deal is known about psychological interventions for the treatment of non-eating-disordered individuals (e.g., individuals struggling with obesity, body-dysmorphia, and people who do not have an eating disorder but struggle with body image), there have been no large, outcome studies that evaluate change in body image specifically in anorectic populations (Rosen, 1995; Thompson, 1996). Cognitive behavioral therapy (CBT) has shown positive results in improving body image in people with bulimia but is less effective with anorectic women (Rosen, 1995). The essential features of Anorexia as defined by the DSM IV-TR are that an individual

refuses to maintain a minimally normal body weight, is intensely afraid of gaining weight, and exhibits a significant disturbance in the perception of the shape or size of his or her body. In addition, post-menarcheal females with this disorder are amenorrheic. (American Psychiatric Association, 2000, p. 583)

To learn more about what are effective interventions regarding body image in anorexia, this researcher conducted a qualitative research study by interviewing 10 licensed psychotherapists who specialize in treating anorexia and other eating disorders. From them, this researcher elicited what they believe has worked and not worked in terms of healing disturbed body image in their anorectic clients.

At this time, according to Crowther and Sherwood (1992) eating disorders (anorexia nervosa, bulimia nervosa, and binge eating disorder) affect 5–10 million girls and women and approximately one million boys and men in the United States (U.S.). The Anorexia and Bulimia Association (Wolf, 2002) reports that anorexia and bulimia strike a million women every year. Statistics regarding prognosis for both diseases are alarming. The National Association of Anorexia Nervosa and Associated Disorders (ANAD) reports “5% –10% of anorectics die within ten years after contracting the

disorder. 18%–20% of people with anorexia will be dead after twenty years, and only 30%–40% ever fully recover, while 20% bounce in and out of hospitals” (as cited in Costin, 1997, p. 20). Bulimia is estimated to occur four or five times more often than anorexia; however, it is more difficult to detect since many people with bulimia are not often underweight and may in fact be overweight. People with bulimia tend to feel shame about their gorge and purge episodes and are therefore secretive about them. Since frequently there is no obvious outward, physical manifestation of the disorder, it often goes undiagnosed unless a person suffering from bulimia seeks help for her or himself (Hesse-Biber et al., 2006). Because of this, it is difficult to estimate the number of people suffering from bulimia but bulimic symptoms can have grave medical consequences such as kidney failure and congestive heart failure (Garner & Garfinkel, 1997).

People with anorexia, as a client group, are known to be scared, stubborn and treatment resistant, especially around compliance with weight restoration. Understanding how to correct body image issues that have fueled this relentless and often lethal pursuit of thinness will be an important contribution to providing effective and lasting treatment for this disorder.

CHAPTER II

LITERATURE REVIEW

This chapter will first address the sociocultural influences that contribute to the pursuit of thinness and disturbed body image in anorectic clients. It will address the sociocultural influences generally as well as what has led to them from a White, feminist perspective. Second, this chapter will examine eating disorder and body image issues in women of color, and the complexity of issues around diagnosis including increased vulnerability as well as protective factors for this population. Finally, this chapter will discuss what research has thus far uncovered regarding techniques and approaches used by therapists to overcome body image issues in anorectic clients who are medically stabilized and committed, even if ambivalently, to recovery.

Although this literature review has a sociocultural/feminist focus, it is important to note that anorexia itself is caused by many psychological influences as well (although this will not be the focus of this thesis). Personality characteristics common across people with anorexia are perfectionism, rigidity, fear of biological and sexual maturation, need for control, and denial. In addition, women who suffer from anorexia have an underdeveloped sense of self, compounded by a need to please others. Usually it is the treatment of these psychological traits that requires long-term treatment (Garner & Garfinkel, 1997).

Sociocultural Influences

As stated in the introduction, there may be different individual reasons why different women develop anorexia, and in the past, clinical models used to explain eating disorders were often accompanied by little awareness of the social and/or environmental factors contributing to these disorders (Robertson, 1992). One factor that all people with anorexia share is an exposure to Western culture and media that uphold unrealistic standards of thinness as the ideal look for women. Through her study of the literature, this researcher has not come across any reports of anorexia reported in non-Western developing cultures and societies. This may be due to two salient factors. One prominent factor is the reality that many people in developing cultures have unstable economies where food can be scarce and its people may be actually dying from starvation. In contrast, eating disorders exist as a psychiatric illness solely in countries with stable economies where food is abundant (Surrey, 1991). Another major factor contributing to women's body image dissatisfaction and eating disorders is the multi-billion dollar media industry that advertises an unrealistically thin, Caucasian shape as the only standard of beauty/norm. Another phenomenon observed is that when non-Western, developing cultures come into contact with dominant Western cultures and adopt the media image ideals, there is a subsequent rise in eating disorders and body image dissatisfaction (Wolf, 2002).

Women's magazines have played a significant role in shaping women's perspectives about ideal body shape. They have existed since the 1860's and at the turn of the century began to take on advertisers. These magazines had always dictated women's fashion but in the late 1960's, as haute couture ended, they had to find another

area of focus. What was left? The body. Historian Roberta Pollack Seid (as cited in Wolf, 2002, p. 67) writes, “*Vogue* began to focus on the body as much as on the clothes, in part because there was little they could dictate with the anarchic styles.” Suddenly the number of articles related to dieting rose 70% from 1968–1972. In the popular press, articles on dieting soared from 60 in the year of 1979 to 66 in the month of January 1980 alone. By 1984, 300 diet books were on the shelves. In 1998 the Calorie Council National Survey stated that 54 million people (27% of Americans) were on a diet (Hesse-Biber et al., 2006). A new cultural obsession and related money making industries were born (Wolf, 2002).

Jean Kilbourne in her well-known documentary “Killing Us Softly: Advertising” and her follow-up book chapter “Still Killing Us Softly: Advertising” documents how the multi-billion dollar corporations hire advertising agencies to inculcate an impossible standard of thinness for women to aspire to in the form of media images. Only 5% of women in a normal weight distribution come near the ideal body type portrayed by advertising images in the media (Kilbourne, 1994). How do these relentless images of unrealistically thin models make the ordinary woman who is bombarded by them feel?

The tyranny of the ideal image makes almost all of us feel inferior. An internal voice rages at us: “You are fat. You are ugly. Your thighs are like jelly. You have cellulite. You have pimples. You have vaginal odor. Your hair is drab. Your skin is dry” (Kilbourne, 1994, p. 396).

The messages put forth by these ads teach women to hate their bodies and therefore, to learn to hate themselves. Women pay a high price for this self-hatred. There is persuasive evidence that negative self-image begets negative self-image,

accompanied by feelings of inferiority, anxiety, insecurity, and depression (Freedman, 1986; Wolf, 2002).

More and more, women are fed the message that the only way to remedy this situation and have the right body is if they consume more and more products. They are told to buy cellulite control cream, spot firming cream, even contouring shower and bath firming gel to get rid of the “dimpled” look. Many women believe that weight-loss can be achieved by buying “magic” diet pills, specialized/individualized meal plans/pre-packed foods/daily meal delivery services, work-out sessions with celebrity trainers, or membership with a weight-loss team or with a weight-loss coach or guru. Maine (2000) reports that during the 1990’s Americans spent an incredible 50 billion dollars annually on diet products alone.

Tiggerman and Pickering (1996) also comment on the media’s role and the socio-cultural pressure on women to be thin. The media “presents women with a constant barrage of idealized images of extremely thin women that are nearly impossible for most women to achieve (Tiggerman & Pickering, 1996, p. 199-200).” They continue:

Only the very thinnest 5-10% of all American women can actually acquire and easily maintain the supermodel’s salient, and most desired feature: her fat-free body. The remaining 90-95% of American women have fallen prey to the message that they are abnormal: that they improve their lives and selves only if they diet, exercise, and lose weight (p. 200).

They believe it is the onslaught of images of thinness that make women believe that the ideal body type is desirable and realistic.

Today, food, weight, eating patterns and body image have become a national obsession (Surrey, 1991). Estimates show that 20 million Americans are currently on a “serious diet” in order to lose weight. Dieting has become a rite of passage into

adulthood for females in a culture that has lost many rituals (Root, 1990). Americans spend more than \$40 billion a year on dieting products (Loeb, 2007).

This is an anomaly in human experience, where hunger and starvation haunt much of the world population. It has been viewed as a function of an affluent society – overfed, overstimulated by food, physically inactive, nutritionally unbalanced, and stressed (Surrey, 1991, p. 237-238).

What are the implications for women? While not many good epidemiological studies have been conducted, a Nielson survey (as cited in Surrey, 1991) revealed that 56% of all American women aged 25 – 45 were “dieting.” This survey also showed that by the standard of current medical definitions (as reflected in life insurance tables) more than 50% of American women are overweight. In the same study, self-report studies show that between 50% and 75% of American women consider themselves overweight. The extent of preoccupation, the number of serious diets attempted, and “the disturbances of self-esteem associated with perceived failure to meet the ideal body weight” all differ significantly for individual women; however, as Janet Surrey of the Stone Center points out, “if 50–75% of American women are living with day-to-day worry about weight control, I believe it must be taken as norm” (Surrey, 1991). By ideal weight, Surrey means the impossible standard of thinness that women hold themselves to.

Surrey points to a few other important studies that demonstrate how concern about weight and disturbed eating patterns can be taken as the norm for quite some time. Rosenbaum (1993) conducted a study with a sample of 30 girls of normal weight between the ages of 11 and 17. When asked to describe what they did not like about their bodies, the leading concerns were related to weight. The number one wish of most girls, when given three magic wishes for anything they wanted, was to lose weight and keep it off.

Around the same time, Garner and Garfinkel (as cited in Surrey, 1991) constructed the Eating Attitudes Test – an objective test of anorectic eating behavior. Other investigators, Thompson and Schwartz (as cited in Surrey, 1991), used the test to find out about the eating behaviors and patterns of a college age female population. They discovered that a large group of normal subjects received extremely high scores on the test, as high as anorectics in the clinical population. This study found that behavior similar to people with anorexia in the clinical population seemed to be prevalent in many apparently well-functioning college women as well.

A third important study was conducted by Surrey (as cited in Surrey, 1991) – a pilot survey of eating patterns at Wellesley College. The study examines a small sample (n=106, or 5% of the population). Important conclusions drawn include the following:

More than 25% of the students indicated that their present weight negatively affects their self-image to a large degree. One-third of the students said that they were always or almost always preoccupied with controlling their eating, and more than half expressed the wish that they could get help in changing their eating patterns. Half of the students surveyed expressed ‘fear of being overweight,’ ‘feeling guilty after eating,’ and ‘giving too much time and thought to eating.’ The young women reported particular difficulty in controlling their eating at night, when alone, and during periods of emotional or academic stress (p. 240).

Clearly there is a crisis in women’s self-image related to weight control (Surrey, 1991).

A Feminist Perspective

Feminist scholars argue that the thin ideal for women arose in reaction to women’s increased political power. As Naomi Wolf, feminist author and social critic, argues in her international best-seller *The Beauty Myth* (2002), throughout American history, the stronger women have become politically, the heavier the ideals of beauty have born down upon them, mostly in order to distract their energy and undermine their

progress. In other words, there is an inverse relationship between women's social and political empowerment and cultural pressure to conform to an unrealistic standard of beauty. In fact, cultural ideals construct the ideal body for both women and men and this changes over time. Currently, the rapid increase in disordered eating and eating disorders among women is just one of many cultural/historical changes that aim to profit from and subjugate women (Hesse-Biber et al., 2006; Kilbourne, 1994; Wolf & Crowther, 1992; Wolf, 2002). For example, the popularity of the flapper look came about when women gained the right to vote. In contrast, the ideal look for women was more voluptuous during the 1950's, a time of little progress, and some might argue regression on the part of the women's movement. Further, Twiggy, a supermodel from the 1960's who popularized the unnaturally thin look that many women today aspire to, was in vogue when women gained access to birth control and obtained a new level of educational opportunities (Brownell & Fairburn, 1995; Hesse-Biber et al., 2006; Wolf, 2002).

Wolf claims that hers is not a conspiracy theory, though others might read it that way. Rather she asserts, "Societies tell themselves necessary fictions in the same way that individuals and families do" (Wolf, 2002). Some of these social fictions include women aren't okay for men as they are; they have to shrink themselves to be pleasing and desired by men, making them vulnerable to developing eating disorders. Possibilities for women have become so open-ended that they challenge and threaten to destabilize traditionally male-dominated institutions. In response to this threat, a collective panic on the part of both sexes has arisen, as they strive to counter this liberating force by superimposing counter-images of an unrealistically thin, even emaciated, female body. Men are creating an unrealistic image/appearance standard for women, and sadly, women

have bought into this fiction as well. Since women historically have not been the holder of educational, economic and legal privilege, these possibilities for women may feel like an incredible triumph or an abject fear, depending on each woman's personal socialization (Wolf, 2002). Both genders colluded in this last battleground for equity. Men, primarily through fashion and diet industry, drove home the unattainable idea of thinness while women instead of fighting back, unfortunately internalized it.

Jean Kilbourne agrees with Wolf's premise (1994). Kilbourne demonstrates how the media and advertising use their tremendous power to influence cultural standards, leading women to believe they are only acceptable when they are as thin as the models they see in print ads and on TV. "This mass delusion sells a lot of products. It also causes enormous suffering for women, involving them in false quests for power and control, while deflecting attention and energy from that which might really empower them" (Kilbourne, 1994, p. 396). Kilbourne points out how ironically one ad slogan for Lady Stetson (a perfume fragrance) cries out "A Declaration of Independence." However, the relentless pursuit for a body as thin as the model's in this advertisement becomes a prison for many women; a woman cannot have agency in this world and have a body in the state of starvation at the same time. Not to mention the media message that a woman's natural body odor is not acceptable to men.

A related but different argument presented by feminists is that women's magazines and other media images have presented to women thinness as the symbol of progress towards women's liberation. "The thin body is [presented as] the antithesis to the ample feminine body, [connoting] highly valued characteristics such as independence and self-control" (Brownell & Fairburn, 1995, p. 226). Scholars on this side of the

argument believe that weight-loss in media images promises a myth of transformation. This myth leads a woman to believe that when she loses weight, to a point of unhealthy or excessive thinness, she will not only become more attractive but will also find a means of escape from traditional sex-role constraints along with interpersonal and financial success (Brownell & Fairburn, 1995). A similar argument put forth by Surrey is that “fat phobia” in Western Culture reflects a cultural debasing or devaluing of the full development of the adult woman (Surrey, 1991). She writes:

Perhaps the new cultural body ideals reflect the current cultural obsession with more traditionally male values, stressing linearity over fluidity, definitive ego boundaries over more permeable and flexible boundaries, and the discomfort with, and avoidance of, certain basic human needs for nurturance and contact (p. 243).

Feminist writers also find it interesting to notice the different associations puberty brings for girls versus boys in Western Culture. For many women preoccupation with body weight begins during adolescence (Surrey, 1991). According to Wooley and Wooley (as cited in Surrey, 1991) “the adolescent growth spurt, the normal tendency to gain weight, and the significant increase in body fat relative to overall weight associated with pubertal development in girls are important factors.” Adolescent girls gaining weight and experiencing the body as “getting fatter” seem to be catalysts for psychological disturbances in body image and the beginning of dieting in affluent countries where being thin is idolized. “Careful studies in the United States, the United Kingdom, and Sweden suggest an increase in eating disorders among the young adolescent group. The mean age for onset of anorexia is thought to be between 17 – 19 years of age” (Surrey, 1991, p. 238).

For boys it is a different story. When boys reach puberty their muscle increases as a percentage of overall body weight. Western culture views these changes as “highly desirable” (Surrey, 1991, p. 239). Normal adolescent boys typically experience these changes as “positive, self-affirming events” (Surrey, 1991, p. 239). However, it is important to note that some boys abuse steroids in order to further add bulk to their physique. The Western cultural standard places a lot of pressure on boys/men to magnify their size in order to feel sexually desirable to the opposite sex and to be perceived as the alpha-male amongst men peers.

An interesting survey conducted by Nyland (as cited in Surrey, 1991), underscores this disparity in this adolescent experience of the self. This survey was of all adolescents (2,370 subjects) in a Swedish town in 1970.

Most girls reported feeling “fat” at some time during this period. Of 14-year-old girls, 26% reported feeling fat; by age 18, the proportion was about 50%. In contrast, 7% of the boys ‘felt fat’ at age 18. For the girls, the percentage attempting to curtail their food intake was 10% of 14-year-olds and 40% of 18-year-olds. In contrast, boys seldom reported dieting (Surrey, 1991, p. 239).

In Western culture, fatness is associated with being weak-willed, docile, passive, dependent and unable to control “oral” impulses. Surrey asks the question: “Could it be that these traits are highly correlated with many of the same traits generally considered to be more ‘feminine’?” (Surrey, 1991, p. 241)

This pressure on women to pay close attention to harsh, external standards creates an accompanying diminishing in awareness of and a lack of attention to their own inner experience. Hilda Bruch, in her seminal and incisive analysis of anorexia, talks about this as the basic definition of anorexia – a girl’s loss of touch with her own inner hunger states. In an effort to meet the standards and expectations of important people in her life,

pleasing others becomes more important than learning to listen to oneself and giving voice to one's own needs and desires (Bruch, 1973). While this can be seen in its extreme form in women suffering from anorexia, it does not seem too improbable to generalize this phenomenon to women obsessed with meeting an extreme and rigid external standard of thinness engineered by Western Culture and the media.

Kilbourne notices how the message that women must be physically "beautiful" and seen and not heard is indoctrinated into girls starting at a young age. Children's television programs feature active boys and passive girls, sponsored by companies whose commercials promote action toys for boys and beauty products and dolls for girls. A print ad with the headline "Simply beautiful," shows a little girl, sitting at a vanity table, looking at herself in the mirror. "Imagine an ad like this featuring a boy: 'Simply handsome,' with a little boy looking into a mirror. Some people would recommend therapy, wouldn't they?" (Kilbourne, 1994, p. 398).

Hesse-Biber (2006) argues that women's crisis in self-image that leads them to focus almost exclusively on their bodies is a result of cultural messages fed to them that often reflect as well as perpetuate traditional gendered roles and perpetuate a mind/body split:

Western societies construct a duality between mind and body, and women are associated with the body and men with the mind. This allocation presumably occurs because of women's reproductive function... Western societies also define men's bodies as the standard against which women's bodies are judged, and women bodies are constructed as deviant in comparison (McKinley, 2002, p. 55).

One sees such a comparison as far back as ancient Greece. In the fourth century, Aristotle observes that men's abilities are superior to women's whom he calls "monsters...deviated from the generic human type" (as cited in Hesse-Biber et al., 2006,

p. 210). Similar to today, Aristotle sets women against the dominant male ideal and finds them lacking. He calls women “mutilated males” (as cited in Hesse-Biber et al., 2006, p. 210) who are “emotional and passive prisoners of their body functions” (Hesse-Biber et al., 2006, p. 210).

Today, the mind body split can still be observed in women who see themselves primarily as a body split off from a mind. One young woman in college writes:

My body is the most important thing. It’s like that’s all I ever had because that’s all everyone ever said about me. My mother would say that I am smart and stuff, but really they focused on my looks. And even my doctor enjoys my looks. He used to make me walk across the room to check my spine and he’d comment on how cute I walked, that I wiggled. Why comment on it at all? (Hesse-Biber et al., 2006, p. 210)

Western culture teaches young women how to be a body and states that their social worth is based on what they see in the mirror.

Body Image Disturbance and Ethnicity

The state of Research on Eating Disorders and Women of Color

American feminism is often criticized as representing only the perspective of White, middle-upper class women, and being poorly representative of ethnic minority and low socio-economic status populations. Science involving human subjects, too, is often negligent about considering ethnicity in the design of their research and in their findings. This has been primarily the case in the research of eating disorders as well. Particularly in early research, researchers who set the course of eating disorders research did not include women of color in their investigations, “possibly because it was assumed that these problems occurred only in White women” (Gilbert, 2003, p. 444). In fact, the common themes relevant to people with eating disorders (the pursuit of identity, power,

specialness, validation, self-esteem and respect) are themes that are also highly relevant to women of color. Research shows that young women and girls are developing eating disorders at younger ages and that eating disorders are no longer limited to a particular class, ethnicity or even gender as was “the conventional wisdom” of early researchers (Hesse-Biber et al., 2006). Therefore, the feminist perspective and eating disorder research are negligent in examining eating disorder and body image issues in women of color.

Another problem lies in the area of methodology, specifically, sampling. The current APA manual’s criteria for eating disorders have been normed exclusively on a White sample (Gilbert, 2003). Further, the settings in which eating disorder research takes place (e.g. private specialty clinics and university counseling centers) are unlikely to serve diverse populations with respect to ethnicity. Similarly, the fact that the majority of therapists treating eating disorders in their private practice are White and almost all nationally recognized eating disorders specialists are White also serve to perpetuate the stereotype that it is only White women and girls who develop eating disorders (Gilbert, 2003).

In the past two decades, eating disorders research has examined more diverse samples and

...conclusions about prevalence rates among diverse populations have been more mixed. It has become clear that women of color do suffer from diagnosable eating disorders and body image disturbances, including binge-eating disorder, which appears to occur with equal frequency across various racial groups or possibly more frequently among Black women (Gilbert, 2003, p. 444).

Furthermore, eating disorders among ethnic minorities may be on the rise “as a result of increasing assimilation to White culture, although there are contradictory findings on this

subject. Finally, few assessment measures and treatment approaches have been validated on diverse samples” (Gilbert, 2003, p. 444), and racially diverse research is often conducted on college students and does not take into account people of other social classes and ages (Hesse-Biber et al., 2006). For all these reasons, more research needs to be done on eating disorders and women of color and existing research on the prevalence rate of eating disorders among women of color needs to be considered with caution. For the most part, women of color have been excluded from theories that explain White middle and upper-middle class women’s troubles with food and body image (Hesse-Biber et al., 2006)

Prevalence of Eating Disorders Amongst Ethnic Minorities

Because large samples are needed to detect the prevalence rate of eating disorders, nationwide data regarding the prevalence of eating disorders amongst ethnic minorities is currently unavailable. In addition, as noted earlier, initial researchers of eating disorders did not include women of color in their investigations. However, individual studies show that body image and eating disorders are not just limited to White upper-class females but are salient for women of color too. For example, one recent study (Bay-Cheng, Zucker, & Stewart, 2002) examined a sample of women 18–45 years of age and discovered comparable levels of concern about weight and body dissatisfaction among Latina and White women, with African American women reporting the lowest levels of body concern among the three groups. These findings are consistent with two other studies (Joiner & Kashubeck, 1996; Perez, Voelz, Pettit, & Joiner Jr., 2002). These two studies also showed Latina women expressing levels of body

dissatisfaction and eating problems on par with those expressed by White women. (Gilbert, 2003).

Another study (Rosen et al., 1988) found high levels of body dissatisfaction and disturbed eating amongst Chippewa American Indian girls and women. The study had a sample size of 85 and found that 74% of the subjects were trying to lose weight. Of those subjects trying to lose weight, 75% were using unhealthy practices and 24% were using purging as a means of weight control. What these studies point to is the need for researchers to “examine differences among diverse groups of women of color, rather than assuming a ‘White-not White’ dichotomy” (Gilbert, 2003, p. 446).

The Complexity of Protective Factors in Women of Color

Clinical lore and limited empirical data suggest that the cultural contexts of people of color provide ‘protection’ against developing eating disorders (Root, 1990). One source of this protection is thought to lie in an “appreciation of a physiologically healthy body-size, less emphasis on physical acceptance, and stable family and social structures” (Root, 1990, p. 527). Women of color may also not compare themselves as much to images of thin, White women in the media and “may be more receptive to other influences such as family and friends” (Root, 1990, p. 527). Among African-American females, extensive kinship networks offer girls and women “a wider array of role models” to look up to (Root, 1990, p. 527).

While these protective factors may provide a buffer against eating disorders for the group, “it does not necessarily protect certain individuals” (Root, 1990, p. 527; Williamson, 1998). Individuals within each ethnic group can be strongly influenced by the dominant culture’s standard of beauty, “particularly when the culture-of-origin is

devalued by the dominant culture” (Root, 1990, p. 527). Some racial identity theorists, including Atkinson, Morton, and Sue (1979) posit that this devaluation of non-Western European originated groups leads to a stage within racial identity development where the person of color rejects their culture-of-origin during adolescence in an attempt to win approval or fit in with the dominant White culture.

According to Root, Fallon and Friedrich (as cited in Root, 1990, p. 527),

This stage of the process leaves an individual without a stable identity or feeling of positive uniqueness; the pursuit of uniqueness or specialness is a central goal for a person with an eating disorder. The process of this stage of ethnic/identity development converges in time with the developmental vulnerability to eating disorders.

The idea, then, of protective factors, is not as simplistic as many clinicians and the general public may believe. One needs to consider the “complex context within which people of color forge a positive self-image” (Root, 1990, p. 527).

One case study, put forth by Willemsen and Hoek (2006), illustrates perfectly this notion of how protective factors in Black culture may protect the group but still leave individuals vulnerable to pressures to assimilate into the dominant White culture. In their case study, a woman living in Curacao initially gained weight in order to become more voluptuous and desirable to Caribbean men. She states, “A woman can almost never be too fat. Even if I had weighed 80 kilos, men would have found me more attractive than if I were thin.” However, when her husband began abusing her, she deliberately lost weight to become less attractive to him. She succeeded, and her husband lost interest in her. Now thin, when she immigrated to the Netherlands, she observed mainly through television that in the Netherlands, being thin was desirable. She continued to lose weight, dropping to 42 kg. (Her highest weight had been 60 kg in Curacao). One can see from

this case that protective factors in this woman's culture cannot shield individuals who are susceptible to developing anorexia. Internalization of the Western ideal of thinness can play an important role in the developing of anorexia.

Problems in Diagnosing Disturbed Body Image and Eating Disorders in Women of Color

As earlier stated, the stereotype of who gets eating disorders (White upper-middle class women) negatively impacts mental health settings in terms of the research they conduct. It also does so from a clinical perspective. The mostly White clinicians in these settings may not be familiar with cultures, lifestyles and values other than that of the dominant culture to which they belong. Clinicians may not have the tools to conduct a culturally sensitive (not to mention gender sensitive) assessment. As an example, a stereotype of African-American and Latina women being plump may deter a clinician from asking her or him about eating and body image. Similarly, a clinician may not assess a thin, Japanese woman for an eating disorder (Root, 1990; Williamson, 1998).

Another problem in diagnosing eating disorders amongst minorities may be that many minorities are hesitant to seek out mental health services, particularly if this type of help-seeking runs counter to the values and beliefs held by their culture. In addition, a person of color may feel like they are "selling out" if they admit to having trouble with body image and eating since this is stereotypically a White and female problem. Having an eating disorder may lead a minority person to feel deviant which is opposite to the approval and acceptance they may be seeking (Thompson, 1994). Finally, a person of color who finds herself in an all White clinic may feel like an object of curiosity, on top of the distress, anxiety and powerlessness she might be feeling for other reasons (Root, 1990).

Increasing Vulnerability for Women of Color?

Several researchers (Hsu, 1987; Pumariega, Edwards, & Mitchell, 1984; Silber, 1984) have put forward the argument that eating disorders are becoming more common in American racial/ethnic minorities, particularly in African-Americans. This phenomenon can be explained by a convergence of factors. A pattern is emerging that may be repetitious of the pattern thought to contribute to eating disorders for White women.

Many of the factors that were thought to contribute to eating disorders in White women are now prevalent in ethnic communities and impact women in those communities negatively. While racism is still a significant obstacle to women of color in terms of social, vocational, and economic advancement, today women of color have more opportunities in these areas than ever before – particularly women who are able to act in ways that conform to the dominant White culture's norms (Root, 1990).

Because few 'successful' (by mainstream standards) ethnic role models exist, many women of color are forging new territories and subsequently may feel they are under tremendous pressure by being test cases, feel they must succeed for their families and all their 'sisters,' and/or are uncertain of standards by which they are being judged particularly in a sexist and racist environment (Root, 1990, p. 529).

According to Silber (1984) feeling the need to correct negative stereotypes about their ethnic group also leads many minorities who are upwardly, socially mobile to put pressure on themselves to look and act "perfectly." Similar to their White counterparts who sought acceptance in a sexist environment, women of color in these settings are vulnerable to believing that by looking like the models displayed in fashion magazines they can win acceptance by the dominant, White culture. Physical appearance (changes

in hairstyles, dress, body-size, make-up and even cosmetic surgery) becomes the ticket to acceptance and promotion. The double oppression of sexism and racism that women of color encounter may lead some women of color to develop unhealthy eating behaviors and distorted body image (Root, 1990).

In addition to the set of challenges for minority women associated with upward mobility, the dominant culture's devaluation of racial features, foods, rituals, and manners influences many women of color to go against their racial stereotype by adopting White standards – standards equated with success, power, respect, acceptance, and self-esteem. In some cases, women are so desiring to be accepted that they will renounce many aspects of their own culture and community-of-origin, and those desiring to fit into the White ideal may even disown attributes that are strongly linked to their ethnicity (e.g. accents, coloring or changing hair texture, food choices, recreational interests) (Root, 1990).

Mass media are largely responsible for oppressive stereotypes: women of color are either fat and powerless (African American and Latina women); fat, bossy, and asexual; corrupt and/or evil (Asian/Pacific Americans, Island and African Americans); obedient, quiet, and powerless (Latinas and Asian/Pacific Americans); exotic (Asian American, mixed race); or hysterical and stupid. American Indian and Alaskan Native women are virtually nonexistent (Root, 1990, p. 530)

These oppressive images cause some women to react by distancing themselves from their culture and community-of-origin. This, in turn, may result in questionable identity and sense of self-worth. “An eating disorder may develop as a way to continue to ensure acceptance and cope with identity issues” (Root, 1990, p. 530)

While proponents of the sociocultural model (like those discussed above) of eating disorders have put forth the argument that ethnic differences in body

dissatisfaction may be diminishing as the Western thin ideal increasingly influences minority women, Roberts, Cash, Feingold and Johnson (2006) conducted a meta-analysis of the literature and found that the relationship between Black-White ethnicity and body image is more complex than previously suggested.

This meta-analysis did find some support for the view that ethnic differences are lessening as the “White” standard of beauty is extended to and internalized by other ethnic groups. However, it also had findings that possibly support a more positive interpretation of the data namely that “as minority women gain greater prominence in the media, it is possible that these images are shaping White conceptions of beauty” (Roberts et al., 2006, p. 1124). Perhaps then, the convergence among Black and White races around body image is occurring not because Black women’s body image is worsening but rather because White women are becoming more content with their appearance. According to the authors of this study, “Unfortunately, it is impossible, on the basis of present research, to determine whether the overall level of body dissatisfaction is increasing or decreasing in either population” (Roberts et al., 2006, p. 1124)

This study looked at differences between Black and White women with regard to weight related measures as well as more global, body image measures. It found that differences in body image as evaluated by weight related measures, have reliably decreased over time. However, the opposite is true on more global body image measures, with increasing Black-White differences over time. “Together, these results suggest that ethnic differences cannot be explained by a single factor such as culturally induced pressure to be thin” (Roberts et al., 2006, p. 1125).

The study also found that ethnic differences in body image are most prominent in college age women. This is an interesting finding since boarding schools and colleges are known for being “breeding grounds” for eating disorders. The authors of this study hypothesize that perhaps a higher percentage of Black women either do not attend college or attend predominately Black colleges (where being thin is not stressed as much). Further, college years can be a time of heavy dating. Most White women believe they need to be thin in order to be attractive to White men, whereas Black women believe that Black men are attracted to heavier and shapelier women (Roberts et al., 2006).

Research on Treatment of Body Image in Anorexia

While a great deal is known about the efficacy of psychological interventions for the treatment of body image disturbance in obesity, body dysmorphic disorder, and non-eating disordered individuals (with clinically severe levels of body image concern) (Thompson, 1996), little is known about how to treat body image problems in anorexia and bulimia. This may seem counterintuitive at first, but makes sense upon further reflection. In anorexia and bulimia, therapists’ first priority is to gain immediate control over issues such as food avoidance or starvation, self-induced vomiting, abuse of laxatives and diet pills, and binge eating. Body image is seen as important but secondary. Furthermore, even if a person is able to recover from anorexia or bulimia, it does not mean that she has come to terms with her physical appearance and weight. Follow-up studies of anorexia and bulimia patients who restored body weight and ceased binge eating and vomiting show that about one- to two-thirds of these success cases still worry excessively about their physical appearance (Rosen, 1995).

Rosen conducted a literature review of body image assessment and treatment in controlled studies of eating disorders. Specifically he looked at: 1) pharmacotherapy; 2) CBT; 3) CBT with added exposure and response prevention (eating in therapy sessions without vomiting); 4) CBT and nonspecific therapy; 5) CBT vs. behavior therapy; and 6) psychoeducational group therapy. The pattern of body image procedures varied. Most studies included some assessment or treatment of body image, but one fourth showed neither. Finally, the studies refer mainly to patients with bulimia (Rosen, 1995).

Looking at pharmacotherapy, Rosen found that two of six pharmacotherapy studies that evaluated body image showed some success in bulimia. According to the Fluoxetine (Prozac) Bulimia Nervosa Collaborative Study Group (1992), Fluoxetine produced statistically significant decreases in body dissatisfaction in patients with bulimia. Examining studies that used tricyclics, according to Walsh, Hadigan, Devlin, Gladis, and Roose (1991), desipramine (Trazadone) showed some improvement in body image in bulimia. However, negative results for desipramine were reported by Leitenberg, Rosen, Wolf, Vara, Detzer, and Srebnik (1994). Finally Hsu, Clement, Santhuse, and Ju (1991) reported no improvement with lithium carbonate (the medication was also unsuccessful at changing eating and purging.)

All five studies that compared CBT to no treatment for people with bulimia showed statistically significant improvements in body image in patients who received CBT, whereas waiting list subjects did not improve (Freeman, Barry, Dunkeld-Turnbull, & Henderson, 1988; Laessle, Waadt, & Pirke, 1987; Leitenberg, Rosen, Gross, Nudelman, & Vara, 1988; Ordman & Kirschenbaum, 1985; Wolf & Crowther, 1992).

Two studies (Leitenberg et al., 1988; Wilson, Eldridge, Smith, & Niles, 1991) compared the standard CBT package with one that added exposure and response prevention (eating in therapy sessions without vomiting) for patients with bulimia. The latter offered the opportunity to discuss body image sensations and thoughts while the patient actually was eating. Findings were that subjects improved equally with either treatment format, although Wilson's patients were still within the clinical range for eating disorders.

Channon, de Silva, Hemsley, and Perkins (1989) found that CBT and nonspecific therapy were equally ineffective with people with anorexia. Kirkley, Schneider, Agras, and Bachman (1985) had the same findings with respect to people with bulimia.

There are only a few studies that compare CBT to Behavioral therapy and they refer only to people with bulimia. Freeman et al. (1988) found the treatments to be equally effective at post, but by follow-up, behavior therapy was superior. According to Fairburn, Jones, Peveler, Hope and O'Connor (1991) and Wolf and Crowther (1992), there was more body image improvement with CBT.

Although psychoeducation about body image issues, including the role of the media, can be an important part of recovery; psychoeducation alone is not effective in healing body image (Berry & Abramowitz, 1989; Connors, Johnson, & Stuckey, 1984; Wolchik, Weiss, & Katzman, 1986).

What conclusions does Rosen draw from these findings? Looking at the few studies that compared CBT that addressed body image with CBT that did not, CBT that addressed body image was more effective. However, it is interesting to note how several other pharmacotherapy and psychotherapy studies reported body image improvement

through a pre and post body image questionnaire, when body image was not directly addressed. “This raises questions about how body image might improve if not addressed in the context of treatment. Could it be mediated by changes in eating or self-esteem or mood?” (Rosen, 1995, p. 340).

While psychoeducation about how Western culture and the media manipulates how women see and value their bodies seems like it would be an important part of recovery, psychoeducation alone is not effective in improving body image; patients need active ways to resist the pressure to be thin. The psychoeducational component in the treatment of anorectics in recovery is seen as a necessary but adjunctive intervention.

Pharmacotherapy and CBT, the two leading treatments for bulimia, both produce about equal change in binge eating and vomiting. However, CBT seems to be more effective at treating body image issues in bulimia. Studies also show that CBT is much less effective for treating body image issues in anorexia than in bulimia.

Another recent study examined what effect mirror confrontation had in the treatment of body image disturbance within an inpatient program for anorexia (Key et al., 2002). The study compared group treatment with (standard) and without (modified) the repeated use of the mirror exposure exercise. Researchers “compared pretreatment and posttreatment measures of body image disturbance of the two therapy groups, which did not otherwise differ in treatment received. Six-month follow-up data were also collected on patients participating in the modified group” (Key et al., 2002).

Both treatment groups consisted of eight weekly sessions of 90 minutes and explored four main themes: 1) Understanding the formation of body, self, image and dissatisfaction; 2) Modification of intrusive thoughts and exploration of underlying

assumptions; 3) Exposure exercises to reduce body anxiety and the use of avoidance behavior; and 4) Development of a sexual self and the relationship to body image.

Therapists followed a written session-by-session manual consisting of a set format (Key et al., 2002).

Treatment for both groups included a mirror confrontation exercise in the first group; however, in the modified group, treatment continued to use mirror exercises in each of the following groups with increasing time spent on the mirror exercise for each person each week.

This exercise involved asking each woman to stand in front of a full-length mirror and look at her whole body (clothed) for increasing periods of time each week. In later sessions, participants were encouraged to wear more figure hugging clothes. A set time period for exposure was decided between the patient and therapist before exposure and may initially only have involved walking past the mirror. Goals were small enough to be achievable in keeping with the principles of systematic desensitization. The standard program used the mirror exercise only during the first session, although the mirror remained in the room for the duration for the program in both treatment conditions (Key et al., 2002, p. 187).

Results of the study were that no improvement occurred in the standard treatment group; however the modified treatment group showed “a significant and sustained reduction in body dissatisfaction and maturity fears at 6-month follow-up and a significant improvement in interoceptive awareness and body avoidance social activities over the group period” (Key et al., 2002, p. 188). The researchers attribute this improvement to the “powerful and immediate emotional experience” elicited by the mirror exercise and “prevented escape from that affect” (Key et al., 2002, p. 189). This response allowed therapists to more easily identify in patients the affective and behavioral components of body dissatisfaction and more cogent links into a developmental body image timeline. Additionally, that patients were able to spend an

increasing amount of time in front of the mirror each week meant that the women experienced a feeling of success.

Another recent study with positive results involves a computer program, the somatomorph matrix – designed by Gruber, Pope Borowiecki, and Cohanne (as cited in Benninghoven et al., 2006). This computer program allows for more accurate measurement and tracking of body image in people with eating disorders by breaking down body image into three components – actual body, perceived body and desired body. The study included 41 female patients with anorexia and 37 with bulimia during an inpatient stay. Researchers describe the somatomorph matrix and its use in the experiment as follows:

The instrument presents the subject with a drawing of a female body that she can ‘morph’ through 10 levels of muscularity and body fat (share of body fat in percent of total body mass. We asked each patient to choose images representing her best estimate of her own body and of the body she would like to have. (Benninghoven et al., 2006, p. 89).

Objective body fat was also measured by means of bioimpedance analysis (BIA).

The somatomorph allowed researchers to measure perceptual body size distortion by computing the difference between the objectively measured body fat (actual body) the body fat of the image representing the patient’s best estimate of her own body (perceived body). Body dissatisfaction was measured by computing the difference between the patient’s perceived body and the body of fat of the image she would like to have (desired body) (Benninghoven et al., 2006).

In this study, the inpatient psychosomatic treatment for patients with anorexia and bulimia included psychotherapy, pharmacology and medical as well as nursing interventions. Individual psychotherapy consisted of cognitive-behavioral and

psychodynamic approaches. In addition to individual psychotherapy, patients also received group therapy, family therapy, creative therapy, relaxation exercises, physical therapy, nutrition management and psychoeducation. Finally, patients participated in a body oriented treatment group (Concentrative Movement Therapy, CMT) three times per week. “The goals of CMT are: focusing attention towards body experiences, verbalizing these experiences and – if appropriate – reinterpreting them in the dialogue with other patients and the group psychotherapist” (Benninghoven et al., 2006, p. 91)

In terms of results, in the patients with anorexia, the objectively measured and the perceived percent body fat increased significantly throughout the course of treatment while the desired percent of body fat did not. In the patients with bulimia, “the body fat remained almost constant throughout the treatment, corresponding to a constant weight. The perceived body fat, however, decreased considerably, while the desired body fat remained the same” (Benninghoven et al., 2006). Body size perception was significantly distorted in both groups at the beginning of treatment. Both patients with anorexia and bulimia overestimated their real body. Overestimation was greater in patients with anorexia and did not change during the course of treatment. However, in the patients with bulimia, perceptual body size distortion decreased significantly. Bulimia patients assessed their body more accurately by the end of treatment. Looking at body dissatisfaction in the patients with anorexia, this measurement did not change during treatment. However, for patients with bulimia, body dissatisfaction decreased significantly by the end of treatment.

At first it might seem that treatment for patients with anorexia was not particularly effective. However, the patients with anorexia were able to tolerate a substantial increase in weight.

Reinterpreting the results from this point of view means that the anorexia patients at the end of treatment were at least able to keep a similar level of body dissatisfaction (difference between perceived and desired body) as at admission, although they not only gained weight (increase of actual body fat) but also perceived their bodies to be bigger than at admission (increase of perceived body fat). Also the distortion of body size perception did not change towards a negative direction although patients' actual and perceived body fat significantly increased. Possibly as an effect of treatment patients were able to tolerate changes of their bodies associated with the increase in weight without an increase of body dissatisfaction and perceptual body size distortion. This is remarkable for patients with anorexia since the main fear of the patients is to gain weight, and as a result, to become even more dissatisfied with their bodies (Benninghoven et al., 2006, p. 93)

Furthermore, these researchers argue that the somatomorph allowed them to pinpoint that additional treatment is needed specifically in the area of perceived body. If this were achieved, patients would more easily be able to adapt their body perception to the higher body weight.

For patients with bulimia, a correction in the perception of their body size took place. "At the end of treatment we still found an overestimation but it was clearly less pronounced than at the beginning of treatment" (Benninghoven et al., 2006, p. 93). Body dissatisfaction also decreased, researchers think, as a result of patients' ability to more accurately perceive the size of their body. It is through the somatomorph that components of body image can be accurately measured and tracked.

Cash and Deagle (1997) conducted a literature review to understand the nature and extent of body-image disturbance in anorexia and bulimia. According to Cash and Deagle (1997), most researchers break out body image into at least two components –

perceptual body-size distortion and cognitive-evaluative or attitudinal dissatisfaction. Similar to the definition used in the previous study involving the somatomorph, “perceptual distortion occurs when a person has difficulty accurately gauging her body size. Eating disordered individuals are hypothesized to estimate their size as larger than is objectively true” (Cash & Deagle, 1997, p. 108). Attitudinal distortion is also referred to as body dissatisfaction or disparagement. Even if an eating disordered client is able to estimate her body size accurately, she is “extremely dissatisfied with her size, shape, or some other aspect of body appearance” (Cash & Deagle, 1997, p. 108) and there is a large discrepancy in her perception of her body size and her ideal size. In their literature review, Cash and Deagle (1997) found these two variables to be largely independent.

In reviewing the literature, Cash and Deagle (1997) found that most research on body image and eating disorders has used perceptual assessment methods while fewer studies in eating disorders have looked closely at the attitudinal variable. Research of both perceptual and attitudinal variables is measured in two ways: 1) by having subjects focus on discrete parts of the body; and 2) by having subjects focus on their whole-body as a uniform gestalt. Cash and Deagle (1997) wished to better understand and clarify the nature and extent of dysfunctional body-image experiences among eating disordered people.

Of the 143 articles that Cash and Deagle (1997) examined, 66 met five basic criteria in order to be included in their meta-analysis.

1. The study looked at people diagnosed with anorexia and bulimia. Studies with quasi-clinical subjects were excluded.

2. The study included one or more control samples of women without eating disorders for reasons of comparison.
3. Any studies whose body image measurements confounded perceptual and attitudinal measures were eliminated.
4. The study provided baseline body-image data prior to any experimental manipulation or intervention.
5. There was sufficient information to compute effect size.

From their review, Cash and Deagle's (1997) most basic conclusion is that "women with clinical eating disorders do have greater body dissatisfaction and perceptual body-size distortion, as compared to women without these disorders" (Cash & Deagle, 1997, p. 116). Their review also yielded "strong evidence for the distinction between perceptual and attitudinal modalities of body experience" (Cash & Deagle, 1997, p. 116). As stated previously, the majority of research on body image in eating disorders examines perceptual disorder versus attitudinal disorder, probably because of the researchers' belief in perceptual distortion as "the central or distinctive body-image dysfunction in the eating disorders" (Cash & Deagle, 1997, p. 116). However, different from Benninghoven's study cited above, Cash and Deagle's (1997) literature review found that:

measures of attitudinal dissatisfaction yielded significantly and substantially larger effects than did body-size distortion indices between women with eating disorders and women without... This relative finding bolsters arguments that question the utility of the methodologies and measurements of the perceptual body-image construct and that regard size overestimation among patients with eating disorders to be a relatively weak, unstable, or nonpathognomic phenomenon" (p. 117).

In other words, how women with eating disorders versus women without saw their own body versus their ideal body (self-ideal discrepancy effects) was considerably

larger than any perceptual distortion. That attitudinal body distortion differs so significantly between women with and without eating disorders is remarkable, given the prevalence of negative body-image attitudes among women in general. Because of the sociocultural pressures to be thin as discussed in the literature review above, women in general suffer from a high degree of body dissatisfaction. That anorectic women's body dissatisfaction is that much higher than non-eating disordered women is noteworthy because any woman that is exposed to the Western ideal of thinness would almost have to develop a negative body-image because almost everywhere in her life she is being told that if she is not thin, she is not okay.

A second finding of Cash and Deagle's (1997) literature review is that when women with and without eating disorders were asked to estimate their whole body versus discrete body areas, there was a greater difference in how women with eating disorders perceived their whole body versus discrete body parts. This finding ruled out hypotheses made by other researchers that:

if certain body sites (e.g., hips or waist) are psychologically salient for an individual, a composite effect may be attenuated by inclusion of other less salient body sites. On the other hand, when forced to make only one gestalt estimate, one may disregard areas that are less important and give an estimate emphasizing those areas perceived as largest and most defining of body-image concerns. The comparison of whole-body procedures with body-part methods using the most distorted site, however, did not appreciably alter the finding of somewhat larger effects with the former (Cash & Deagle, 1997, p. 117).

To summarize Cash and Deagle's findings (1997), women with eating disorders overestimate the size of their body and have greater body dissatisfaction than women without. Regardless of size, women with eating disorders have the highest dissatisfaction with their bodies. Also, when comparing women with bulimia versus women with

anorexia, the bulimic women reported a much higher level of body dissatisfaction. Thus, it is important for researchers to appreciate the complexity of body image when planning their studies and interventions. This study by Cash and Deagle (1997) underscores the complexity of body image and points out that if researchers have good reason to evaluate perceptual disorder among people with eating disorders, they should concomitantly examine attitudinal disorders (looking specifically at self-ideal discrepancy) and compare its utility against the distortion index.

Conclusion

This literature review reveals that body image is a highly complex construct because there are three components to it (e.g. perception of body size vs. actual body size vs. ideal body size). It is the chronic discrepancy between actual and ideal body size that creates body dissatisfaction. Further, none of the studies reviewed focused on all three components of body image. Moreover, one literature review that examined the treatment of body image in anorexia and bulimia (Rosen, 1995) found that body image can improve without a specific body image treatment protocol. This raises the possibility that when a woman is successfully treated for anorexia (success would be defined by factors such as medical stabilization, weight restoration to set-point, return of menses and lowered distress tolerance to intake of nutrition), body image may also improve. In such cases mood and self-esteem appear to be mediating factors. This researcher's review of the literature found that the specific techniques used to improve body image with anorectics have mixed results. On the one hand, Rosen (1995) concludes that pharmacotherapy, CBT and stand-alone psychoeducation are not effective treatments for anorectics in recovery. On the other hand, one successful intervention seems to be mirror

desensitization. Overall, this review found a small group of disparate studies that studied specific body image interventions with eating disordered women. In the majority of studies, anorectic and bulimic women were studied together. This researcher's study is unique because she is only studying the body image component of treatment of women with anorexia.

This review also found that when examining body image issues, sociocultural factors play a large role. While it is debatable whether Western culture/media and the myth of the thin ideal cause women to become or stay anorectic, this myth is constantly perpetuated by the media and now influences girls at increasingly younger ages to go on diets which could place them at risk for developing an eating disorder. Feminists would argue that our culture of female beauty, that causes women to obsess about their weight and appearance, arose in response to female emancipation. This point of view cannot be "proven" but Wolf makes two notable observations. First, 95 to 99% of people suffering from anorexia and bulimia are women. Second, while the United States is the leading country in terms of women who have made it into the traditional male spheres, it also leads the world with the highest number of female anorectics (Wolf, 2002). This may suggest that there is a relationship between women's emancipation (i.e. choosing careers that were predominately male dominated and/or challenging traditionally female socialized roles in adulthood) and the genesis of eating disorders, which have only been reported in the last 40 to 50 years in American history.

A serious limitation in the body image field is that racial and class variables have been largely ignored. This perpetuates the stereotype that eating disorders are an upper-class, White woman's disease when in fact this may not be true. There are too few

studies to make any definitive conclusions about eating disorder and body image issues in African-Americans, Asian-Americans, Latinas and Native Americans. However, it is thought that as women of color begin to identify with the values of the dominant (White) culture, their risk for developing an eating disorder increases.

A critical part of recovering from anorexia is restoring weight and maintaining it. Developing a healthy body image is an important predictor of lasting recovery. Currently, research in this area is lacking. This study aims to learn more about effective treatments and interventions by talking to therapists about what has worked, as well as not worked, in the area of body image healing, out in the field with anorectic clients in recovery.

CHAPTER III

METHODOLOGY

The purpose of this study was to explore how therapists help their adult, female anorectic clients (who are post medical stabilization and have committed to some level of therapeutic treatment and recovery) overcome body image issues related to the pursuit of thinness prescribed by Western culture and the media. This researcher's instrument (face-to-face and phone interviews) asked participants 11 questions covering different facets of this research question including: therapist professional training on eating disorder/body image issues, therapists' treatment approaches of body image disturbance, time and frequency of body image healing interventions, how to counteract destructive media and sociocultural images, theoretical orientations, experience using Cognitive Behavioral Therapy (CBT), factors predicting a successful treatment outcome, practice of positive body messages when treatment is successful, client chief concerns, most challenging/resistant components of body image work, body image perception versus body image satisfaction, and treatment differences for people of color.

Since a review of past studies revealed that these questions had rarely been directly investigated before, an exploratory study using qualitative methods was chosen. Padgett (1998) states that when studying novel phenomena in social science research, qualitative methods are the method of choice because little is understood about the topic and qualitative inquiry focuses on depth-oriented experiences of participants. Also qualitative methods inspire the researcher to develop new theoretical propositions, which

can then be tested quantitatively with a larger population. In-depth, structured interviews were conducted with 10 clinicians who self-identified as having worked with at least one adult female anorectic client who was post medical stabilization and had restored weight to the point of reaching a Body Mass Index (BMI) of 19 and/or having restored their menses. Findings were then analyzed qualitatively.

Obtaining a Sample

The target size for this sample was 12. To qualify, participants had to be licensed psychotherapists (at the Masters level or above), with at least two years of post-license experience, who had worked with at least one adult female anorectic client who met this researcher's research criteria of having restored weight to the point of reaching a BMI of 19 or higher and/or restoring their menses.

Two lists were generated in order to obtain and select the sample. The first was a list of names of eating disorder specialists provided by an eating disorder expert who works in a college mental health setting. The second was a more extensive list of names from another eating disorder expert who works in an eating disorder intensive day treatment program in a hospital. Most of the professional contacts worked in an outpatient, private practice setting.

Potential participants were screened by phone to ensure they met the study's criteria, and then were scheduled for interviews. The small sample size meant it was not possible to reflect the wider diversity of all therapists in regard to gender, age, race/ethnicity, or religious affiliation. Diversity was further limited because all the participants worked in the Suburban Bay Area of Northern California and in the private

sector. This researcher attempted to reach a more diverse sample in San Francisco but was unsuccessful in this regard.

A total of 49 clinicians were contacted regarding participation and their eligibility in this study. Of the 49 contacted, 22 clinicians did not return calls, or this researcher began telephone exchanges with them but they ultimately ended up not following through. Three did not meet the criteria for having treated people who had advanced far enough in recovery. Nine specialized in treating adolescents, while this researcher's thesis focused on adult women. Five said that although they have treated people with eating disorders, they do not consider themselves specialists and did not feel comfortable participating in the interview for that reason. In the end, ten professionals agreed to be interviewed and fit the study's criteria.

Participants

The final sample was comprised of 10 participants (nine women and one man). One participant self-identified as AmerAsian (part Asian and part American of British descent); all other participants (n=9) self-identified as Caucasian. Two of those nine self-identified as Jewish. Participants held various degrees including M.D. (n=1), Doctorate (n=7) and Masters (n=2). Average number of years in practice was 18 (range 2.5 to 38 years). All ten clinicians specialized in working with eating disorders.

Data Collection

The design of this study was approved by the Human Subjects Review Board of the Smith College School for Social Work. Informed consent letters were sent to all potential participants (see Appendix B) in advance of the interviews. This letter

described the study and defined the selection criteria for participants. It also outlined the risks and benefits of participating in the study. Informed consent was obtained before the interviews began.

The method for data collection was an open-ended but structured interview that focused on the areas described above. Face-to-face interviews were conducted in the location designated by the participants, usually their office but on one occasion on the phone. The length of each interview ranged from 45 minutes to 1 hour and 30 minutes, depending upon the participant's responses. A pre-defined list of questions was used to guide the interviews (see Appendix C).

Data Analysis

Transcripts were reviewed to identify data relevant to the specific research areas which included: participant demographics and training; client body image issues and chief complaints; treatment of body image disturbance; positive body image beliefs and practices developed when recovery is successful; and factors that lead to recovery.

Interviews were analyzed, re-formatted, and color-coded to capture the relevant data according to each topic/question and across all participants, thus providing a visual representation of the data that allowed for easier identification of themes and patterns. Representative quotes were used to substantiate themes that emerged. Data were also compared to determine similarities and differences with respect to the literature review.

Due to the small sample size, narrow geographic location of participants (the suburban Bay Area) and selected qualitative research design, generalizations to the broader population cannot be made from the results of this study. Rather, the findings

provide an in-depth understanding of some of the experiences of clinicians who have worked with adult female anorectic clients (who are post medical stabilization and have committed to some level of therapeutic treatment and recovery). It is hoped the data gathered through this study and presented here will inspire and inform future research.

CHAPTER IV

FINDINGS

Demographic Data

Participant Demographics

As noted in the chapter on methodology, this study was based on in-depth interviews with ten therapists (nine women and one man) in the Bay Area who have treated clients with anorexia. The majority of participants self-identified as Caucasian (n=9) and one as AmerAsian (part Asian and part American of British descent). Of the Caucasian participants, two (one male, one female) self-identified as Jewish. Most of the participants were in their 40's (n=6). Participants' average age was 50.1 (range 34 to 72). Participants held various degrees including Masters (n=2), Doctorate (n=7) and M.D. (n=1). Average number of years in practice as a licensed psychotherapist was 18.0 (range 2.5 to 38). All of the clinicians (n=10) specialized in working with eating disorders. All of the participants (n=10) were in private practice at the time of the interview, however, one also ran a day treatment program in a hospital and another also worked in a college mental health clinic. More than half (n=6) had worked on a hospital in-patient, out-patient (or both) eating disorder unit before entering private practice. All participants were currently working in Northern California.

Client Demographics

Participants estimated working with a total of 5,635 clients whose diagnosis was anorexia nervosa (range 11 to 5,000). It was explained to participants that this research study is limited to studying what factors are helpful in body image healing of adult, anorectic female clients who have advanced far enough in recovery to have restored weight to the point of reaching a BMI of 19 or higher or to have restored their menses. Participants were asked to focus solely on that segment of patients who fit these criteria. Nine of the participants estimated that they worked with a total of 289 clients who meet this criterion (range 11 to 60). One participant who had reported treating 5,000 female anorectic clients stated that he could not estimate the number who had advanced to this stage but stated that “the vast majority” did.

Therapist Training

Participants were asked about their training and what type of special training they received in working with adult, anorectic clients in recovery. Specifically, they were asked if they received any such special training and if so, whether that training took place during graduate school or elsewhere in their training.

Training

Six of the ten participants stated that they received no formal training related to eating disorders in graduate school. One of the younger participants who is in her early 30’s did receive some training in graduate school. Another participant who is in her 40’s stated that she was fortunate enough to work on a research project about eating disorders during her undergraduate studies which sparked her interest in the field. The majority of participants (n=7) received their training “hands-on” in a hospital setting before moving

into private practice. One participant stated that she has received the majority of her training at professional conferences throughout the years. Another participant went to two specialized training sites, one in New York City and one in California. Both programs offered supervision, and group trainee discussion of articles, books and formal case presentations. Participant 3 noted that many of the formal training sites for eating disorders no longer exist due to lack of funding while ironically the number of women with eating disorders is on the rise.

Client Body Image Issues and Chief Complaints

This section contains participants' reports of client body image issues and complaints. Participants were asked three main questions regarding this area of exploration. First, what were clients' chief concerns regarding body image disturbance during this phase of treatment? Second, as therapists, what component of body image have they found most challenging/resistant to change in working with this segment of clients? The third question asked participants about their experience around overestimation of body size and/or body dissatisfaction resulting from the disparity between actual and ideal weight in their adult, female anorectic clients who have advanced in recovery, an issue raised in the literature.

Client Chief Concerns Regarding Body Image

In discussing the first question, all ten participants agreed that fear of gaining weight was the chief concern of their clients during this phase of treatment. According to Participant 5, "They [clients] do not believe they would ever be comfortable with any weight that was higher than the absolute lowest weight medically tolerable." Participant 5 also noted clients have an experiential fear when they eat, for example, five bites more of

a meal: “they don’t like the feeling in their stomach, they don’t like the feeling in their body, and anxiety comes up. Just these terror states.”

Not only was gaining weight a concern, but more than half of the participants (n=6) stated that gaining weight uncontrollably was also a primary fear. As Participant 10 put it,

The most common one [concern] was that they were going to become huge, that somehow they were going to end up looking like the ‘fat lady in the circus’ kind of thing. And of course they already felt huge. And once they gained a certain amount of weight to become more medically stable, they also felt huge.

Two participants noted that if clients were able to reach their medically stable weight, their chief complaint shifted into gaining fat in unacceptable areas. These areas included sexual parts of the body like hips, thighs and breasts as well as the belly and underarms.

Two other client concerns that participants mentioned were fear of gaining fat versus muscle, and feeling like other people won’t be attracted to them.

Five participants elaborated on different metaphors for what weight gain means to clients. Participant 1 believed that when clients talk about gaining weight they are talking about the negative parts of themselves that they dislike. She told this researcher,

A lot of therapists will say to the patient ‘Oh you’re not fat’ or ‘You’re not going to get fat’ in a way to try to reassure the patient. But the patient is not really reassured because they’re not really talking about weight. They’re talking about weight but they’re not. They’re talking about the negative parts of themselves that they don’t like. And you can’t really reassure somebody ‘Oh you don’t have those parts of self’ because we all do...The real question is ‘how do I live with these parts of myself that I don’t like?’ That’s what you have to address. So we have some really, really interesting questions.

Continuing with metaphors, Participant 5 then described how some clients are able to articulate certain associations they have with being skinny and waif-like, e.g., feeling fragile and beautiful versus feeling sturdy and strong. These clients believe that if

they gained more weight “then they would somehow feel like all the weight of the world is upon them and they have to carry on and that’s too hard and scary.”

Participant 7 then considered her clients’ starving themselves to be a metaphor for what they’re not allowing themselves to experience emotionally.

You tend to go back and forth on how they’re stopping themselves from being a certain kind of person – a sexual person, a powerful person, a loud person, a fulfilled person. And so I would say throughout treatment, we are constantly sort of weaving in and out of these themes.

Two participants regarded restricting food as a way for clients to feel “great” and “superior” and one of the only ways that the client has felt a sense of empowerment or that something was under their control. This perspective led them to ask clients and discuss such questions as: “How else would you like to feel empowered in your life?” or “How else would you like to feel as if you have some say in what your life’s like?” and “Can you make those things happen on more fronts than just keeping your body in jail?”

In answer to this question, three participants discussed how part of their patients’ concern over gaining weight stems from comparing themselves against cultural stereotypes and magazine models. Participant 1 talked about the privilege that her clients experienced from looking like a supermodel.

Lots of these women are able to finally talk about the privilege that comes with the way they look and how guilty they feel about being attached to that privilege. And yet when they can finally talk about that, and really trusting their bodies to the point where they might be ten pounds heavier than they are now. And that ten pounds might make a difference in the real world between somebody being perceived as sleek and walked out of a magazine or sort of more natural in their attractiveness. And there are certain privileges that come from a certain look. So they’ll talk about the fear of losing that privilege.

Component of Body Image Most Resistant to Change

In answer to the second question about what component of body image have they found most challenging/resistant to change in this segment of clients, participants had a variety of answers. Two participants believed that one of the hardest things for anorectic women in recovery is taking risks to trust their body and their appetite. For example, not counting calories for a day or letting themselves eat from a carton of something and trusting that at some point their body will tell them to stop. Participant 1 believed that brain chemistry and rigidity associated with anorexia makes relaxing caloric intake and trusting your body especially hard:

I think probably the brain chemistry of anorexia makes this particularly hard for people because there's so much rigidity and if they gain...it's hard to let themselves try something out and trust that whatever you find out you're going to survive. And so that aspect is really a kind of a global force that the patients are working against. They're trying to constantly work against in therapy. And you know you can think of that as anxiety. You can think of that as fear. You can conceptualize it in a lot of different ways, I think.

Participant 2 compared clients' fear of eating and relaxing caloric intake to a phobia and saw the most challenging aspect of recovery as getting clients to trust her that they will be okay at a higher weight and that they'll feel better; in this respect, she saw the therapeutic alliance as especially important:

The most challenging part is getting them to trust me. You know, I tell them, I promise things will get better with time but you've got to be willing to go through this initial phase of anxiety and horror and fear about the weight gain. And they don't know. Again, it's like if you're afraid of flying on planes, you're going to avoid flying on planes. You say I'm not going to go there. I'm not going to test that theory. It scares me too much. They do the same thing. They just avoid and avoid. And ultimately, they kind of have to turn their trust over to somebody and say, "okay I'm going to try it your way...we'll see where this goes." So the treatment alliance really matters.

Six participants elaborated in different ways on the way in which clients have a hard time liking and accepting their body at a weight that is healthy for them. Participant 4 explained:

I guess it would sort of be really accepting that the weight and shape that is healthiest for them is really okay. Does that make sense? 'Cause it's not just the weight on the scale, it's what their body actually looks like. So the curves, the fullness, the clothing size. But for them to really accept that this is really okay for them. They'll get there, they'll achieve it, they'll even maintain it, but they might hate themselves the whole time. So I think that is the hardest thing...to really get to a point where they're going okay, I'm good and I'm me.

Participant 5 thought that it is especially hard for a woman to like her body when it weighs more because she believed that, unlike for men, for women, there is not an acceptable range for what a woman's physique should look like:

And I think there's sort of a range of acceptability for men like having a football physique is fine. And having a basketball physique is fine. And having a runner's physique is fine. And having, you know, whatever. But for women, it hasn't occurred in the way that I hoped it might when women's athletics came to the fore...It hasn't broadened the range of the kind of look that's fine for females.

Participant 7 thought that when her clients believe that they have to look like a supermodel, it is a way of cutting themselves off from being in relationships.

So the idea that I can only be happy if my body looks the way some super models look is again keeping them out of relationships. They're wanting that admiration, that awe from afar but they're too frightened to put themselves into relationships.

Along analogous lines, Participant 9 saw this aspiring to be perfect as an underlying narcissism:

At some level, I think some of this is underlying narcissism in aspiring or thinking they can be perfect...some issues for dealing with feelings of shame for having failed or disappointed or not met some measure on something they see as controllable.

Participant 6 stated that body image distortion is the most resistant component to change. She said:

How they see themselves, sort of really not seeing how thin they are. I find it much easier for them to see the *effects* of the thinness like that they're not as strong to do their dancing, or other people are constantly worried about them. Those kinds of things keep them in the hospital and those kind of effects they can see when they get their bone scan.

As a client restores enough weight to menstruate and stays committed to treatment, Participant 3 found a variation on the above theme. Rather than not accepting her body as a whole, the client has a difficult time accepting specific body parts where she has put on fat:

And that's another piece to work through when it's not the whole body or weight per se but again, "I can't stand what's happening to my arms" or "I can't stand the fact that I see more than bone on my fingers." And "I feel I used to love my fingers, but now I have meat on my fingers so suddenly my fingers are stubby and ugly" (which they aren't at all). "And the veins don't pop out so much," so then the person feels "I'm fat."... So almost body dysmorphic concerns about specific body parts, and enemy number one seems to be belly fat.

Two Components of Body Image: Perceptual Distortion and Body Dissatisfaction

Under the section regarding client body image issues and complaints, the third question referred back to the literature and asked therapists what has been their experience around overestimation of body size (perceptual distortion) and/or body dissatisfaction resulting from the disparity between actual and ideal weight in their adult, female anorectic clients who have advanced in recovery. More than half (n=6) of participants believed that clients overestimate the size of their body. Participant 4 stated:

They can't estimate worth squat what they really look like. When I lecture, especially when I go to classroom kinds of settings, I will tell them that an anorectic woman will be able to look around this room and tell each and every one of you (never having met you before) pretty much the right height and the right weight for you. But herself, she can't do it. There's a whole distortion thing.

Participant 4 went on to tell an illustrative anecdote:

And I remember years ago, I had someone in my building come up to me and say, can I ask you what kind of work you do? And I'm like sure, I'm a therapist. He said, well you seem to see all these girls. And I said, yeah, I specialize in eating disorders. He's like, oh, I thought you were running a modeling agency or something. Because all these gorgeous, skinny girls were coming in and out of my office. And he had noticed that. That goes to show you right? So these girls are in my office crying hysterically, "I don't look good," and out in the world, they're seen as envied...

Participant 6 talked about how frustrating it was to work with this aspect of recovery told a similar story about how anorectic women can accurately perceive someone else's body size (including another anorectic woman) but not their own.

And what's so interesting is how they can see it in other people. It was really clear on an inpatient unit where they were around other kids. And they would look and say, "Oh my gosh, she looks scary," and they would be thinner... That's what I remember when I first started working with this population was "How could they not see it in themselves but they can see it in others?"

Two participants observed body image distortion in the early phases of recovery when an anorectic woman is malnourished. As their nutrition improves and they reach a BMI of 19 or 20, they see that shift. Participant 8 has found that good nutrition with an emphasis on high quality protein is the primary antidote to body image distortion. This participant cited examples where a client would look in the mirror and see themselves as fat, go eat some protein (because that's what this participant teaches his clients to do), come back to the mirror, and the distortion would be gone.

Other participants (n=4) disagreed; they did not really believe that anorectic women see their bodies as bigger than they are or do not believe that is the relevant question. As stated above, Participant 1 believed when an anorectic woman complains about being fat, she is complaining about the negative parts of herself:

Well, the perceptual thing is not very interesting. And I just don't think people understand what is really being expressed there. When somebody is saying "I'm

so fat! I'm so fat!" even though they're not, I think what they're saying is "I can see evidence on my body of my negative self"... You can argue forever about what are they really seeing in their mind's eye and all that. And it's just not a very interesting question. Who cares?

Participant 2 believed that anorectic women know they are thin and thinner than other people but it's not good enough. They want to be even thinner:

I mean they do feel fat but again, objectively they can say, I know that I'm not. So again, it's helping them get more realistic about...you know wanting to weigh 70, 80, or 90 pounds is not appropriate. It's not where you're going to function best. It's important to look at all the factors that make you think that's a good weight to be.

Regarding the question whether body dissatisfaction, resulting from the disparity between actual and ideal weight, has been a focal point in therapy, nine participants stated that it was. Participant 3 put it this way:

So clients who are at that stage, still it's a struggle because that means they've had to restore sufficiently enough that they're menstruating so they've achieved some status of health which is good. But they're probably still below their set point and need to keep working on that. So the sense of their actual size versus their ideal weight – so those are two very different numbers. And a hundred percent of the time, the ideal weight in their mind is a weight that will induce total clinical anorexia or a BMI of like 16 or 17.

Participant 5 blamed Western culture and the media for promoting the idea that adult women are supposed to look like prepubescent bodies:

I hear people who are sitting in front of me, and clearly almost skeletal, touching their thighs, and being able to pull a little bit of skin loose from the bone and say but look, that's fat. And as if that's a problem. And not get that yeah, we are going to have a little skin, a little muscle, a little fat covering the muscle, a little softness, you know that's a good thing. That's how bodies survive...And being able to make peace with the fact that bodies look like actual bodies rather than stuff in women's magazines is a big part of the journey.

Participant 1 whose views differed on this issue agreed that a disparity exists but thought, "that's not the interesting part of it":

...It's a relational issue I think. It has to do with your relationship with yourself. And how you treat yourself, and are you abusive to yourself or are you neglectful of yourself or are you nurturing of yourself. And the sort of surprising truth that you will experience the world the way you experience yourself and how you treat yourself. So you know if you're just walking around and thinking that you're the scum of the earth and there's a speck of fat on your body and you just deserve to be humiliated and rejected and so on and so forth, the whole universe is going to feel that way to you. And to me, that's where the problem is. And you do relationship work on that... You go back to John Gottman's work about what makes human relationships good and what makes human relationships toxic. We have some very good empirical research on that now... We internalize all these different kinds of relationships in ourselves and we have to work on them, and we have to make relationships between our parts of self better.

Treatment of Body Image Disturbance in Anorexia

The following section includes data on treatment approaches and interventions.

These include specific therapeutic approaches, time and frequency in therapy spent addressing body image issues, theoretical orientation, use of cognitive behavioral therapy, and counteracting sociocultural/media images in American culture that have impacted clients' body image.

Specific Therapeutic Approaches

Given clients' body image issues and chief complaints, participants were asked what specific approaches they found helpful in addressing clients' body image issues. Nine approached this "sticky" part of recovery from different angles, using various interventions and report being integrated in terms of theoretical interventions in their approach. Although there was much overlap between these nine participants' responses, there were also some approaches described that were unique. One participant approached the treatment of body image and the treatment of anorexia from a purely nutritional approach.

Although all ten participants worked in conjunction with a nutritionist and a medical doctor when treating a client with anorexia, only three talked about time spent in therapy focused on nutrition. Two believed that getting a client “nutritionally up to par” is more effective in treating body image disturbance than therapy. Participant 8 approaches the treatment of anorexia and body image healing from a purely nutritional standpoint:

Simply put, lots and lots of protein and a balanced diet that included some fat. Because fat is necessary for the menses to occur. And it is basically a balanced healthy diet that would be not the kind of diet that one often gets in packaged and processed foods and McDonald’s and stuff like that. But just basic healthy foods that people have been eating since time immemorial . That seems to have the greatest impact on their self-image from my perspective. So there are no specific therapeutic things except for helping them understand what is going on, why they feel so out of control and fat, and helping them understand the basic physiology that is distorting their concepts of themselves.

Three participants work to educate patients around the idea of a genetic set point and help them to accept that their body’s optimal weight (the weight where they feel and function best) is to a large degree genetically predetermined – just like their eye color or their height is. Participant 7 stated: “A lot of the work I do is also around body acceptance and giving up this illusion that you can pick the body that you want. That’s not up to us.”

Two participants reported that they “hit patients really, really hard with the physiological piece” and the biological effects of long-term anorexia, especially with respect to osteoporosis and infertility; and hence the necessity to choose health over harm.

Two other participants engaged their clients in body tracing and drawing. One exercise involved the client drawing what they think they look like and then tracing them

in a different color. Or tracing a client's body and having them talk about what feelings they associate with different parts of their bodies in order to help the client be in tune with how they are thinking about their body.

Four participants reported that their work is fueled by a feminist perspective; of those four, two have their clients read Naomi Wolf's, *The Beauty Myth* and one had them watch the video, *Killing Us Softly*. Participant 2 described how she tries to help her clients look at the socio-cultural context of their eating disorder, the focus that Western culture has on extreme thinness and how that is "completely unrealistic, unnatural and unachievable for 95% of the population." She put it this way:

So I try to get them more kind of focused on...again, you weren't born with this belief that thinness is attractive. Somebody drilled this into you. This has been forced upon you. I don't think that you consciously made this decision yourself. So looking at all the factors that have contributed to this whether it's watching the movies, or the magazines they're reading, or mothers or fathers or boyfriends telling them they need to be thinner. Who made you come to this conclusion?...So again, trying to empower them, get them enraged. Like wait a minute...This isn't fair! How did I get talked into this? I don't want to buy into this anymore! I want to fight back! And it works for some at different stages of recovery. Usually, the earlier someone is in their recovery, the less that tends to influence them. They either say, "I don't care." Or, "I still want to be thin." But I think the further along they are in their recovery, the more they can use that as strength to fight the system.

Two therapists in their work with clients' body image issues tried to help their clients examine "trade-offs" between what they lose being thin versus what they gain by being at a higher weight. Both these therapists cited this approach particularly when working with athletes and the fact that "you can't be strong and that thin...you can't have both." But even for clients who were not athletes, this approach was still cited as helpful in terms of helping clients try to take the focus off food and weight and instead focus on finding things they like to do, having fun, building relationships, developing a voice and

an identity, developing a wider emotional repertoire – all of which are hard to do when someone is wrapped up in an eating disorder.

Three participants cited helping clients integrate flaws and negative parts of themselves as central to their work on healing body image. One participant explained that as a client is more able to accept the different parts of herself (including “the good, the bad and the ugly”), she will in turn become more accepting of her body. As described earlier, Participant 1 in particular believed when an anorectic woman complains about being fat, she is complaining about the negative parts of herself; therefore a primary focus of recovery is to help the client develop a more harmonious relationship with the different parts of herself. She conceptualizes body image in terms of

the part of you that is talking when you say “I this” and “I that” and the part of you that is listening when you’re talking about your body. So when you’re saying things about your body (and they’re nasty things), you are also hearing it. You’re hearing it with a part of yourself that identifies with your body or your body self. It’s as if someone is saying all those things about you. So if someone is saying really nasty things about you, you’re probably going to feel bad. So the way that you feel better about your body is that you work on the relationship between these two parts of self, and maybe more parts of self (whatever’s relevant). And usually people with eating disorders have a very abusive or neglectful or both relationship between the “I” self and the “body self.” You know, what you experience of the universe is really much of your internal world. And when your internal world becomes this peaceful and cooperative kind of place, it just changes everything.

Two participants stated that they often hear clients with anorexia say that they don’t want to turn into their mother. However, they went on to explain that it’s more complicated than a client not liking her mother’s body. It’s also a bit of who she is and what she represents to the client; and so sometimes there was specific relational work to do and specific work around maturation issues – not wanting to become powerful, not

wanting to have more of your own voice. These two participants cited these issues as sometimes needing a lot of work and support.

In addressing body image issues, two participants found it helpful for clients to have another experience of their body besides the visual experience of looking at it in a mirror or looking down at a chair and seeing how big their thighs look. Participant 3 encourages her clients to do some sort of activity which will allow them to appreciate their body for what it can do and to experience a sense of mastery:

I encourage my clients to engage in some kind of body gratefulness/body appreciating activity. And usually that takes the form of yoga or some kind of dance therapy, movement therapy, so there is a way that the person can really experience having fun in one's body ...a slower, martial arts like karate or tai kwon do – something that helps them to appreciate being in their body that isn't about calorie burning which cardio has often become...So I encourage that, and most people really enjoy it and for the first time develop a capacity to enjoy their body, not in terms of how thin I am but in different ways of experiencing self and body such as mastery, the functioning, the strength, the power, the perseverance of cultivating an art and being able to do it well.

Participant 10 has clients tighten and release each part of their body – tighten and release their hands, and then their arms, and then their shoulders, and then their thighs, and so forth – so that they would start to have other kinds of senses of their body.

These two participants also mentioned as separate approaches other body gratefulness exercises. One tries to cultivate in her clients an awareness and gratitude for their mouths when they speak, for their arms when they hug someone. The other one cultivates this same sense of awareness and gratitude through body meditation assignments. For this Participant 3 uses a book called *Body Love* that is a book of 101 different meditations on the body. She believed the most powerful meditations are the ones that emphasize you only get one body:

And love it or hate it or be ambivalent towards it, it's the only one you're going to have in your life. And...even if you wish it so, even if you thought you wanted to throw your body away...you're not going to get another one...This is it. And given this is the only body you're going to get, and if you don't take care of it, you can die, let's talk about different ways to nurture your body. Because this is the only one you're going to get. Because somehow many people in recovery fantasize that they can change their body, or that they can will their body to stay a certain weight and have all sorts of fantasies about particular appearance and happiness which is in fact erroneous.

Another book that Participant 2 found helpful is called *A Case for Curves*. It is a book of beautiful images of women of larger sizes. This participant has her clients look at the images and some of them for the first time see women at healthy body weights represented in print in a beautiful way, and clients will tell this participant that they feel better after looking at that book. Participant 2 described why that is in the following way:

I think that's one thing that's so missing in our culture is just a diversity of sizes. That people don't get to see that okay people are short, and they're tall, and they're fat, and they're skinny, and they're shaped this way, and they're shaped that way...The research suggests that just a couple of minutes looking at a women's fashion magazine, your self-esteem plummets...Versus this book, women can actually say, "Yeah my body looks like this...cool." That's validating. That's kind of normal for a body to look like that.

To help women with their body image, two participants reported externalizing the eating disorder voice. Participant 2 explained how she connects the fear of fat with the eating disorder and presents a litany of evidence as to why the eating disorder voice is deceiving the client by telling her she is overweight:

This is not reality...this is part of the illness. The eating disorder makes you feel fat when you're not. It makes you obsess about weight when it's really not an issue. Everyone else can see that you're too thin. So helping them kind of differentiate their healthy, wiser, saner self from the voice of anorexia. So what does the eating disorder tell you? Okay so let's look at that more objectively and rationally. What is everyone else telling you? What are your doctors telling you? What is your therapist telling you? What are your friends telling you? Okay, is it

possible that the eating disorder is feeding you a bunch of lies? So I think...separating and externalizing the voice of the eating disorder.

While there was much overlap between participants' responses (as described above), there were also some unique approaches. Participant 1 believed it was important to focus on the brain chemistry and the mood dysregulation aspect of the disorder and believed it was important to work with a good psychopharmacologist. She believed that a lot of people with anorexia "probably in some other century would have some sort of OCD related thing; there's probably some hard wiring here that expresses itself differently in different cultures." She also believed that in some cases, there "could be some mild, delusional thinking" and a low dose, atypical anti-psychotic medication has helped a lot of her patients. She reported that antidepressants, on the other hand, "don't make a dent in anorexic behavior."

Participant 2 helps her clients realize that when they feel fatter on some days than others, objectively their weight has not gone up but that some disturbing issue is causing them to focus on that now.

So we can look at it just as a sign that something else is off kilter as opposed to the objective reality that 'I'm fat today.' Your weight probably didn't change overnight so it's probably a good clue that there's something psychological.

Another unique approach cited by Participant 3 was a spiritual one and seeing your body as a "temple for God":

And your body is actually really a sanctuary where God and you commune, and it is a really sacred entity. And only you get to be the gatekeeper. So when you harm it, it could weaken your relationship with the divine because it weakens your body, it weakens your mind. And if you behold your body as if it is God's temple, it is just shift in consciousness...

Participant 4 uses a variety of creative approaches to get at body image issues. She has her clients do collages on body work and pin them up in their room so that they

have a visual. She does exercises where she has them bring in various sizes of clothing that they have worn or wear to compare, “So I’ll lay the size zero on top of the size four.” She uses photographs at various stages. This participant also orders “People” magazine for her office and purposefully leaves out the cover stories about anorexia and eating disorders to provoke conversation versus thinking “Oh gosh, this is going to set them off. I’d much rather that they talk to me about it.”

Helping clients focus on other aspects of themselves, and helping them measure their worth by other means than a number or their weight has been an important piece of treatment for Participant 6: “To be able to have them think of themselves as something other than their weight and value other parts.”

Finally, one participant aims for the rate of weight gain to match the emotional development and growth in therapy. She has found that doing this helps the client experience the weight gain as “not so terrifying.”

Time and Frequency

In response to the literature, participants were asked if addressing issues around body image in therapy was something they discussed throughout recovery or something they saw as a discrete component of treatment that occurred at a specific point in time. Participant 1 reported “doing a little bit of both” and nine reported visiting it throughout. She was cited above as reporting conceptualizing body image as the ability to manage and integrate different parts of the self. She approaches the healing of body image both as a discrete component of treatment but also visits it throughout:

Umm. A little bit of both. This is a subject that is very close to my heart because my work is centered around body image. My web site, bodypositive.com...I put that up in the mid to late ‘90’s. It has been *the* body image web site for a gazillion

years now. So it's a really important thing. And it's also something that I conceptualize very differently from a lot of people. I try to teach people about body image in a different way.

The nine other participants who stated that they treat body image issues throughout recovery do so in large part due to clients' resistance to weight gain. As one participant put it:

Pretty much day one it's part of treatment. My goal for them is to gain weight and they are resistant, reluctant or fearful to gain weight. So it's talked about at every step of the way...how they're feeling about weight gain.

While nine participants discussed body image issues throughout, they differed on whether this was more of a focus at the beginning of treatment versus at a later stage. Two participants did not find it helpful to focus on body image at the beginning when the client is so nutritionally and psychologically compromised and instead chooses to focus on the re-feeding process. Seven participants, however, did address body image from the very beginning and gave different reasons for doing so. Participant 3 stated that one of her primary goals at the beginning of treatment is to sell clients on the fact that what they see in the mirror is a distortion of reality:

On the whole it has felt to me that at least in the way I do my work, there was not a strategically planned: "Okay, from week 6-12 we're going to really focus on body image issues." But it is more as it came up, which was pretty frequently. And the number one body image issue that we had to work on was more weight restoration and accepting that anorexia can be a brain illness, or a depletion of neurotransmitters in the brain that people can see themselves as fatter. But that's a distortion in their brain. The illness causes that, so educating clients about the biological correlates and brain correlates of what anorexia does [is important] and that was step one. And that is to have them accept that what they see in the mirror, what they are calling fat is a distortion of reality. That was a huge first hurdle.

Participant 5 in her assessment tried to:

find out at what point and what about their life experience has translated into "Oh, I'm too fat" as a conclusion. Maybe they were rejected by peers, or disappointed

in a love relationship, or upset about other areas in their life. At what point did it click into, “Oh, I better lose weight.”

Another participant addressed it in the beginning by “using the EDI [Eating Disorder Inventory] as an initial, right off the bat, information collector.” Participant 8 who found success in addressing body image disturbance through a nutritional approach with an emphasis on protein commented that body image is more of an issue at the beginning of treatment when clients are malnourished. He found that as clients recover nutritionally, their body image disturbance subsides substantially:

They do most of that discussion early on in treatment because as people get better physically and nutritionally, they seem to be able to handle the body image distortions because they become less and less prominent in their lives. I think in our society, all women (and some men) have major concerns about their body image. And I assume that’s always going to be on everybody’s mind, whether or not they have an eating disorder. It’s just on people’s mind. So then I don’t think it ever ends. But I don’t think it’s related to the disease itself except possibly in the early parts in the progression of the illness. As the illness gets better, so does the distortion

Theoretical Orientation

In discussing treatment, participants were asked what theoretical orientations they pull from when treating the body image component of anorexia nervosa. Eight participants reported being blended in terms of their approach, drawing from many different theories both because eating disorders are so complex and also in an effort to be comprehensive. These participants emphasized the need “to be able to juggle many different paradigms to see what might be helpful to a specific person at this time and given their belief structure in the context of their lives.” Two participants used a single theoretical approach in treating body image issues in anorectic women.

The list below shows the theoretical models identified most frequently by the participants (in order of frequency):

<u>Theoretical Model</u>	<u># of Participants</u>
Psychodynamic	9
Cognitive/CBT	7
Family Systems	4
Psychoeducation	3
Drawing	2
Control Mastery	1
Couples Therapy	1
Dialectical Behavioral Therapy	1
Guided Imagery	1
Interpersonal Therapy	1
Medical/Nutritional	1
Narrative Therapy	1

Of the nine that used a psychodynamic approach, two therapists specifically cited using self-psychology. One of these participants explained her reason for using self-psychology as follows:

...my notion being that it's problems with self-regulation of affect and problems with self-regulation within interpersonal relationships, and problems of distress tolerance and problems of being able to negotiate other aspects of ones life (particularly one's emotional turmoil) that get translated into a drama about the body.

Of the two whose work on body image was informed by only one theoretical orientation, one used an insight/psychodynamic approach and one used a

medical/nutritional approach. Participant 8 who reported using solely a medical nutritional approach was a psychiatrist, and he explained his unique stance:

It's basically a physiological orientation. There's no theory. It's well known physiological facts that occur in people who are malnourished which can easily come about in the kind of dieting people do today. So I don't belong to any school of thought except for basically it's a medical approach (if you want to use that term). It's a medical approach to treating psychological issues since I happen to be one of those rare people in the field of medicine and psychology that believes that the mind and body are truly integrated. And I think if anything, eating disorders teach us that better than any other disease I've ever run across.

Use of Cognitive Behavioral Therapy (CBT)

The majority of participants (n=8) reported using CBT in their work although none of them relied on it solely. The two who did not use it were Participant 8, who stated that he helps patients understand the basis of their distortions but doesn't believe he's doing formalized CBT and Participant 7 who saw it "as a structure for eating and exercise." Of those who use CBT as part of an integrated theoretical approach, three talked specifically about how they use CBT to help a client look at her belief systems.

Participant 1 put it this way:

I consider CBT a way to talk about a person's belief system. And it is part of so many different therapies. To sort of ask "What does that mean? If you say you feel fat, what would you be saying? What does fat mean? What does blowing up to 800 pounds mean?" And the CBT techniques are about teaching somebody that the meaning of what they do with these ideas makes them feel a certain way. And that they have an influence over how they feel by choosing the beliefs that they hold. And they have a way to evaluate their beliefs using logic and other forms of evidence.

This participant saw CBT like a "meditation technique." You can track what you're saying about yourself. When your attention shifts to something you don't want to be saying to or about yourself, you shift it back to the thing you want to be saying.

Participant 4 who also saw CBT as a way to evaluate a client's belief system enumerated some of the cognitive distortions that she believes are important to address in the treatment of anorexia:

...minimizing what is being gained by entering recovery while maximizing or catastrophizing what still isn't working or what it means to restore this weight and a lot of beliefs around thinness and happiness and superiority and those kind of rotate on the same axis. And the false sense of self-esteem that's attained by that.

Two participants discussed how they use CBT as a form of reality testing. One of the two, Participant 5, reported that even though she does not see herself as a CBT specialist, there are different behavioral approaches she has used on occasion.

One that comes to mind is I remember someone (and I sort of think of it as kind of reality testing) who was just kind of inconsolably bemoaning how fat she was and couldn't stop talking about how she wanted to be thin like her roommate. My guess, from my eyes, was that she was skinnier than her roommate but she couldn't get that. I finally convinced her to try on her roommate's pants which were too loose on her...And it was sort of a reality way to be able to feel, touch, look at and acknowledge, "Oh, maybe my eyes aren't quite accurate on this matter."

While most participants do use CBT, Participant 1 warned against the pitfalls of relying solely on it.

I just think if you only do that, what is hard for me to grasp and picture is how the relational part of that works when it's not really addressed. And a lot of the manualized kind of approaches, it seems like those sorts of issues are deliberately ignored; and I think anorexic people are incredibly good students and incredibly obedient and compliant, and they'll do your cognitive behavioral steps and do your structured workbook. Then they'll get a gold star. So what happens after they're no longer your patient? Have they done anything that they can claim for themselves? Have they done anything new that's different from being a good student? I think therapy ought to be more than what somebody's going to do from a book.

Sociocultural Issues

Nine participants addressed sociocultural/media images as a part of their treatment for anorexia and helped their clients find specific ways to counteract those

images. Six participants wanted their clients to understand eating disorders from a feminist/sociocultural standpoint. Of those six, Participant 1 believed anorexia is a disease of culture. She is also the founder of the body image web site, Bodypositive.com. She stated:

Every once in a while I'll tell a patient well I just got off the phone with a reporter from *Shape* magazine. They want to do their body image issue and they want bullet points on how to have a better body image and I told them well, you're going to have to say they shouldn't read your magazine. And the patient and I are having a good laugh.

In terms of techniques to counteract media images, Participant 1 said she will talk about the media and TV shows. And her clients will talk about size acceptance and how unusual it is to see that in Western culture. And sometimes her clients will talk about "seeing somebody who they recognize that they kind of admire – a fat person – who seems worthy of respect."

Participant 2 is a feminist and gives her clients lots of reading about eating disorders and the pressure to be thin from a feminist standpoint. Part of her intervention for anorexia is to help her clients get enraged about being talked into losing their power by adopting an eating disorder.

And again, I'm a feminist, so I do think there is something inherently sexist in that pressure to be thin. I think it takes away women's power. I think it makes them weak. And I think it makes them not think clearly, not think strong, not stand up for themselves...And I want them to fight back and not want to be a part of that. So they see my outrage and I hope that that's inspiring in some way. I try to get them equally outraged. You know it's not okay. How did I get talked into this?...And it works for some at different stages of recovery. They usually find the earlier someone is in their recovery, the less that tends to influence them. They either say, "I don't care." Or, "I still want to be thin." But I think the further along they are in their recovery, the more they can use that as strength to fight the system.

Participant 6 uses two specific techniques to counteract sociocultural/media images. One exercise she had her clients do was to walk around the street and pay attention to what percentage of people actually look like the people they see in magazine ads – “sort of trying to have them compare this image with the reality of what they see around them.” She also has them link weight to things like happiness:

Like who’s someone you know that’s happy that has a few extra pounds. Sort of like someone they respect. Or someone who doesn’t look like that. And so, do you need to look like that to be happy or successful?

Participant 8 talked about sociocultural/media influences at the beginning of treatment. He shows before and after photos of clients who got well and warns clients that they could become bulimic or obese if they don’t seek treatment. However, he finds as patients eat more, they’re less interested in comparing themselves with others.

Participant 7, who doesn’t spend a lot of time on sociocultural/media images, reported that she doesn’t think it’s productive to blame the media and that “it’s our choice to idolize them.” She felt that she could deal more easily with the wish to be awed and admired.

Full Recovery

This next section contains participants’ perspectives on clients who are fully recovered. Two questions clustered around this topic. First, participants were asked, “In your experience, what do you think are the most powerful messages that a client takes away from psychotherapy regarding positive body messages when treatment is successful?” Second, “For those anorectic clients that are in your opinion “fully recovered” what factors helped them to overcome their body image issues?”

Positive Body Messages

Participants' answers to the first question converged on several themes. Four participants believed a fully recovered person would be educated on their natural, genetic set point. Participant 2 elaborated on this saying that part of her work is to help convince clients that this is the weight where they will feel best, think more clearly, have good relationships, their emotions will be less dramatic, where they won't think about food all the time and where they'll be able to go out and have different foods and experiment and not be anxious. Participant 4 believed a recovered person would be able to stand up for herself and say, "I'm the expert on myself, and tough luck if you don't like how I look. This is my body, and this is what my body does naturally."

Four participants talked about how they hoped that their clients who are fully recovered would come to understand what do eating disorders mean from a feminist perspective, and as noted earlier, two mentioned having their clients read Naomi Wolf's *The Beauty Myth*.

Along the lines of incorporating a feminist perspective, two participants believed a fully recovered person would have a new appreciation for the female form. Participant 4 does a slide show where she shows the female form throughout the ages to point out how much culture dictates what is beautiful for a woman; whereas the female body itself basically stays the same.

Three participants believed that when a client is fully recovered, they will have made a commitment to health – being able to value health as they're thinking about how they look and changing the picture of how they want to look to include some healthy fat. Participant 8 who approaches eating disorders from a purely nutritional/medical model

stated that he does not pay a lot of attention to body image because he thinks it's putting the emphasis in the wrong place. His goal is health and "for somebody to have the best personality they can possibly have and to share that personality with the rest of the world."

Two participants echoed one another in terms of a fully recovered person being able to see their body as a partner and to see their body as whole, although they each put it in different ways. Participant 1 talked about trusting your body and having a partnership with it.

I think the most positive message is that you can trust your body. In fact I'm writing a chapter in a book about this – these moments of body trust and how recovery is sort of filled with these moments, small and large, of being able to see your body more as a partner. And sort of coming home to yourself.

Participant 3 stated this message in terms of a person feeling whole. Participant 3 hoped a recovered person would feel whole in their body and that there would not be this separation between the body and what the person weighs versus their mind, intellect, emotional life and interpersonal relationships. She hoped that all parts are harmonious and integrated. She further hoped that the body would no longer be a battleground on which to harm the self.

Participant 10 listed several positive body statements that she believed a fully recovered person would take away. These statements were congruent with other positive body themes mentioned above.

Factors that Lead to a Full Recovery

Participants gave a wide range of rich responses as to what factors help someone with anorexia recover fully. Four participants said in different words, developing other

interests that come to mean more or become more important than maintaining the eating disorder. Participant 1 called this “having a life” which she feels is “the best defense against having an eating disorder.” She also stated in answer to this question, that getting back on track developmentally is paramount to overcoming an eating disorder.

“Ultimately, you see somebody whose developmental unfolding has gotten derailed into the eating disorder behavior. And what you see happen when they get back on track is that they resume their developmental unfolding.” Participant 7 discussed the need for the person in recovery to find other focuses, other things that are important to them.

And I think it’s that [finding other focuses], or wanting to be successful in college and be able to sort of have a life, or it’s wanting to have friendships, sort of getting connected socially. So there’s something that drives them away from [the focus on body image]. They’re not just leaving behind the focus on body image but they’re going to something that’s valuable to them. And I think that has kind of been the most powerful thing. So if you’re going to drop this focus, there has to be some reason to do that, and something that you want to engage in. So it seems like I do a lot of focus on finding those things for people, to find some other way to feel valuable and connected.

Two participants talked about how people who are successful in recovery take risks and face their fear of allowing themselves to be at a healthier weight. Participant 1 stated:

The weight feeling is always the prognostic stick, if you can relax the weight feeling. One of the questions I ask people when I’m assessing them in the initial stages is whether they can allow their weight to fluctuate a little bit, and if so how much. And that is a pretty strong prognostic indicator about how much they’re going to be able to hang with this recovering, how quickly they’re going to be able to move through it, or how stuck they’re going to stay.

Participant 2 compared anorexia to a phobia.

It’s like a phobia. You’re phobic about being at this good, healthy weight, and as long as you continue to avoid that weight, you confirm the phobia. You prove it. Yup, it’s too devastating, it’s too scary, it’s too anxiety provoking. I can’t handle it. So they’ve got to be able to manage that initial anxiety and feeling to be at that

weight. And once you do that enough times, again, when you're stabilized at that weight and you've been there for a while, you desensitize yourself. You realize I can handle this, this is fine, I actually feel better at this weight.

Going hand-in-hand with taking risks, Participant 5 noted that a lessening of perfectionism is an important factor in making a full recovery.

Participants 4 and 5 described the importance of receiving love, both from oneself and others as an important factor in recovery. Participant 4 stated:

This is probably not clinical. I will tell you what I really think. When they are receiving a lot of love into their lives, I'll be honest with you, I think that's the most healing thing in the world. When they allow somebody to truly love them, I think that's the most healing piece of it. I think it starts with me. I think the relationship that I create with them and then being able to receive my genuine care for them starts it. I really believe that. I don't think I've got pearls of wisdom spouting out of me. I've done this work too long. It's about the relationship. It's what they're able to tell me. What they're able to confide in me, what they're able to share with me. That's truly the basis of this. So when they learn to let somebody in and to let somebody care for them and love them in a way, I think that's ultimately the most healing thing.

Participant 5 believed that more self-love as opposed to self-hate, more compassion and empathy for oneself enables one to finally decide "I don't want this for myself. I don't want to be hungry with my anorexic brain thinking about food and calories all the time."

Participant 7 saw "cognitive flexibility, maintained by good nutrition" as "number one [factor] by far." She saw cognitive flexibility as being intertwined with anxiety and being obsessive.

So whether it's temperament or not...I think, you know, that cognitive flexibility term that I'm using, I also think that tends to correlate usually with some lessening rates of depression and anxiety. So I think depression and anxiety are a set up for eating disorders but are also worsened by eating disorders. And you know, it can be created by eating disorders. So you see a lessening of anxiety, a lessening of depression, an increasing cognitive flexibility.

Participant 7 also believed that having good female role models can be an important positive influence for someone in recovery.

And what I mean by that are having role model or relationships with women their age or older who are powerful, productive, independent, outspoken – not sort of some female prototype, but are out there living their lives fully – help women want to be like that. I find that it's more helpful for people to have positive role models than somebody they don't want to be like, like their mother. It's harder to move away from somebody and you get more stuck in fear than moving towards somebody you want to be like.

Finally participant 7 has found that a woman with anorexia, by becoming more comfortable with her body sexually, can allow herself to change her body image.

Thinking that their sexuality is a good thing. Thinking that being in a relationship (typically with men but could be with women) is something that they're hoping for and look forward to. And that the idea of being touched and having a sexual life sounds appealing and playful. I think that and having an image of a relationship with a partner who is really a good friend as opposed to somebody who is going to hold them in esteem only for how they look. So those are factors that allow women to enjoy their bodies and enjoy a changed body image.

Participant 8 believed family and friend support is extremely important, and particularly, being surrounded by family and friends who are not image-oriented.

Getting the parents to not be themselves if they tend to be people who are very body image oriented. Getting them off that kick if I can. Very, very important. That really makes a difference to the patients. So friends and the kinds of friends they have. Relationships that they're into because many times because of the eating disorder they haven't seen themselves straight and they've gotten into bad relationships with people who are really disruptive in all kinds of ways. And they need to take a hard look at that. As they get better, that really makes a difference. Because I've seen this over and over again where people have changed their "best friends" as they're getting better because they've found that their "best friends" were less helpful than they had at one time thought.

Treatment issues regarding Women of Color

Participants were asked about their treatment of women of color. Specifically, how did these clients' body image issues and participants' subsequent treatment differ, if any, from clients who are White?

Four participants out of 10 believed that there were specific issues of race and ethnicity that were unique to women of color with anorexia. One participant (number 6) had only treated White women and girls, and five said their treatment did not differ.

Participant 1 has worked with African-American clients and stated that all of her clients had been under-diagnosed, “They had anorexia and had not been diagnosed properly. And the people who they were around just didn’t expect to see it. So they didn’t diagnose it.” Furthermore, according to this participant’s clients, there are certain issues stemming from our country’s legacy of racism that are at play in the treatment of African-American women. Participant 1’s African-American clients have shared with her that because there are so many Black men in jail and dying, it’s hard for them as Black women to feel like they’re on equal footing in a heterosexual relationship. Therefore, there is increased pressure to have the perfect body because these women feel that they are already coming from a disadvantaged position. A couple of her clients have stated, “I resent the perception that this isn’t a problem in my community. It absolutely is.” Participant 1 has also heard the same complaint voiced by the Lesbian community. While the Lesbian community “does have a way of accommodating the beauty of people of a lot of different sizes, it also has pockets, if not bigger than pockets, that are extremely fat phobic and thin obsessed as well.”

Participants 1, 3 and 5 talked about how in their treatment of women of color (collectively they have treated African-American, Asian-American and Native American women), clients were struggling to fit into a “White” standard of beauty. Participant 1 believes that this issue is “perpetually under-recognized.”

It's sort of like the argument Toni Morrison makes in *The Bluest Eye* that everybody is sort of given the same aesthetic standards to aspire to even if there's just no relevance about it. And so if you're African American, it's better to have lighter skin, it's better to have straighter hair. For Asian-Americans, it's better to have rounder eye... There was a body image essay in *Essence* back in the 1980's that said, there's every bit as much of the eating disorder symptomology among our readers as there are in the *Glamour* body image study."

Participant 3 noted in her treatment of Asian-American women, what she finds tragic, is how so often their eyelid surgery or nose surgery that helps them to come closer to a "White" standard of beauty has been a graduation gift from their mothers. Participant 3 notes, "So the family too, has bought into White standards of everything mainstream in order to fit in and to succeed." Participant 5 came up against the same issues in her treatment of a Native American woman who always felt "round and brown" compared to her White peers.

Participant 2 found that treatment differed for African-American and Latino clients, in a recovery-enhancing way. These women, she believed, came from cultures that were more accepting of larger female bodies.

While patients might not be identifying with that [acceptance of larger female bodies] in the moment, they can see that that possibility is out there – the fact that other people in their community may find larger bodies attractive... So I think it's been helpful that they have that to draw from.

Those participants who stated that their treatment of women of color did not differ from women who were White gave varying reasons. Participant 4 has experience treating African-American, Latino and Asian-American clients and shared that her treatment differs "very little." She elaborated: "And it really isn't that different because it's such an internal thing, especially with anorexia. So even though an African-American culture is where a larger woman is accepted, revered, found more beautiful, it doesn't matter to an

anorexic.” Participant 7 had treated some Asian-American women who were third generation and did not find that their treatment differed. Participant 8 stated that he has treated clients who are Asian, Asian-American, African-American, Latino, and White patients from a different culture such as Russia. (About a third of his current caseload is Asian-American.) Commenting on difference in treatment for racial and ethnic minorities, he stated: “No difference at all. They have the same symptoms, the same concerns. It’s amazing.”

Summary

The data presented in this chapter reflect the participating clinicians’ experiences of working with adult, female anorectic clients in recovery who have reached a BMI of 19 or higher and/or have restored their menses. There were differences in the clinicians’ discipline (i.e. psychiatry, psychology, and marriage and family therapist).

When discussing chief concerns regarding body image, participants unanimously agreed that fear of gaining weight was the chief concern of their clients during this post medical stabilization phase of treatment. More than half reported that gaining it uncontrollably was also a primary concern. Six elaborated on different metaphors that describe what gaining weight means to a client.

With regards to client body image issues and chief complaints, participants gave a variety of answers to the question about what component of body image have they have found most challenging or resistant to change. More than half agreed that clients’ accepting their body at a weight that is healthy for them is the most challenging component of treatment at this phase. More than half of the participants also believed that clients overestimate the size of their body and nine reported that body dissatisfaction,

resulting from disparity between actual and ideal weight, has been a focal point of therapy.

In thinking about the treatment of body image disturbance in anorexia, nine participants approached this challenging part of recovery from different angles, using various interventions and reported being integrated in terms of their theoretical interventions and in their approaches. One participant approached the treatment of body image and the treatment of anorexia from a purely nutritional orientation. Although there was much overlap between these nine participants' responses, there were also some approaches described that were unique. Specific approaches that were described by two or more participants included: educating clients around the idea of a genetic set point; educating clients on the biological effects of long-term anorexia; body tracing and drawing; fueling their work from a feminist perspective; helping clients examine "trade-offs" between what they lose being thin versus what they gain by being at a healthier weight; helping clients integrate flaws and negative parts of themselves; working through clients' fears of turning into their mother; engaging their clients in body gratefulness exercises; and externalizing the eating disorder voice.

Again with respect to treatment, regarding the question about time and frequency of addressing body image issues, all ten participants stated that they treat body image issues throughout recovery and do so in large part due to clients' resistance to weight gain. One also treats it as a distinct component of recovery. Seven participants reported treating body image from the very beginning while two did not find it helpful to focus on body image at the beginning when the client is so nutritionally compromised.

In terms of their theoretical orientation, eight participants reported being blended in terms of their theoretical interventions and approaches because eating disorders are so complex and also in an effort to be comprehensive. Two participants used a single theoretical approach in treating body image issues in anorectic women. None of the participants used CBT as a stand-alone approach but when integrating it as part of a broader treatment strategy, they found it to be helpful. All participants addressed sociocultural/media images and the pressure to be thin as part of therapy; however, they used a variety of techniques and interventions.

In evaluating treatment of clients who are fully recovered, participants listed several positive body statements that a fully recovered anorectic person would take away from treatment. Participant 10 summarized the statements of the other participants well in her response to this question:

Well, in terms of positive body messages, “My body is okay,” “I love my body,” “I love what my body can do,” “I feel good being in my body,” “How I look is not the sole criterion of my worth,” “What I weigh is not the sole criterion of my worth,” “I am a wonderful and valuable person and my body shape and size does not determine that.” So things where they can really accept who they are, feel good about who they are as people, and see their bodies as the vehicle of their soul and it’s what allows them to be on this planet...it’s not just this prison.

In discussing factors that lead to a full recovery, participants named a number of different factors that have helped their clients who are fully recovered overcome anorexia. These include: “having a life” and developing other interests that are more important than the eating disorder, getting back on track developmentally, taking risks and overcoming “the phobia” about being at a healthy weight, lessening of perfectionism, developing self-love and receiving love from others, “cognitive flexibility maintained by

good nutrition,” having good female role models, becoming comfortable with your body sexually, and finally, being surrounded by friends and family who are not image-oriented.

With respect to treating women of color with anorexia, four participants believed that there are issues in treatment unique to women of color and affect treatment while five did not believe treatment differed for racial and ethnic minorities. Collectively, these participants have treated African Americans, Latinos, Asian-Americans and Native Americans. One participant reported that she had only treated women who are White. Of those, who thought treatment for racial and ethnic minorities differed in certain respects gave several reasons and case examples to substantiate their belief. One stated that the African-American women she had treated had been misdiagnosed before they came to see her. She believes this population in general is under-diagnosed. She also cited an issue of *Essence* magazine which stated that eating disorders are every bit as much of an issue for their readers as for the readers of *Glamour* magazine.

Another treatment issue participant 1 talked about was about how the legacy of racism has played a role in the development of anorexia in African-American women. Because of the large number of African American men in jail or dying, her clients tell her that they do not feel like they are on equal footing in heterosexual relationships and that as a result, there feel an increase in pressure to have the “perfect body.”

Participants 1,3 and 5 talked about the pressure for women of color to assimilate to a “White” standard of beauty. Participant 3 noted how this plays out in her Asian-American clients who by the time they have come to recovery have frequently undergone plastic surgery for their eyelids and nose.

In summary, to learn more about what are effective interventions regarding body image in anorexia, this researcher conducted a qualitative research study by interviewing 10 licensed psychotherapists who specialize in treating anorexia and other eating disorders. From them, this researcher elicited what they believe has worked and what have been the challenges in terms of healing disturbed body image in their anorectic clients. Furthermore, this study sought to explore whether there are specific issues pertaining to race and ethnicity that are unique to the treatment of body image in women of color with anorexia. People with anorexia, as a client group, are known to be scared, stubborn and treatment resistant, especially around restoring their weight. Understanding how to correct body image issues that have fueled this relentless and often lethal pursuit of thinness is an important contribution to providing effective and lasting treatment for this disorder.

CHAPTER V

DISCUSSION

The purpose of this study was to answer the following question: “How do therapists help their adult, female anorectic clients overcome body image issues related to the pursuit of thinness prescribed by Western culture and the media?” For the purpose of this study, body image issues refer to “dissatisfaction with physical appearance and excessive importance given to physical appearance in self-evaluation” (Rosen, 1995, p. 331). In anorexia, critical evaluation of the self (specifically the fear of gaining weight and fat) is the most important body image variable to overcome. Study participants included nine female and one male mental health clinicians who have specialized in the treatment of eating disorders for two years or more.

The findings built on the literature regarding treatment of body image in anorexia, which consisted of a small number of disparate studies, most of which examined anorexia and bulimia together. This study was unique because it examined the treatment of body image in anorexia alone. It contributes to the existing literature by revealing the wide range of creative ways in which therapists practicing in the field tried to break through and transform their clients’ initial negative body image so that they can fully recover, embrace their natural set point, and prevent relapse.

Therapeutic Strategies for Helping Clients Overcome Body Image Issues

Because many of the previous studies examining body image in anorexia and bulimia and analyzed in Rosen’s review of the literature (1995) tended to study a stand-

alone approach to overcoming body image issues, they seemed to have missed a major finding of this study. Based on in-depth interviews with ten seasoned therapists (average number of years in practice was 18.0), who specialized in the field of eating disorders, this study found that all but two reported being “blended” in their psychological orientations and using a variety of interventions simultaneously – thus approaching the complex construct of body image in anorexia from multiple angles. This multi-pronged approach of the participants versus the single approach in some of the studies may account for why those studies discussed in the literature review found that the therapy or intervention they were studying was not effective compared to the self-report of the therapists interviewed in this study.

A second contribution to the literature is the discovery of the creative range of interventions that these therapists found helpful in approaching body image healing in anorexia. They included body tracing; educating clients around the idea of a genetic set point; educating clients on the biological effects of long-term anorexia; feminist-consciousness-raising; reading assignments including Naomi Wolf’s *The Beauty Myth* (2002); watching Jean Kilbourne’s documentary, *Still Killing us Softly* (Kilbourne, 1994); empowering clients to achieve something that they can claim as their own; helping refocus clients energy and concern off food and weight and onto meaningful activities (as one therapist put it, “getting a life”); looking at images of attractive fuller-figured women with curves in order to appreciate a diversity of sizes and counteract images of extremely thin women shown in the general media; externalizing the eating disorder voice; reconstructing critical events and moments – finding out how this all began; holding sacred one’s body as a temple for God; creating magazine collages; finding female role

models one admires who are not thin; using before and after photos of people who got well; helping clients to love, accept and value themselves; helping clients get comfortable with their sexuality; employing body gratefulness exercises; and lessening perfectionism.

Three additional approaches that stood out as unique and compelling warrant discussion. The first that stood out was a purely nutritional approach. Participant 8 (by far the most experienced both in terms of number of years having practiced and number of patients successfully treated, and the only psychiatrist) sees and treats anorexia solely as a nutritional/medical disease. While he was an outlier in viewing the disease solely from this one perspective and through a medical lens, other therapists interviewed also seemed to implicitly agree with his belief that nutrition is a vitally important, if not the most important component of recovery. Two other therapists talked about the rigidity in thinking that occurs when someone is underweight and that recovery cannot really proceed until nutritional restoration is in place. A third therapist echoed this point of view with a strong statement that nutritional restoration alone is more effective than psychotherapy. Although it is known and recognized that one of the primary treatment goals for someone with anorexia is to restore weight to the client's previous set point, in her review of the literature, this researcher did not find one study that addressed this or studied it as a specific way to correct body image disturbance and dissatisfaction. However, this researcher noted in her literature review that Rosen (1995) found that body image may improve without a specific body image treatment protocol. This raises the possibility that when a woman's weight returns to her normal set point, body image may also improve without any specific body image interventions.

A second approach that seemed compelling was treating anorexia and body image like a phobia. This theory and approach stood out because this therapist reported a high success rate (80%) and because, if anorexia is a kind of phobia, then successfully established protocols may be used. Perhaps the learning from the treatment of other phobias can be extended to anorexia. Participant 2 subscribes to this approach and runs a day treatment program where she eats and supervises meals with her patients every day. A major component of her treatment consists of educating and helping clients see that they have an irrational fear of eating and weight gain. She empathizes with patients that the first few meals will be terrifying but also reassures them that as they continue to confront their fears, eat regular meals, and restore their weight through good nutrition, their mood will improve, they will feel better about themselves, they will think more clearly, their relationships will improve, and their emotions will be less dramatic. She acknowledges that the therapeutic alliance and having her patients trust her is a key component to this approach. Interestingly, the study in the Literature Review that reported the greatest success in treating body image in anorexia was one that used a desensitization exercise – one empirically validated method for treating phobias (Key et al., 2002).

A third approach that stood out was a more psychodynamic approach taken by Participant 1 who is a nationally recognized expert on body image, has “*the*” body image web site (self-report), and is often quoted in women’s magazines and cited in academic journals on this subject. According to this therapist, when clients say they are afraid of becoming fat, that’s not what they’re really talking about. Instead, they’re talking about the negative parts of themselves that they don’t like. According to this therapist, the real

question is “How do I live with these parts of myself?” She believes this is one of the key questions that needs to be addressed in order to heal body image in anorexia. As she aptly put it, “what you experience of the universe is really much of your internal world. And when your internal world becomes this peaceful and cooperative kind of place, it just changes everything.”

A Sociocultural/Feminist Perspective

As this researcher stated, in her review of the literature, she did not find one report of anorexia in cultures that have not been exposed to Western culture and media. Nine out of ten participants addressed sociocultural/media images as a part of their treatment for anorexia and helped their clients find specific ways to counteract these images. One example given by a participant of how she perceives Western culture and media images continuing to oppress women was that even with the recent advent of women’s sports, there is still a much wider range of physiques that are acceptable for men than for women. For a man to have a runner’s physique, or a wrestler’s physique or a football physique is fine, she said, but not for most women.

Four therapists reported that their work is fueled by a feminist perspective. Two therapists reported having their clients read *The Beauty Myth* (Wolf, 2002), and one has her patients watch *Still Killing Us Softly* (Kilbourne, 1994). Participant 2 uses an unusual approach. She goes beyond educating her clients on the sociocultural component of anorexia and tries to empower them to “get enraged.” She admits that early on in therapy, patients will often say, “I don’t care” or “I still want to be thin.” But she believes that the further they are along in their recovery, “the more they can use that as strength to fight the system.”

Participant 2 also agrees with Wolf that women's magazines have played a detrimental role in how women see their bodies (Wolf, 2002). As an antidote, she shows them a book called, *A Case for Curves* (author not given). It is a book of beautiful images of women of larger sizes. She reported that clients tell her they do feel better about themselves after looking at that book.

Treatment Issues and Women of Color

Just under half (n=4) of the therapists interviewed stated that treatment issues of women of color with anorexia differ from women who are White. The other six stated that their treatment of racial and ethnic minorities did not differ in any way.

For therapists who believed that there were specific issues of race and ethnicity that were unique to women of color, their responses were consistent with the literature (Gilbert, 2003; Hsu, 1987; Pumariega et al., 1984; Root, 1990; Rosen et al., 1988; Silber, 1984; Williamson, 1998). Participant 1 stated that her clients with anorexia who are African-American had been misdiagnosed and she believes that, in general, African-Americans with anorexia are under-diagnosed because of the stereotype that anorexia is a White upper-middle/upper class disease. She reported that her African-American clients resent the perception that anorexia is not an issue in their community. On the contrary, these clients have told her, "It absolutely is." Participant 1 noted she has heard this complaint from her lesbian clients as well who attest that their community has pockets that are extremely fat phobic.

Participant 1 also referred to *Essence* magazine (a fashion magazine targeted at Black women), which, according to this participant, reported that eating disorders are every bit as much an issue for their readers as they are for the readers of *Glamour*

magazine. Her clients tell her that the legacy of racism also plays a role in the development of anorexia in African-American women. Because so many African-American men are in jail and dying, it is hard for them to feel like they are on equal footing in a heterosexual relationship. Thus, they feel increased pressure to have the perfect body.

Also consistent with the literature, Participants 1, 3 and 5 talked about the struggle of women of color to fit into a White standard of beauty. Collectively, these participants have treated African-American, Asian-American and Native American women in their practices. Participant 1 believes that this issue is “perpetually under-recognized.”

Participant 2 had a different perspective from the participants listed above that was also consistent with the literature. She saw being African-American or Latino a recovery-enhancing factor for clients because of the perceived acceptance of fuller body sizes. She admitted that at the beginning this was not something her clients necessarily embraced but it was at least a possibility they could draw from later on.

It is interesting that six participants did not see any unique issues for women of color and one wonders if, as stated in the literature review, this is due to the fact that early researchers who charted the course for eating disorder research did not take into account racial and ethnic minorities into their studies (Gilbert, 2003; Hesse-Biber et al., 2006). Furthermore, as stated above, the majority of therapists specializing in eating disorders are White as are the national eating disorder experts, thereby perpetuating the stereotype that anorexia is a White woman’s disease.

Beyond these particular therapeutic techniques and issues, this sample of ten therapists described 22 different approaches listed above to help their anorectic clients overcome body image issues (as previously defined). Anorexia is regarded as particularly difficult to treat, and this thesis contributes to the literature by uncovering, through semi-structured but open questions, the range of creative efforts developed by therapists who work with this pervasive, challenging disorder.

Strengths and Limitations of the Study

This researcher consulted with an outside eating disorder expert to develop the interview guide, which strengthened the validity and increased its utility in addressing pertinent experiences of clinicians. By using an open-ended questionnaire, participants were able to share their unique perspectives and experiences, thereby yielding rich and diverse data to add to the knowledge base. Many of the participants indicated that the study would be useful to them and they were interested in this researcher sharing the results. This is an indicator that the topic of the thesis has significant practical value.

At the same time, generalization to the larger population of clinicians is limited for several reasons. First, time constraints and limited resources only allowed for a small sample. The sample is not random. All the participants work in one, atypical area of the country. Their willingness to participate may contain a bias among all of the therapists asked. For example, they may have a more positive experience in treating clients with body image issues in anorexia than those who did not choose to be interviewed.

Other forms of bias may be inherent in the data. Researcher and interviewer bias cannot be ruled out. According to Anastas, an interview is “a special case of conversation...in which two participants are to one extent or another mutually

influencing the interaction and thus the data it will yield” (Anastas, 1999, p. 354). So, the intersubjective nature of the interview process could be biased by a number of qualities of the interviewer and participant.

This qualitative, exploratory study focused primarily on therapists’ perceptions of successful interventions of the healing of body image in anorexia. Appropriate future research would include follow-up studies that are longitudinal and follow these treatment interventions and their effects. This study focused solely on therapists’ points of view. In the future, it would also be important to find out clients’ perceptions of the different interventions discussed in this study, as well as the observations of significant others. This study revealed that treatment issues and interventions might differ by ethnicity and class so it would be important to break out the research in this way.

Implications for Clinical Practice and Future Research

This small, qualitative study contributes a new perspective on the literature by revealing the blended perspectives and creative interventions that therapists have devised to be effective with clients suffering from anorexia. Central to some of those interventions in the Findings is arming clients with knowledge and an attitude that can protect them when living in a culture that celebrates thinness and makes women feel inferior if they fail to measure up. One implication of this study is that the hands-on creative strategies that emerged need to be evaluated. Do they work? The participants who developed or used them think they do, but no one knows the degree to which they selectively remember their successes and forget about their failures.

Underlying the interventions used are dynamic differences that need assessment. Some are confrontational and challenging, even grounded in anger. How well do they

work? Others are supportive and nurturing, even spiritual. Are they more effective, perhaps, for some clients but not others? One implication is that therapists need to learn “different strokes for different folks.” One therapist’s anger-inducing therapeutic interventions may be effective for certain clients but not others, while a second therapist’s nurturing techniques may work better for certain of her clients, while others would benefit more from the approach of the first. For this reason, more research needs to be done on anorectic clients, identifying ways in which they understand their body image issues at different stages of recovery, different needs they have, and how they respond to different body image healing interventions. More research on clients would also fill in missing data on outcomes; for few of the interventions unveiled in this study have been evaluated in terms of long-term impact on clients’ lives.

The revelation of so many interventions for reaching clients with anorexia and helping them cope with feeling fat in a commercial culture that emphasizes thinness suggests that therapists could benefit from learning what others are doing and by considering ways to combine therapeutic approaches. To facilitate this, the approaches could be organized into a matrix and clustered by distinctive characteristics. For example, some focus on consciousness-raising, while others focus on helping the client to become more engaged with her life, such as finding and pursuing a hobby or special interest. Still others involve pictures and visuals. A fourth dimension that characterizes some of these interventions is improved self-image. Or, the deeper dimension of learning to accept and integrate different parts of one’s self and coming to terms with one’s body, and temperament. Therapy for this stubborn disorder, where therapists often struggle for months or years trying to make progress, could benefit from trying a combination of

interventions from each of the categories. It would make sense to raise a client's consciousness *and* use visuals *and* support a process of feeling good about who you are. The above might make sense as an edited book in which therapists each describe an intervention, the thinking behind it, and how it works in practice.

At the same time, if the nutritional/physiological dimension is so central to not only gaining a healthy weight but also to thinking sensibly and feeling better, as it seems to be, then all therapists who specialize in treating anorexia should take a course on this subject. This study did not investigate whether there are different interventions or schools of thought about restoring good nutrition, and that needs to be researched.

Likewise, the idea of one therapist that anorexia works like a phobia might be a key insight that could move therapy from developing "home-grown" techniques to realizing that well-established theory and practice known to work on other phobias can be applied to treating clients with anorexia. Further research needs to investigate this possibility, and controlled trials would be warranted. Since the phobia concerns food intake and nutrition, these two seminal ideas could be combined to form a highly skilled approach to the successful treatment of anorexia – a nutritional program together with cognitive therapy for a phobia. This thesis opens doors to better therapy for healing body image issues in clients with anorexia

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Appendix A

HUMAN SUBJECTS REVIEW COMMITTEE APPROVAL LETTER

February 6, 2007

Holly Light
3012 ½ Partridge Avenue
Oakland, CA 94605

Dear Holly,

Your amended materials have been reviewed. You have done an excellent job with your revisions and all is in order. We are now happy to give final approval to this interesting study.

Please note the following requirements:

Consent Forms: All subjects should be given a copy of the consent form.

Maintaining Data: You must retain signed consent documents for at least three (3) years past completion of the research activity.

In addition, these requirements may also be applicable:

Amendments: If you wish to change any aspect of the study (such as design, procedures, consent forms or subject population), please submit these changes to the Committee.

Renewal: You are required to apply for renewal of approval every year for as long as the study is active.

Completion: You are required to notify the Chair of the Human Subjects Review Committee when your study is completed (data collection finished). This requirement is met by completion of the thesis project during the Third Summer.

Good luck with your project.

Sincerely,

Ann Hartman, D.S.W.
Chair, Human Subjects Review Committee

CC: Fred Newdom, Research Advisor

Appendix B

INFORMED CONSENT FORM

April 23, 2007

Dear Potential Research Participant:

My name is Holly Light, and I am a graduate student at Smith College School for Social Work. I am conducting a study on how therapists help anorectic clients (who are post-medical-stabilization and committed, even if ambivalently, to recovery) overcome body image issues related to the pursuit of thinness prescribed by Western culture and the media. Data obtained in this study will be used solely to complete my master's thesis topic.

Your participation is requested because you specialize in treating anorexia and other eating disorders. If you are interested in participating in this study, you must have been treating this population for at least three years. If you choose to participate, I will interview you about your experience in working with this population. The interview will be conducted in person, will be tape-recorded, and will last approximately one hour. At the start of the interview, I will be collecting some demographic data about you, the clinician. The risks of participation are minimal.

The benefits of participating in this study are that you have the opportunity to contribute to an area of research that is relatively new, and to enlighten other clinicians in the field about important and helpful interventions to heal body image in anorexic clients.

To protect confidentiality, I will label all interview notes with a pseudonym instead of your real name. I will delete any identifying material in the tapes and none

will appear in the transcriptions. I will keep signed, Informed Consent forms separate from other materials, and the two will only be connected through assigned pseudonym. My thesis advisor will have access to the data only after identifying information has been removed. I will lock consent forms versus audio tapes and interview notes in two separate file drawers during the thesis process and for three years thereafter, in accordance with federal regulations. At such time, I will either maintain the material in their secure locations or destroy it. If an additional data handler, transcriber, or analyst is used in this study, I will require him or her to sign a confidentiality agreement. Please remember not to use any identifying information when describing your clients.

Participation in this study is completely voluntary. You may refuse to answer any interview question(s), and you may withdraw from the study at any time without penalty by indicating in writing that you are no longer interested in participating. If you withdraw, all materials pertaining to your participation will be immediately destroyed. You have until April 31, 2007 to withdraw from the study; after this date, I will begin writing the Results and Discussion sections of my thesis.

YOUR SIGNATURE INDICATES THAT YOU HAVE READ AND UNDERSTAND THE ABOVE INFORMATION AND THAT YOU HAVE HAD THE OPPORTUNITY TO ASK QUESTIONS ABOUT THE STUDY, YOUR PARTICIPATION, AND YOUR RIGHTS AND THAT YOU AGREE TO PARTICIPATE IN THE STUDY.

Signature of Participant

Date

If you have any further questions about this study, participation, rights of participants, or this consent form, please feel free to ask me at the contact information below. (I suggest that you keep a copy of this consent form for your records.) Thank you for your time, and I greatly look forward to having you as a participant in my study.

Sincerely,

Holly Light

510.648.5905

hlight@email.smith.edu

APPENDIX C

INTERVIEW GUIDE

First, I need to ask you a couple of demographic and informational questions before we get into the interview questions.

Can I start with your current age?

And the ethnicity with which you identify?

What is your professional degree?

For how many years have you been practicing psychotherapy (as a licensed mental health professional)?

For how many years have you been treating clients with anorexia and other eating disorders as a licensed psychotherapist?

What is the treatment setting under which you have primarily treated your eating disorder clients (private practice, college mental health, outpatient group therapy, day treatment, residential treatment, hospital outpatient, hospital inpatient)?

Approximately, how many cases of anorexia have you treated post-license?

Have you treated patients who are committed to recovery as evidenced in part by restoring weight to a BMI of 19 or higher?

What has been the menstrual status of clients who have successfully graduated from therapy with you?

Approximately, how many cases of anorexia have you treated where the client is committed to recovery as evidenced in part by getting their period without birth control?

As we discussed, this research study is limited to studying what factors are helpful in body image healing of adult anorectic, female clients whose menstrual cycle has been restored through weight restoration, and I'd like you to focus solely on that segment of patients who fit this criterion. I will be asking you ten questions and some questions will have sub-questions. This will take about an hour. Do you have any questions for me? If not, let's begin.

1. Did you receive any special training in working with adult anorectic clients in recovery? If so, did you receive your training in graduate school or elsewhere? Please describe your training.
2. Now I'm going to ask you a question regarding time and frequency in therapy where you addressed body image issues. In your experience working with female anorexic clients in recovery, did you and your clients address issues around body image? If so,

- was this something you discussed throughout recovery, or, something you saw as a discrete component of treatment that occurred at a specific point in time? Please elaborate.
3. This question has to do with thinking about the female anorectic clients who are committed to recovery and have had their periods restored. What were clients' chief concerns regarding body image disturbance during this phase of treatment?
 4. For clients who are committed to recovery and have restored their periods, what specific therapeutic approaches did you find effective in helping your clients overcome body image disturbance?
 5. This question has to do with your theoretical orientation. What theoretical orientations have informed your work when focusing on the body-image healing component of your work with anorectic clients who are committed to recovery and have restored their period?
 6. This question is about using Cognitive Behavioral Therapy (CBT) as a theoretical orientation. Have you used CBT to work on body image issues? If so, what aspects of CBT were helpful?
 7. This next question has to do with treatment outcomes. I would like to know in your experience what do you think are the most powerful messages that a client takes away from psychotherapy regarding positive body messages when treatment is successful?
 8. For those anorectic clients that are in your opinion "fully recovered" what factors helped them to overcome their body image issues?

9. The literature states that body image in anorexia can be broken into two components – one component states that anorexics often overestimate the size of their body. The second component states that anorectics' body dissatisfactions result from the disparity between actual and ideal weight. What is your clinical experience around either of these components? Have size overestimation and/or actual versus ideal weight been a focal point of the body image healing in your work?
10. What component of body image have you found most challenging/resistant to change in working with your anorectic clients
11. Have you ever treated anybody for anorexia who is a person of color? If so how did their body image issues and your subsequent treatment differ, if any, from clients who are White?